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December 2015

**MEDICAID  
MANAGED CARE**

**Trends in Federal  
Spending and State  
Oversight of Costs  
and Enrollment**

# GAO Highlights

Highlights of [GAO-16-77](#), a report to congressional requesters

## Why GAO Did This Study

The importance of managed care in Medicaid—under which states contract with MCOs to provide a specific set of services—has increased as states expand eligibility for Medicaid under PPACA and increasingly move populations with complex health needs into managed care. States have flexibility within broad federal parameters to design and implement their Medicaid programs, and therefore play a critical role in overseeing managed care. GAO was asked to examine managed care expenditures and provide information on certain components of state oversight of Medicaid managed care.

In this report, GAO analyzes (1) federal expenditures for Medicaid managed care and the range in selected states' payments made to MCOs; (2) selected states' MLR standards and how they compare with federal standards for other sources of health coverage; and (3) selected states' methods for automatically assigning Medicaid beneficiaries to MCO plans. GAO analyzed federal data on Medicaid expenditures for comprehensive risk-based managed care. GAO selected eight states because they used managed care for some portion of their Medicaid population and were geographically diverse. For these states, GAO reviewed state payment data and documentation, including contracts with MCOs, and interviewed state officials. GAO also reviewed federal laws to describe MLR minimums in Medicare and the private insurance market.

The Department of Health and Human Services had no comments on this report.

View [GAO-16-77](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

December 2015

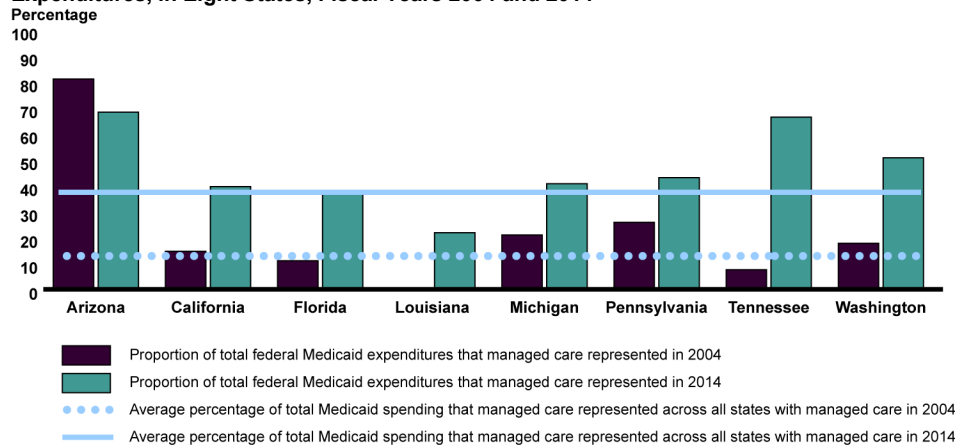
## MEDICAID MANAGED CARE

### Trends in Federal Spending and State Oversight of Costs and Enrollment

## What GAO Found

Federal spending for Medicaid managed care increased significantly from fiscal year 2004 through fiscal year 2014 (from \$27 billion to \$107 billion), and represented 38 percent of total federal Medicaid spending in fiscal year 2014. Consistent with this national trend, managed care as a proportion of total federal Medicaid spending was higher in seven of eight selected states in fiscal year 2014 compared with fiscal year 2004.

**Federal Expenditures for Medicaid Managed Care as a Percentage of Federal Medicaid Expenditures, in Eight States, Fiscal Years 2004 and 2014**



Source: GAO analysis of federal data. | GAO-16-77

Total and average per beneficiary payments by states to managed care organizations (MCOs) varied considerably across the eight selected states in state fiscal year 2014. For example, total payments ranged from \$1.3 billion in one state to \$18.2 billion in another, and average payments per beneficiary ranged from about \$2,800 to about \$5,200.

While not required by federal policy to do so, five of the eight selected states required MCOs to annually meet minimum medical loss ratio (MLR) percentages—standards that ensure a certain proportion of payments are for medical care and, in effect, limit the amount that can be used for administrative cost and profit. These state minimums generally ranged from 83 to 85 percent, similar to the 85 percent minimums established in the Patient Protection and Affordable Care Act (PPACA) for other sources of health coverage. All MCOs in the five states had MLRs in state fiscal year 2014 that were above the state-required minimums.

GAO also found that all eight selected states focused on beneficiary factors, such as assigning a beneficiary to the same managed care plan in which a family member is enrolled, when the state selects a plan for the beneficiary in the absence of the beneficiary choosing a plan—referred to as auto assignment. States also considered plan performance, for example, on quality measures and program goals, such as achieving a certain distribution of enrollment across plans. Auto assignments of beneficiaries ranged from 23 to 61 percent of managed care enrollees across the seven selected states that tracked such data.

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### Abbreviations

CMS	Centers for Medicare & Medicaid Services
FFS	fee for service
FPL	federal poverty level
HEDIS	Healthcare Effectiveness Data and Information Set
LTSS	long-term services and supports
MA	Medicare Advantage
MCO	managed care organization
MLR	medical loss ratio
NCQA	National Committee on Quality Assurance
PPACA	Patient Protection and Affordable Care Act

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December 17, 2015

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Frank Pallone Jr.  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

The importance of managed care in Medicaid—a federal-state health financing program for low-income and medically needy individuals—has increased over the past decade. Under the managed care delivery model, states typically contract with managed care organizations (MCOs) to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary per month—referred to as capitation payments—to provide those services.<sup>1</sup> In Medicaid, as in other types of health coverage, managed care is designed to ensure the provision of appropriate health care services in a cost-effective manner.

As of July 2013, the most recent enrollment data available, about 55 percent of total Medicaid enrollment was in managed care, a percentage that has likely grown since then. Under the Patient Protection and Affordable Care Act (PPACA), states may opt to expand eligibility for Medicaid to individuals at or below 138 percent of the federal poverty level (FPL), with additional federal funding available for this expansion

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<sup>1</sup>States may have different types of managed care arrangements in Medicaid. In this report, where we refer to Medicaid managed care, we are referring to comprehensive, risk-based managed care, the most common type of managed care arrangement.

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population beginning in January 2014.<sup>2</sup> Many of the people newly eligible under a Medicaid expansion were expected to be enrolled in managed care. As of May 2015, 29 states had exercised the option to expand Medicaid eligibility.<sup>3</sup> In addition, states are increasingly moving new populations of Medicaid beneficiaries into managed care, including individuals with disabilities and those with complex health care needs who require long-term services and supports (LTSS).<sup>4</sup> Increased spending for managed care will accompany this potential growth in managed care enrollment, making effective federal and state oversight of this large and complex component of the Medicaid program even more critical.<sup>5</sup>

States have flexibility within broad federal parameters to design and implement their Medicaid programs and therefore play a critical role in overseeing Medicaid managed care. Under federal Medicaid policy, states can require MCOs to meet standards—similar to those established by PPACA for Medicare and health insurance plans offered in the private market—to govern the proportion of capitated payments that MCOs must spend on medical care and other services, referred to as a medical loss

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<sup>2</sup>Pub. L. No. 111-148, §§ 2001, 10201(c), 124 Stat. 119, 271, 918 (2010), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA. Under PPACA, states may expand Medicaid eligibility under their state Medicaid plans to nonpregnant, nonelderly adults who are not eligible for Medicare and whose income does not exceed 133 percent of the FPL. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the FPL. The FPL for a family of four in the 48 contiguous states and the District of Columbia in 2015 was \$24,250; 138 percent of this amount would be \$33,465.

<sup>3</sup>For the purposes of this report, we consider the District of Columbia a state.

<sup>4</sup>LTSS include many types of health and health-related services, including both institutionally based services, such as nursing home care, and home and community based services, such as home health and adult day care. LTSS are for individuals of all ages who have limited ability to care for themselves because of physical, cognitive, or mental disabilities or conditions.

<sup>5</sup>The Medicaid program is on GAO's high risk list, in part because of concerns about managed care payment oversight and the need for better data. See GAO, *HIGH RISK SERIES: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015). For additional issues related to Medicaid managed care oversight, see GAO, *Medicaid: Key Issues Facing the Program*, [GAO-15-677](#) (Washington, D.C.: July 30, 2015).

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ratio (MLR).<sup>6</sup> States may also establish enrollment procedures for managed care, including procedures for the automatic assignment of beneficiaries to managed care plans when the beneficiary does not choose a plan for themselves, and have some discretion in setting the methods for doing so. In June 2015, the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services responsible for overseeing Medicaid—issued a proposed rule to modernize the regulations governing Medicaid managed care, thereby making the first major changes to these regulations since 2002.<sup>7</sup> The proposed rule includes provisions to align standards for Medicaid managed care with those for other sources of coverage, improve accountability for the rates paid to MCOs, ensure beneficiary protections, and promote quality care. For example, it includes provisions related to MLRs and state methods for automatically assigning beneficiaries. While certain new standards may represent a change for some states, other states may have already adopted similar standards in managing their programs.

To better understand the costs and oversight of Medicaid managed care, you asked that we provide information on spending, state MLR requirements, and certain state enrollment policies for Medicaid managed care. In this report, we provide information on

1. federal expenditures for Medicaid managed care and the range in selected states' payments made to MCOs;
2. selected states' MLR standards and how they compare with federal standards for other sources of coverage; and
3. selected states' methods for automatically assigning Medicaid beneficiaries to a managed care plan.

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<sup>6</sup>Medicare is the federal health insurance program that covers seniors aged 65 and older, and certain disabled persons and persons with end-stage renal disease. Medicare Parts A and B are known as Medicare fee-for-service. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D.

<sup>7</sup>80 Fed. Reg. 31098 (June 1, 2015).



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To examine federal expenditures for Medicaid managed care services and the range in selected states' payments to MCOs, we analyzed federal Medicaid expenditure data for federal fiscal years 2004 through 2014 and selected states' payment data for state fiscal year 2014.<sup>8</sup> Specifically, we reviewed data from CMS's Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, known as the CMS-64 form.<sup>9</sup> We reviewed these data for trends across states and over time, focusing on the federal share of spending for comprehensive, risk-based managed care.<sup>10</sup> In addition, we reviewed state data on state payments to MCOs in state fiscal year 2014 for eight selected states. We selected states that used managed care to deliver care to at least a portion of their Medicaid beneficiaries and were geographically diverse. Our selection also included states that required MCOs to meet MLR standards and states that did not. The selected states were Arizona, California, Florida, Louisiana, Michigan, Pennsylvania, Tennessee, and Washington.<sup>11</sup> (See appendix I for more information on our selected states.) To understand the range in state payments, which comprised both the federal and state shares of Medicaid expenditures, we reviewed relevant documentation for each of the states, including, where available, the most recent set of capitation rates approved by CMS, and CMS summaries of state reported information on characteristics of their managed care programs. To supplement this review, we analyzed CMS data on managed care enrollment as of July 2013, and interviewed Medicaid officials from the eight selected states. To assess the reliability of the federal expenditure data, we reviewed related documentation, including the form used to collect the data and its instructions, and performed manual and electronic tests for outliers or anomalies. We also interviewed knowledgeable officials at CMS about the data set and the form. To assess the reliability

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<sup>8</sup>In this report, unless otherwise noted, fiscal year refers to the federal fiscal year.

<sup>9</sup>State Medicaid agencies submit expenditure information to CMS on a quarterly basis by means of the CMS-64 form within the Medicaid Budget and Expenditure System. CMS collects managed care expenditures on specific lines of the CMS-64 form.

<sup>10</sup>To analyze trends over time, expenditures were adjusted for inflation using the gross domestic product price index to 2014 dollars. Under comprehensive risk based managed care, MCOs cover all or most Medicaid-covered services for beneficiaries and are at financial risk if spending on benefits and administration exceeds capitation payments from the state, which provide a set amount of payment per beneficiary per month.

<sup>11</sup>With the exception of Michigan, the state fiscal year 2014 for the selected states runs from July 2013 through June 2014. Michigan's state fiscal year 2014 is from October 2013 through September 2014.

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of the state payment data, we performed manual and electronic tests of the data to identify any outliers or anomalies, followed up with state officials as necessary, and incorporated any corrections we received. We determined that the federal and state data were sufficiently reliable for the purposes of our analyses.

To provide information on selected states' MLR standards and how they compare with federal standards for other sources of coverage, we reviewed the most recently approved or reviewed state contracts with MCOs for our eight selected states, identifying information on any required MLR minimums and potential sanctions that could be used to enforce any minimums. Where available, we also reviewed state documentation of the methodology for calculating the MLR. To supplement our review, we interviewed Medicaid officials from each of the selected states about their MLR policies and the use of any sanctions. In addition, where available, we analyzed state data on MLRs by MCO, generally for state fiscal year 2014 or calendar year 2014. Finally, we reviewed federal law and regulations, and interviewed CMS officials about MLR standards for managed care plans in Medicare and the private insurance market. To assess the reliability of the state MLR data, we performed manual and electronic tests of the data to identify any outliers or anomalies, followed up with state officials as necessary, and incorporated any corrections we received. We determined that the data were sufficiently reliable for the purposes of our analyses.

To provide information on selected states' methods for automatically assigning Medicaid beneficiaries to a managed care plan, we reviewed documentation of auto assignment methods and relevant portions of the state contracts with MCOs for our eight states, as applicable, to determine the types of factors states considered when assigning beneficiaries.<sup>12</sup> For example, we determined whether the states' methods considered beneficiary factors, such as prior enrollment in a managed

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<sup>12</sup>Six of our eight states had one auto assignment methodology, while the other two states, Arizona and Florida, had separate auto assignment methodologies for two groups of beneficiaries. Arizona had separate methodologies for acute care and long-term care beneficiaries, and Florida had separate auto assignment methodologies for its Managed Medical Assistance Standard and MediKids beneficiaries. Unless otherwise specified, references to Arizona and Florida refer to the acute or standard beneficiaries.

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care plan, in assigning beneficiaries.<sup>13</sup> We also interviewed state officials about their methods, including any planned changes to those methods. Finally, we collected and reviewed the rate of beneficiaries automatically assigned to plans from the seven states that tracked these rates, generally for fiscal year 2014, and information about how these rates were calculated.

We conducted this performance audit from March 2015 through December 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

As of December 2014, 39 states were using comprehensive, risk-based managed care in their Medicaid programs. States vary considerably in the extent to which they enroll beneficiaries in managed care versus delivering care through the more traditional fee-for-service (FFS) model.<sup>14</sup> For example, as of July 2013—the most recent enrollment data available—rates of managed care enrollment among states using it ranged from 7 to 100 percent.<sup>15</sup> (See fig. 1.) As is true with Medicaid FFS, states vary in terms of the populations and services included in their managed care programs. For example, some states carve out certain types of services from their managed care contracts, such as behavioral

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<sup>13</sup>We defined beneficiary-related factors to include factors such as: (1) prior beneficiary relationship with a plan or provider, (2) current family plan or provider, or (3) enrollment in related plans, such as an affiliated long-term care plan. We considered a state to have beneficiary factors as part of its auto assignment methods if the factors were included in the auto assignment documentation or relevant section of the state managed care contract (typically the enrollment section). For example, Louisiana specifically included prior plan relationships and other beneficiary factors in its auto assignment documentation, while Michigan addressed beneficiary factors through contract enrollment policies.

<sup>14</sup>Under FFS, Medicaid pays providers for each service provided to a Medicaid beneficiary.

<sup>15</sup>Between July 2013 and December 2014, the number of states using managed care increased from 37 to 39.

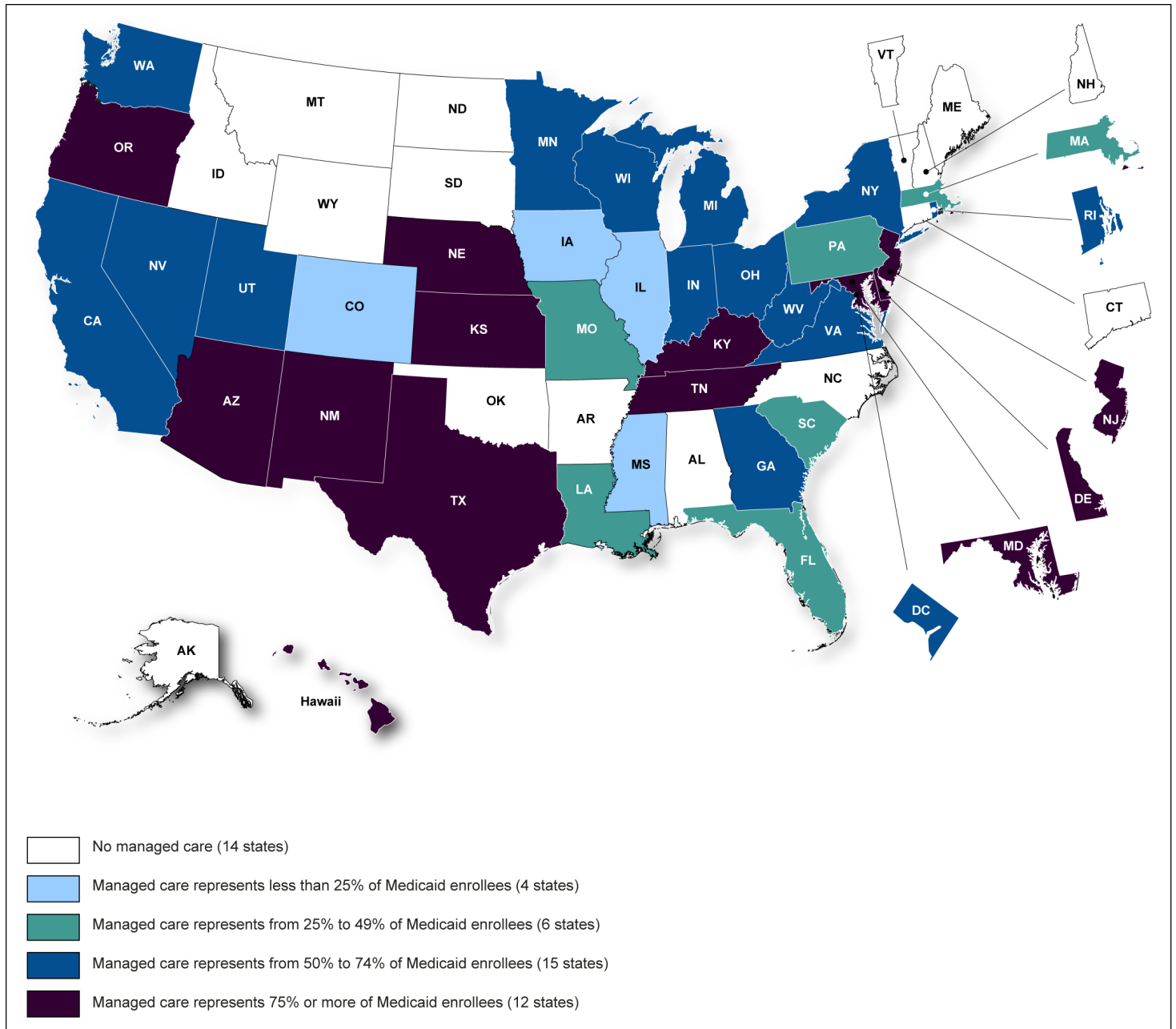
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health care services or dental services, and provide those services separately, while other states include those services.<sup>16</sup>

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<sup>16</sup>States may provide the services they carve out of their managed care contract to beneficiaries either through FFS or in another type of managed care program.

Figure 1: Comprehensive Risk-Based Managed Care Penetration in Medicaid by State, as of July 1, 2013



Sources: GAO analysis of Centers for Medicare & Medicaid Services data (data); Map Resources (map). | GAO-16-77

States have the flexibility within federal parameters to determine whether enrollment in managed care will be mandatory (required for beneficiaries)

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or voluntary (beneficiaries have a choice between managed care and FFS).<sup>17</sup> Further, states may have mandatory enrollment for some populations, but voluntary enrollment for others, and can also transition populations between voluntary and mandatory enrollment over time.

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### State Methods for Setting MCO Payment Rates

Under contracts between states and MCOs, the state pays the MCO a set amount (or “rate”) per member (or beneficiary) per month to provide all covered services and, in turn, the MCO pays providers to deliver the services. In addition to covering medical services for beneficiaries, the payment rates are expected to cover an MCO’s administrative expenses and profit. Under such contracts, the MCO is at risk for any costs above the agreed upon rate. Rates must, by law, be actuarially sound, meaning that they must be appropriate for the populations to be covered and for the services furnished.<sup>18</sup> Rates can vary by type of beneficiary to reflect estimated differences in utilization. For example, a state may have different rates for children, adults under age 65, and adults 65 years of age and older. Rates may also differ by geographic region within a state.

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### Medical Loss Ratio Standards under PPACA and in Medicaid

While not applicable to MCOs operating in Medicaid, PPACA requires that private insurers operating in the large group insurance market, as well as the organizations and sponsors offering coverage through the Medicare Advantage (MA) and Medicare Part D programs, meet or exceed an 85 percent MLR standard.<sup>19</sup> Furthermore, private insurers operating in the individual and small group markets must meet an 80

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<sup>17</sup>The level of state discretion depends on the legal authority under which the state is operating the program.

<sup>18</sup>In general, states use actuarial accounting firms to certify their annual MCO payment rates. States use either previous Medicaid MCO encounter data or claims data from the Medicaid FFS population as data sources to develop the rates. States build a certain percentage for administrative expenses and profit into the rates.

<sup>19</sup>Insurance offered by large employers is known as large group insurance. Federal law defines a large employer as having an average of 51 or more employees during the preceding calendar year; however, states may apply this definition based on an average of 101 or more employees. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

MA is the private plan alternative to the traditional Medicare FFS program. CMS contracts with MA organizations to provide covered services to beneficiaries who enroll in one of their plans. Under Medicare Part D, prescription drug plan sponsors—including private health insurers—contract with CMS to provide a voluntary outpatient prescription drug benefit for Medicare beneficiaries.

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percent MLR minimum.<sup>20</sup> To comply with these standards, under PPACA, insurers, MA organizations, and Part D sponsors with a relatively small enrollment have some flexibility in accounting for the disproportionate effect of random claims variability (where actual claims experience varies significantly from what is expected) on their ability to meet the MLR standard. While all insurers may experience some random claims variability, the effect of these deviations is greater for insurers with a small customer base.

PPACA mandated a specific MLR formula for private insurers, and CMS rules implementing MLRs in Medicare established a specific formula for MA organizations and Part D sponsors.<sup>21</sup> For example, the MLR for private insurers expresses the percentage of premiums collected (less state and federal taxes, and licensing and regulatory fees) that insurers spend on their beneficiaries' medical claims and quality improvement activities.<sup>22</sup> In general, the greater the share of beneficiaries' premiums spent on medical claims and quality initiatives, the higher the MLR. (See fig. 2.)

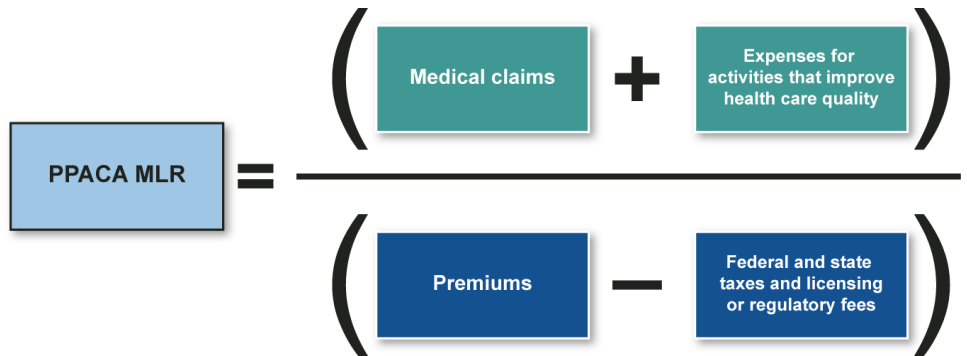
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<sup>20</sup>Insurance purchased by individuals in a non-group setting is individual insurance. Insurance offered by small employers is known as small group insurance. Federal law defines a small employer as having an average of 1 to 50 employees during the preceding calendar year; however, states may apply this definition based on an average of 1 to 100 employees. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

<sup>21</sup>Private Insurers: Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 136, 885 (codified at 42 U.S.C. 300gg-18(b)(1)(A)), 45 C.F.R. §§ 158.101 et seq. (2014); MA organizations: 42 C.F.R. § 422.2400 et seq. (2014); Part D sponsors: 42 C.F.R. § 423.2400 et seq. (2014).

<sup>22</sup>MA organizations and Medicare Part D plan sponsors must also account for direct benefits to beneficiaries in the form of reductions, if any, of Medicare Part B premiums. Specifically, the MLR for MA organizations and Part D plan sponsors is expressed as the percentage of total revenue (less state and federal taxes, and licensing and regulatory fees) that is spent on medical claims, quality improvement activities, and any direct benefits to beneficiaries in the form of reduced Medicare Part B premiums.

**Figure 2: PPACA Medical Loss Ratio (MLR) Formula for Private Insurers**



Source: GAO. | GAO-16-77

Note: This figure represents the formula used by private insurers required to meet the minimum MLR established under the Patient Protection and Affordable Care Act (PPACA). Medicare Advantage organizations and Medicare Part D plan sponsors, which are also subject to an MLR minimum under PPACA, must use a slightly different formula.

MLR requirements established under PPACA include as expenses for quality improvement activities that are primarily designed to (1) improve health outcomes; (2) prevent hospital readmissions; (3) improve patient safety and reduce medical errors; or (4) implement, promote, and increase wellness and health activities. Insurers are also allowed to include certain other expenses, such as health information technology required to accomplish activities to improve healthcare quality.<sup>23</sup> As such, insurers are able to include expenses for a variety of activities in the numerator of the MLR formula. Examples of such quality improvement activities include case management, care coordination, medication and care compliance initiatives, patient-centered education and counseling, activities to lower the risk of facility-acquired infections, and wellness assessments.

Under these requirements, for each year that a private insurer does not meet the required MLR minimum, it must pay rebates to its

<sup>23</sup>See 45 C.F.R. §§ 158.150(b), 158.151 (2014).



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policyholders.<sup>24</sup> Likewise, MA organizations and Medicare Part D sponsors must pay CMS a remittance if they do not meet the required MLR minimum in a contract year.<sup>25</sup> MA organizations and Medicare Part D plans are also subject to enrollment sanctions and contract termination after failing to meet the MLR requirement for three and five consecutive years, respectively.

States are not required under federal policy to have contracted MCOs meet a minimum MLR standard. However, states may choose to establish their own MLR standards governing the proportion of capitation payments MCOs may be required to spend to provide medical services to beneficiaries, thus, limiting the amount of payments allowed for MCO profit and administrative expenses.<sup>26</sup> States may also choose to establish their own formula for calculating MLRs for contracted MCOs.

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## Auto Assignment in Medicaid Managed Care

When automatically assigning a beneficiary to a Medicaid managed care plan offered by an MCO, states may offer beneficiaries a certain amount of time (the length of which is at the discretion of the state) to choose a plan at the time of enrollment. If the beneficiary does not choose the plan within that time frame, the state automatically assigns—or defaults—the beneficiary to a plan. Alternatively, in some cases, states can automatically assign beneficiaries to a plan at the time of enrollment, providing them no initial period during which to choose among plan offerings. The beneficiary is then given a certain number of days after the

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<sup>24</sup>In our previous work on the implementation of MLR requirements, we found that private insurers paid about \$1.1 billion in total rebates to enrollees and policyholders who paid premiums in 2011, the first year that insurers were subject to the PPACA MLR requirements, and about \$520 million in rebates in 2012. See GAO, *Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees*, [GAO-14-580](#) (Washington, D.C.: July 10, 2014).

<sup>25</sup>The rebates for private plans and the remittances for MA organizations and Part D plans are determined by taking the difference between the applicable PPACA MLR standard and the insurer's actual MLR and multiplying it by the insurer's premiums, after federal and state taxes, and licensing or regulatory fees are removed.

<sup>26</sup>Under CMS's proposed rule, if the state requires MCOs to meet an MLR minimum, that minimum would have to be 85 percent or higher. In addition, CMS's proposed rule would require states to ensure that MCOs calculate and report MLRs annually, and that the reported MLRs are taken into account in the rate setting process and rates would be set such that MCOs can reasonably achieve an MLR of at least 85 percent.

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assignment is made to opt out and choose another plan if they do not want to be enrolled in the one into which they were assigned.

Current Medicaid policy requires states to consider certain factors—with some factors taking priority—in designing auto assignment methods, but also allows states discretion to consider other factors. States using a default enrollment process must give priority to maintaining existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries.<sup>27</sup> If that is not possible, states must equitably distribute beneficiaries among participating plans. However, states may also consider other factors, such as a beneficiary’s geographic location or the enrollment preferences of their family members.

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## Federal Spending for Medicaid Managed Care Was Over \$100 Billion in 2014, and Selected States’ Payments to Managed Care Organizations Varied Widely

Federal spending for Medicaid managed care nationally increased significantly from federal fiscal years 2004 through 2014, representing over a third of total federal Medicaid spending in 2014. Total payments to MCOs and average per beneficiary payments showed considerable variation across selected states in state fiscal year 2014.

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<sup>27</sup>See 42 C.F.R. § 438.50(f) (2014). An “existing provider-beneficiary relationship” is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year.

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## Federal Spending for Medicaid Managed Care Represented 38 Percent of Total Federal Medicaid Spending in 2014

Federal spending for Medicaid managed care increased significantly over the past decade—from \$27 billion in fiscal year 2004 to \$107 billion in fiscal year 2014—and represented a significantly larger portion of total federal Medicaid spending in 2014 than it did 10 years earlier.<sup>28</sup>

Specifically, managed care expenditures grew as a proportion of overall federal Medicaid spending from 13 percent in fiscal year 2004 to 38 percent in fiscal year 2014.<sup>29</sup> (See fig. 3.) A number of factors have likely contributed to growth in federal expenditures, including states increasing the proportion of their population that they enroll in managed care. For example, in state fiscal year 2014, Florida expanded the populations for which managed care was mandatory, which increased enrollment from 1.4 million to just fewer than 3 million beneficiaries, according to state officials. There was also significant growth from fiscal years 2013 through 2014, which suggests that the Medicaid expansion to low-income adults—and the increased availability of federal funds beginning in January 2014—also contributed to growth.<sup>30</sup> CMS’s Office of the Actuary reported in 2015 that Medicaid expenditures for and enrollment in managed care has grown in recent years and projected accelerated growth over the next 10 years.<sup>31</sup> The office attributed this acceleration to many states continuing to enroll those newly eligible due to the Medicaid expansion in managed care and the expanded use of managed care to cover the aged and disabled, and LTSS.

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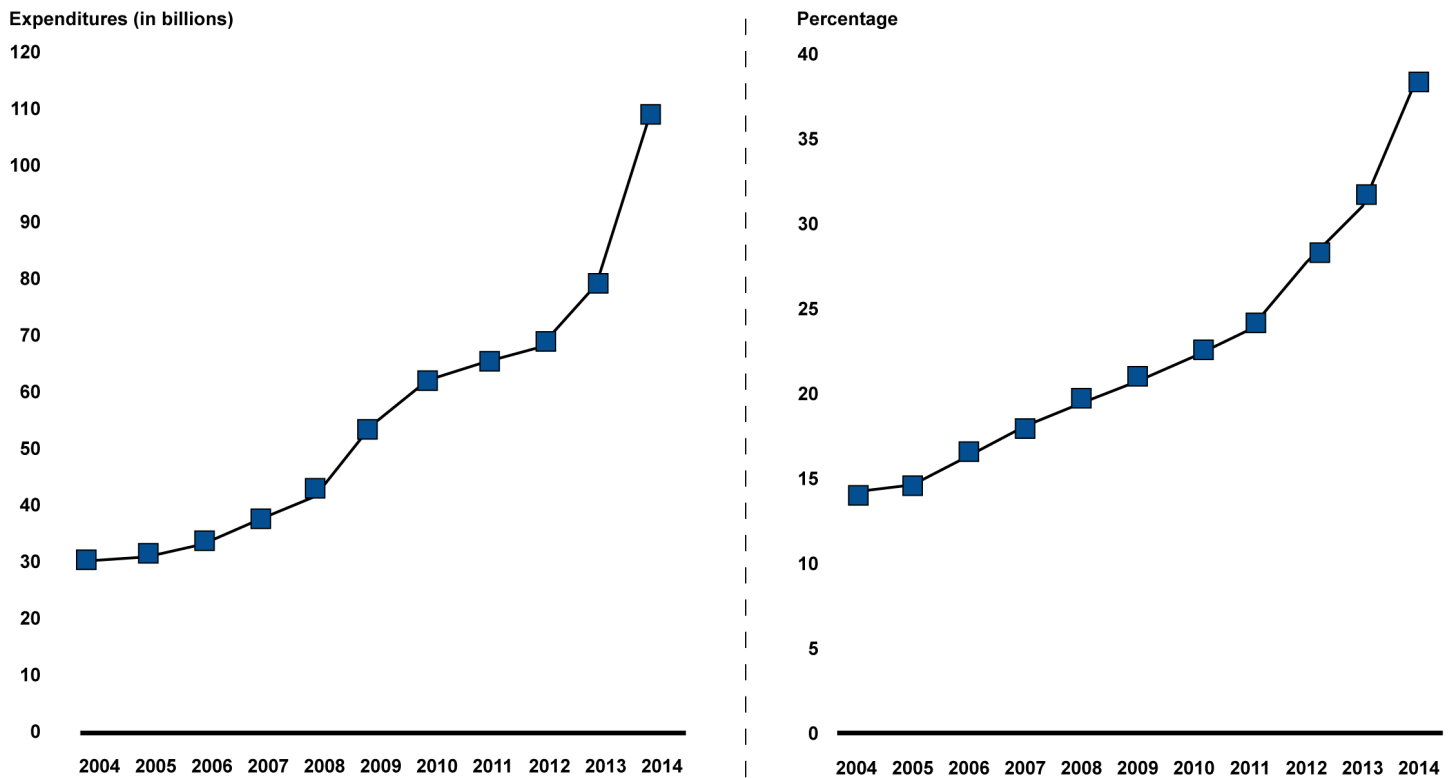
<sup>28</sup>These numbers reflect federal expenditures for comprehensive, risk-based managed care reported by all states and the District of Columbia. Combined federal and state spending for managed care in fiscal year 2014 totaled \$170 billion.

<sup>29</sup>For this analysis, expenditures were adjusted for inflation using the gross domestic product price index to 2014 dollars. The proportion of federal expenditures for managed care in fiscal year 2014 was slightly higher than the proportion of state expenditures for that purpose—38 percent and 34 percent, respectively. Expenditures for managed care in 2014 represented 36 percent of total, combined federal and state Medicaid expenditures.

<sup>30</sup>The federal government matches state expenditures for Medicaid services on the basis of a statutory formula based, in part, on a state’s per capita income. Federal law specifies that this federal match may range from 50 to 83 percent. For states that expand Medicaid, the federal government will pay an enhanced match—100 percent of the cost of covering newly eligible enrollees—in 2014, 2015, and 2016, with the federal match gradually reduced to 90 percent by 2020.

<sup>31</sup>See Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2014 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

**Figure 3: Federal Comprehensive Risk-Based Medicaid Managed Care Expenditures, Total and as a Percentage of Overall Federal Medicaid Expenditures, Fiscal Years 2004-2014**



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-77

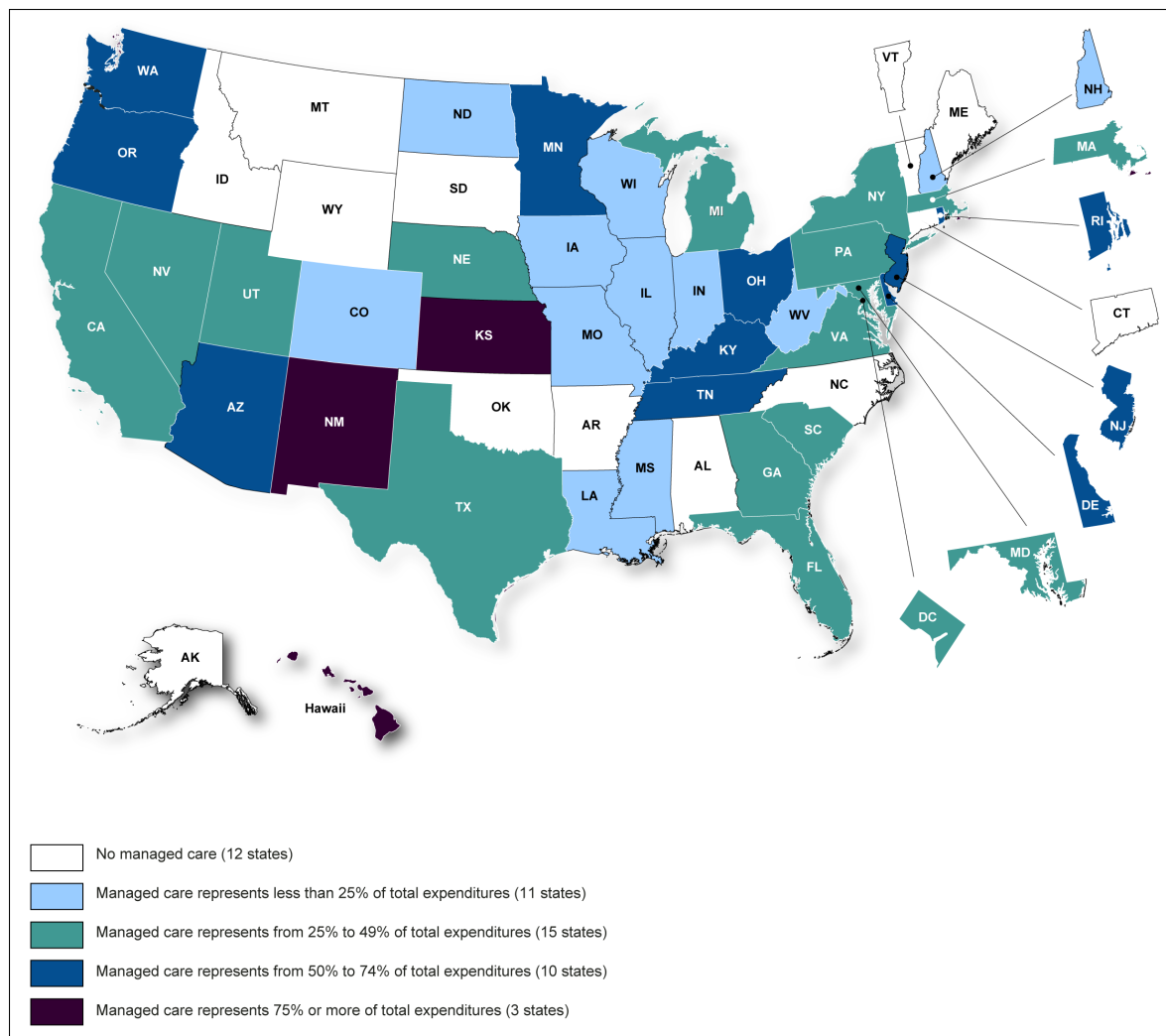
Note: For this analysis, expenditures were adjusted for inflation using the gross domestic product price index to 2014 dollars.

Federal expenditures for managed care varied widely by state—ranging from \$5.8 million in North Dakota to \$14.3 billion in California—in fiscal year 2014.<sup>32</sup> (See appendix II for expenditures by state.) Also, in fiscal year 2014, federal spending for managed care as a percentage of total federal Medicaid spending varied considerably across the 39 states with managed care. For example, in 11 states, expenditures for managed care represented less than 25 percent of total federal Medicaid expenditures,

<sup>32</sup>Differences in the federal matching rate, which can range from 50 to 83 percent, may have contributed to this variation.

while in 3 states such expenditures represented 75 percent or more of total federal Medicaid expenditures. (See fig. 4.)

**Figure 4: Federal Expenditures for Comprehensive Risk-Based Managed Care as a Percentage of Total Federal Medicaid Expenditures, Fiscal Year 2014**

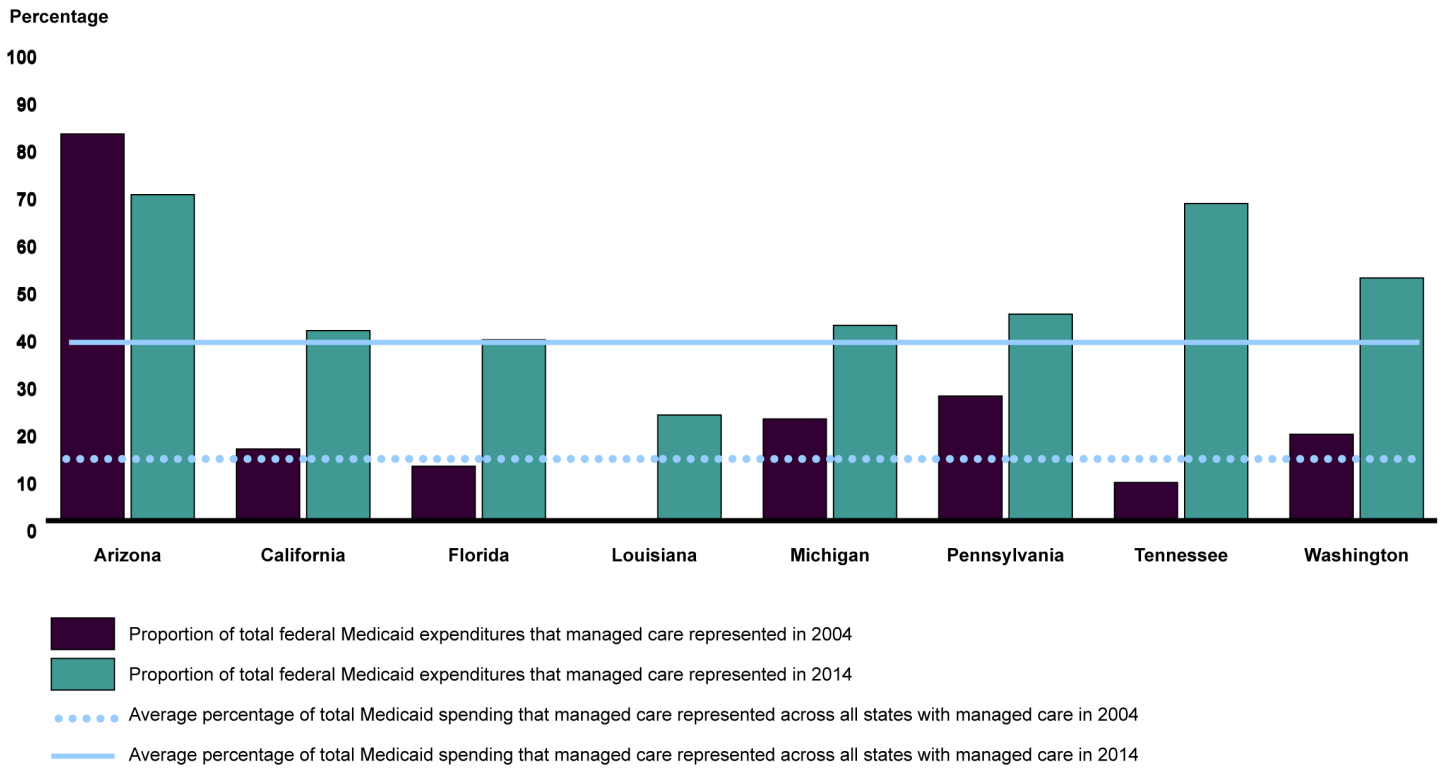


Sources: GAO analysis of Centers for Medicare & Medicaid Services data (data); Map Resources (map). | GAO-16-77

Consistent with the national trend, in seven of our eight selected states, the proportion of total federal Medicaid spending represented by managed care was significantly higher in fiscal year 2014 than in fiscal year 2004, with increases ranging from 17 to 59 percent. For one state—

Arizona—the proportion of managed care expenditures as a percentage of total Medicaid expenditures declined from 82 percent in 2004 to 69 percent in 2014. However, state officials attributed the entire decline to a change in how behavioral health expenditures were reported by the state, with the 2004 data including behavioral health expenditures and 2014 not including them. (See fig. 5.)

**Figure 5: Federal Expenditures for Comprehensive Risk-Based Medicaid Managed Care as a Percentage of Total Federal Medicaid Expenditures in Eight Selected States, Fiscal Years 2004 and 2014**



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-77

Notes: For this analysis, expenditures were adjusted for inflation using the gross domestic product price index to 2014 dollars. Arizona officials told us that the state reported behavioral health service expenditures as part of comprehensive risk-based managed care in 2004, but did not include those expenditures in data reported for 2014.

Total and Average per Beneficiary Payments Varied Considerably across Selected States, with Differences in Covered Populations and Services Contributing to the Variation

Reflecting variation common in the Medicaid program, generally, state payments to MCOs varied considerably across and within states. In state fiscal year 2014, total capitated payments to MCOs in the eight selected states ranged from \$1.3 billion in Louisiana to \$18.2 billion in California.<sup>33</sup> Payments to individual MCOs ranged from \$17.3 million to \$3.1 billion across states and varied widely within some states, with at least one MCO receiving payments above \$1 billion in six of the eight states. (See table 1.)

**Table 1: Capitation Payments to Medicaid Managed Care Organizations (MCOs) in Selected States, State Fiscal Year 2014**

State	Capitated payments by state to MCOs			
	Number of MCOs	Minimum (millions)	Maximum (millions)	Total (billions)
Arizona <sup>a</sup>	9	\$107.5	\$1,344.1	<b>4.5</b>
California	22	164.8	3,107.6	<b>18.2</b>
Florida <sup>b</sup>	38	0.01	774.7	<b>4.5</b>
Louisiana	3	401.6	467.8	<b>1.3</b>
Michigan	13	17.3	1,238.1	<b>5.2</b>
Pennsylvania	8	360.9	2,684.5	<b>8.4</b>
Tennessee	3	886.7	2,594.6	<b>5.2</b>
Washington	5	302.8	1,096.0	<b>3.1</b>

Source: GAO analysis of state reported data. | GAO-16-77

Note: In states with multiple comprehensive risk-based managed care programs or models, these data include payments to MCOs in all programs or models.

<sup>a</sup>Arizona's numbers include data for one MCO that participated for only a portion of the state fiscal year.

<sup>b</sup>During state fiscal year 2014, Florida began phasing in mandatory enrollment in managed care statewide. Thus, the data do not reflect a full year of the expanded program, and some MCOs may have only participated in the program for a portion of the year.

The average annual amount of payment per beneficiary also varied significantly across the selected states. Specifically, average capitated payments per beneficiary ranged from \$2,784 in California to \$5,180 in Pennsylvania for state fiscal year 2014.<sup>34</sup> (See table 2.)

<sup>33</sup>Capitation payments include both the state and federal share of the cost, as applicable.

<sup>34</sup>These numbers reflect the average payment per full year equivalent, which represents 12 months of enrollment.

**Table 2: Average Per Beneficiary Payments to Medicaid Managed Care Organizations (MCOs) in Selected States, State Fiscal Year 2014**

State	Beneficiaries (full-year equivalents)	Total capitated payments to MCOs (billions)	Average payment per beneficiary	Populations enrolled included those qualifying for LTSS <sup>a</sup>	Examples of services excluded from capitation <sup>b</sup>
Arizona	1,206,517	\$4.5	\$3,766	✓	Behavioral health services and related prescription drugs
California	6,552,653	18.2	2,784	✓	Inpatient behavioral health and dental
Florida	1,428,520	4.5	3,136		Institutional long term care and inpatient behavioral health
Louisiana	423,071	1.3	3,092		Behavioral health and dental
Michigan	1,371,734	5.2	3,785		Inpatient behavioral health and dental
Pennsylvania	1,620,614	8.4	5,180		Behavioral health
Tennessee	1,174,378	5.2	4,403	✓	Pharmacy and pediatric dental
Washington	942,749	3.1	3,259		Behavioral health and dental

Source: GAO analysis of state data and Centers for Medicare & Medicaid Services documentation. | GAO-16-77

<sup>a</sup>State enrollment of beneficiaries who qualify for long-term services and supports (LTSS) into managed care may be limited to certain counties.

<sup>b</sup>Examples of services excluded from capitation payments are not comprehensive; states may exclude additional services. Services may be excluded from the capitation rate for some populations, but not others.

A number of factors may have contributed to the variation in average per beneficiary cost.

- **The populations the state enrolled in managed care:** States varied in the populations they enrolled in managed care. For example, three of our selected states enrolled elderly or disabled beneficiaries qualifying for LTSS in their managed care programs, while the remaining five did not.<sup>35</sup> In Arizona, the average annual payment per beneficiary for the population qualifying for LTSS was \$37,700 compared to the average annual payment of \$3,000 for all other populations.

<sup>35</sup>CMS data indicated that 14 of the 37 states with managed care as of July 2013 enrolled individuals requiring LTSS.



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- **The services included in the capitation rate:** Some of our selected states carved certain types of services out of their programs and provided them separately.<sup>36</sup> For example, Arizona provided behavioral health care through separate programs for certain populations. In contrast, Tennessee included those services in its program.
  - **Geographic differences in costs and utilization of care:** Our review of approved rates indicated that rates for similar populations could differ across states. Because rates reflect a state's assumptions on utilization and cost for a given population and are generally developed using cost data from previous years, the variation across states likely reflects some geographic differences in costs and utilization. For example, payment rates for children under the age of 1 ranged from \$416 to \$769 per beneficiary per month across four of our selected states that specified a rate for that age group.<sup>37</sup> Similarly, in the four states with a separate rate for maternity care, rates ranged from about \$4,960 in areas of one state to over \$11,000 in certain areas of another state.<sup>38</sup> Rates also ranged regionally within several states. For example, one state approved rates at the county level and its rates for children under the age of 1 ranged from \$416 to \$551 per beneficiary per month. In past work, we found that service utilization in managed care varied by state and by population—including whether beneficiaries were enrolled for a full year or part of a year—and that MCO payments to providers for particular services can also vary considerably across states.<sup>39</sup>

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<sup>36</sup>CMS data indicated that of the 37 states with managed care as of July 2013, 3 provided LTSS separately, 13 provided behavioral health services separately, 5 provided dental services separately, and 10 provided transportation services separately.

<sup>37</sup>For the state with the lowest rate, rates were for calendar year 2013. For the state with the highest rate, the rates were for calendar year 2015. For the two remaining states, rates were for contract year and state fiscal year 2014, respectively.

<sup>38</sup>For the state with the lowest rate, rates were for the contract year beginning in February 2015. For the state with the highest rate, the rates were for July through December of 2014. For the two remaining states, rates were for contract year and state fiscal year 2014, respectively.

<sup>39</sup>See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, [GAO-15-481](#) (Washington, D.C.: May 29, 2015) and *Medicaid Payment: Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance*, [GAO-14-533](#) (Washington, D.C.: July 15, 2014).

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## Over Half of Selected States Set Medical Loss Ratio Minimums Similar to Federal Standards for Other Coverage Types, with Some Variation in Calculation Methods

Five of our eight selected states—Arizona, Florida, Louisiana, Michigan, and Washington— required MCOs to annually meet a minimum MLR percentage. The MLR minimums required in the five states generally ranged from 83 to 85 percent for most populations. The exception to this range was that Washington set a separate MLR minimum for its program covering beneficiaries who are blind or disabled at 88 percent.<sup>40</sup> The required minimums in the five states were similar to the 85 percent federal MLR minimum mandated by PPACA for private, large group insurers, MA organizations, and Part D sponsors.<sup>41</sup> (See table 3.)

The methodologies used to calculate the MLRs differed across the five states with required MLR minimums. These differences in methodology were most pronounced regarding whether the state counted MCO expenses for activities to improve health care quality as expenses that qualify toward meeting the state’s required minimum. Three of the five states specifically allowed MCOs to include activities to improve health care quality, as PPACA allows for private insurers, MA organizations, and Part D plan sponsors. The remaining two states either accounted for more limited quality activities—for example, Arizona allowed for the inclusion of case management for its LTSS population—or did not account for them at all. All else being equal, states that allow MCOs to include the costs of quality activities would expect to see higher MLRs. We also found differences in how states defined medical expenditures for inclusion in the MLR calculation. For example, Florida allowed MCOs to include funds provided to graduate medical education institutions to underwrite residency position costs and contributions to the state trust fund for the purpose of supporting Medicaid and indigent care in the numerator as medical expenses.

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<sup>40</sup>While not an MLR minimum, Washington applies an MLR risk corridor of 86 to 92 percent to MCOs that is specific to the adult expansion population. This risk corridor represents the range of MLRs that the state ensures is maintained for the adult expansion population covered by MCOs. If an MCO has an MLR for this population that is below 86 percent it must refund a certain proportion of funds to the state. If it has an MLR that is above 92 percent, the state will pay additional funds to the MCO up to a defined threshold.

<sup>41</sup>As previously noted, under CMS’s proposed rule, if the state requires MCOs to meet an MLR minimum, that minimum would have to be 85 percent or higher. In addition, CMS’s proposed rule would require states to ensure that MCOs calculate and report MLRs annually, that the reported MLRs are taken into account in the rate setting process, and that rates would be set such that MCOs can reasonably achieve an MLR of at least 85 percent.

**Table 3: State Required Medicaid Medical Loss Ratio (MLR) Minimums in Selected States in Calendar Year 2014 Compared With Federal Minimums for Other Coverage Types**

	State MLR minimum	Inclusion of quality activities in the MLR numerator
<b>States with a required MLR minimum</b>		
Florida <sup>a</sup>	85%	Yes
Louisiana	85%	Yes
Washington <sup>b</sup>	85%	Yes
Arizona	85%	Partial <sup>c</sup>
Michigan	83%	No
<b>Coverage types with required federal MLR minimum</b>		
Large group private	85%	Yes
Small group private	80%	Yes
Medicare—Medicare Advantage organizations and Part D plan sponsors	85%	Yes

Source: GAO analysis of state documentation, statements by state officials, and federal law. | GAO-16-77

Note: State requirements are for managed care organizations (MCOs) providing comprehensive risk-based managed care.

<sup>a</sup>Florida’s required minimum is applicable to the acute care program. The state’s program for the population requiring long-term services and supports is not subject to an MLR minimum requirement.

<sup>b</sup>Washington has two programs—Apple Health Family and Apple Health Blind/Disabled—that are subject to different MLR requirements. The table reflects the required MLR minimum for the Apple Health Family program. The MLR minimum for the Apple Health Blind/Disabled program is 88 percent. The MLR minimum requirement in Washington represents the MLRs that MCOs must have in order to keep its profits and not share them with the state. If an MCO has an MLR between 83 and 85 percent it would have to share profits with Washington. MCOs with MLRs below 83 percent would have to pay the state all of its profits that exceed 5 percent for the year. Washington refers to this as a gain-sharing model.

<sup>c</sup>Arizona includes case management in the calculation of MLRs for MCOs that enroll its long-term services and supports beneficiary population. It does not include case management or any other quality activities in the calculation of MLRs for MCOs that enroll its acute care population.

Three of the remaining eight selected states—California, Pennsylvania, and Tennessee—did not require MCOs to meet MLR minimums, but did monitor MLRs. For example, Tennessee officials explained that the state has routine processes in place to monitor MLR performance. The state requires MCOs to submit annual MLR reports, and according to officials, will follow up with MCOs if it has concerns about reported MLRs. Officials from California told us the state uses MCO MLRs to observe trends for most populations in its managed care programs. The state Medicaid agency does not require MCOs to submit MLR-specific data, but does

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calculate MLRs for MCOs using their reported financial information.<sup>42</sup> Additionally, in 2014, for the adult expansion population only, California applied an MLR risk corridor of 85 to 95 percent to MCOs. While not an MLR minimum, this risk corridor represented the range of MLRs that the state maintains for the adult expansion population covered by MCOs.<sup>43</sup>

Data provided by the five selected states with required MLR minimums indicated that MLRs were above the required minimums for all MCOs in 2014. Among the three selected states without required minimums, the average reported MLRs fell generally within the same range as the states with required minimums. (See table 4.) Furthermore, officials from the five states with required MLR minimums told us that their participating MCOs generally met the MLR minimums. A high percentage of MCOs meeting the MLR minimums may be expected; for example, we found in previous work that over three quarters of private insurers met or exceeded the PPACA MLR minimum requirement in 2011 and 2012.<sup>44</sup>

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<sup>42</sup>In its proposed rule, CMS would require that MCOs annually submit a report to states containing pertinent information for calculating the MLR. These elements would be reconciled with the audited financial reports that CMS also proposes that plans submit to states annually.

<sup>43</sup>If an MCO has an MLR for its expansion population that is below 85 percent it must pay the state the difference between 85 percent of total net capitation payments to the MCO and the actual allowed medical expenses incurred for that region. If an MCO has an MLR for its adult expansion population that is above 95 percent, then the state will pay the MCO the difference between the MCO's allowed medical expenses and 95 percent of net capitation payments received for that region. Pennsylvania is planning to implement a similar MLR risk corridor policy in 2015.

<sup>44</sup>[GAO-14-580](#).

**Table 4: Reported Medical Loss Ratios (MLR) in Selected States, Calendar or State Fiscal Year 2014**

State	State MLR minimum requirement	Weighted average of reported MLR	Range of reported MLRs	Inclusion of quality activities in the MLR numerator
<b>States with MLR minimum requirements</b>				
Florida <sup>a</sup>	85%	92%	87%-117%	Yes
Louisiana	85%	92%	91%-93%	Yes
Washington <sup>b</sup>	85%	89%	86%-100%	Yes
Arizona	85%	89%	87%-98%	Partial <sup>c</sup>
Michigan	83%	87%	84%-93%	No
<b>States without MLR minimum requirements</b>				
California	n/a	89%	74%-98%	No
Pennsylvania	n/a	91%	88%-97%	No
Tennessee	n/a	86%	85%-87%	No

Source: GAO analysis of state data and documentation, and statements by state officials. | GAO-16-77

Notes: State requirements and reported MLRs are for managed care organizations (MCOs) providing comprehensive risk-based managed care. Reported MLRs are for state fiscal or calendar year 2014, and may not coincide with the state contract year. As such, they may not reflect the MLRs that were used to assess MCO compliance or to trigger a sanction if appropriate. Reported MLRs were for the following time periods: Louisiana's and Washington's were for calendar year 2014; California's, Florida's, Pennsylvania's, and Tennessee's were for state fiscal year 2014; Arizona's were for contract year 2014; and Michigan's were for the final quarter of state fiscal year 2014. According to Michigan officials, these quarterly MLRs are representative of state fiscal year 2014 MLRs. Weighted averages were developed using enrolled beneficiary months in state fiscal year 2014, with the exception of Florida where the averages were weighted based on expenditures.

<sup>a</sup>Florida's data reflects MLRs for 12 of the 38 MCOs contracting with the state in state fiscal year 2014. During 2014, the state expanded its managed care program, and the state had not calculated MLRs for MCOs added to the program in that year.

<sup>b</sup>Washington has two programs—Apple Health Family and Apple Health Blind/Disabled—that are subject to different MLR requirements. The table reflects the required MLR minimum and the range of reported MLRs for the Apple Health Family program. The MLR minimum for the Apple Health Blind/Disabled program is 88 percent, and the reported MLRs ranged from 98 percent to 108 percent. The MLR minimum requirement in Washington represents the MLRs that MCOs must have in order to keep its profits and not share them with the state. If an MCO has an MLR between 83 and 85 percent it would have to share profits with Washington. MCOs with MLRs below 83 percent would have to pay the state all of its profits that exceed 5 percent for the year. Washington refers to this as a gain-sharing model.

<sup>c</sup>Arizona includes case management in the calculation of MLRs for MCOs that enroll its long-term services and supports beneficiary population. It does not include case management or any other quality activities in the calculation of MLRs for MCOs that enroll its acute care population.

If MCOs do not meet the minimum MLR requirements, there are a range of sanctions that our selected states might impose, but officials from the five states with required minimums confirmed that they had employed sanctions related to MLR requirements rarely if at all in the last three

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contract or fiscal years. Potential sanctions outlined in MCO contracts included requiring MCOs to submit corrective action plans, restricting an MCO's enrollment by freezing automatic assignment, or terminating an MCO from the managed care program. Two of the five states with MLR minimum requirements for Medicaid managed care—Louisiana and Washington—require MCOs to reimburse the state if the MLR minimum requirements are not met. Officials from Louisiana—which requires MCOs to pay a rebate—were not aware of any occasion where the state sought a rebate from an MCO.<sup>45</sup> Washington officials told us that one of its MCOs did not meet MLR minimums for the July 1, 2012, through December 31, 2013, contract, and as a result, was required to pay the state over \$4 million.

Information from two states indicated that they also monitor MCOs with MLRs that they consider to be high, because high MLRs could be an indication that rates are not adequate. Specifically, Florida indicated that the state will monitor the financial performance of MCOs with MLRs at or above 95 percent. In addition, although Tennessee does not have a required MLR minimum, officials indicated that they engage MCO representatives about MCO fiscal performance if MLRs are trending above 92 percent, as well as if they are trending below 85 percent. Officials told us the state also used the MLR as a measure to inform their rate setting process, which is done to determine whether the rates paid to MCOs are appropriate and sufficient.<sup>46</sup>

Interviews with state officials indicated that MLR standards are just one of several methods used by states in their effort to ensure that MCOs are using an appropriate amount of payments to provide medical care. Officials from seven of the eight states indicated that they also use the rate setting process, during which states review data on medical and administrative costs for prior years. In Tennessee, officials told us that the

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<sup>45</sup>The preamble to CMS's proposed rule encourages, but would not require, states to use remittances as an incentive for MCOs to comply with a state MLR requirement if implemented.

<sup>46</sup>Under CMS's proposed rule, rates must be set to allow MCOs to account for a reasonable amount of administrative costs. In the preamble, CMS explained that in addition to setting rates such that MCOs are allowed to reasonably achieve an MLR of at least 85 percent, states should set rates so that MLRs do not exceed a reasonable maximum threshold to account for reasonable administrative costs.

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state surveys MCOs to obtain specific data regarding their administrative costs.

Officials from several states with MLR minimums questioned their effectiveness and stated that they may not be applicable to all populations and programs. For example, officials from one state with a required MLR minimum explained that if an MCO disproportionately covers an inherently high-expenditure population (such as patients with human immunodeficiency virus), it will be easier for it to meet the MLR minimum than another MCO that has an inherently less expensive patient mix (such as children). Furthermore, officials from two other states with required minimums told us that the potential subjectivity in classifying certain expenses may dilute the usefulness of the MLR. CMS officials told us that MLR minimums are one measure of assessing MCO performance and that MLRs should be interpreted in the larger context. Officials noted that if a state were to set a 90 percent minimum and an MCO reports an MLR of 80 percent, it could be that the rates were set too high and the state overpaid. It could also mean that the rates were set appropriately, but the MCO performed very efficiently.

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## Selected States' Auto Assignment Methods Primarily Focused on Beneficiary Factors, and Then Considered Plan Performance and Program Goals

The eight selected states varied in their methodologies for automatically assigning beneficiaries to plans offered by MCOs, but all of them first considered beneficiary factors, such as prior participation in a plan offered by a Medicaid MCO.

- Louisiana, for example, assessed four specific beneficiary factors to determine plan auto assignments; namely, whether the beneficiary had (1) family members who participated in a particular health plan; (2) a prior primary care provider who is participating in a Medicaid plan in the state; (3) prior claims history that could be used to identify a most frequently visited primary care provider; and (4) a Medicaid plan in which they were previously enrolled.
- Tennessee's auto assignment method also initially considered beneficiary factors, for example, by re-enrolling beneficiaries who had lost Medicaid eligibility in the plan in which they were previously enrolled.
- Washington's and Michigan's processes prioritized automatically assigning beneficiaries to the same plan as family members.

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After considering beneficiary factors, four states—Arizona, California, Michigan, and Washington—also considered a variety of plan performance factors, such as performance on quality measures, in their auto assignment methodologies. Michigan and California assigned points to plans—that is, they gave preference to plans based on performance on multiple measures, such as the provision of well-child visits or comprehensive diabetes care. Michigan officials told us they change the performance measures considered on a quarterly basis to avoid a preference for plans that consistently do well in only a few measures. California also awarded points to account for plan improvement. Beginning in July 2014, Washington began considering plan performance on the completion of beneficiaries’ initial health screens. According to state officials, including this measure in its auto assignment methods has been a useful tool in helping the state increase the initial health screening rate among beneficiaries. While not all of our selected states linked auto assignment to performance on quality measures, they all required MCOs to report on quality measures, including nationally recognized or other state-developed measures. Further, six of the eight selected states required MCOs to be accredited by the National Committee on Quality Assurance (NCQA) or other accrediting organization, a process that includes an independent review of the MCO and assessment of performance on quality. (See appendix III for more information on the selected states’ methods for overseeing MCO quality.)

Three of these states also considered administrative, cost, or other plan performance factors in their auto assignment methodologies. For example, Michigan assigned points based on administrative measures, such as performance on claims processing. Arizona’s methodology factored capitation rates and scores on the plan’s contract proposal, with plans with the lowest awarded capitation rate and highest proposal score receiving an advantage in auto assignments. In addition to cost, California’s auto assignment method included plan performance on two safety net measures, with plans earning points based on how the plan compares to the other plan scores in their geographic region.

All eight of our selected states considered overall program goals in their auto assignment methods.<sup>47</sup> (See figure 6 for an illustration of a state auto assignment method that considers beneficiary factors, plan performance,

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<sup>47</sup>Overall program goals were generally considered after plan performance factors in the four states that considered such factors.

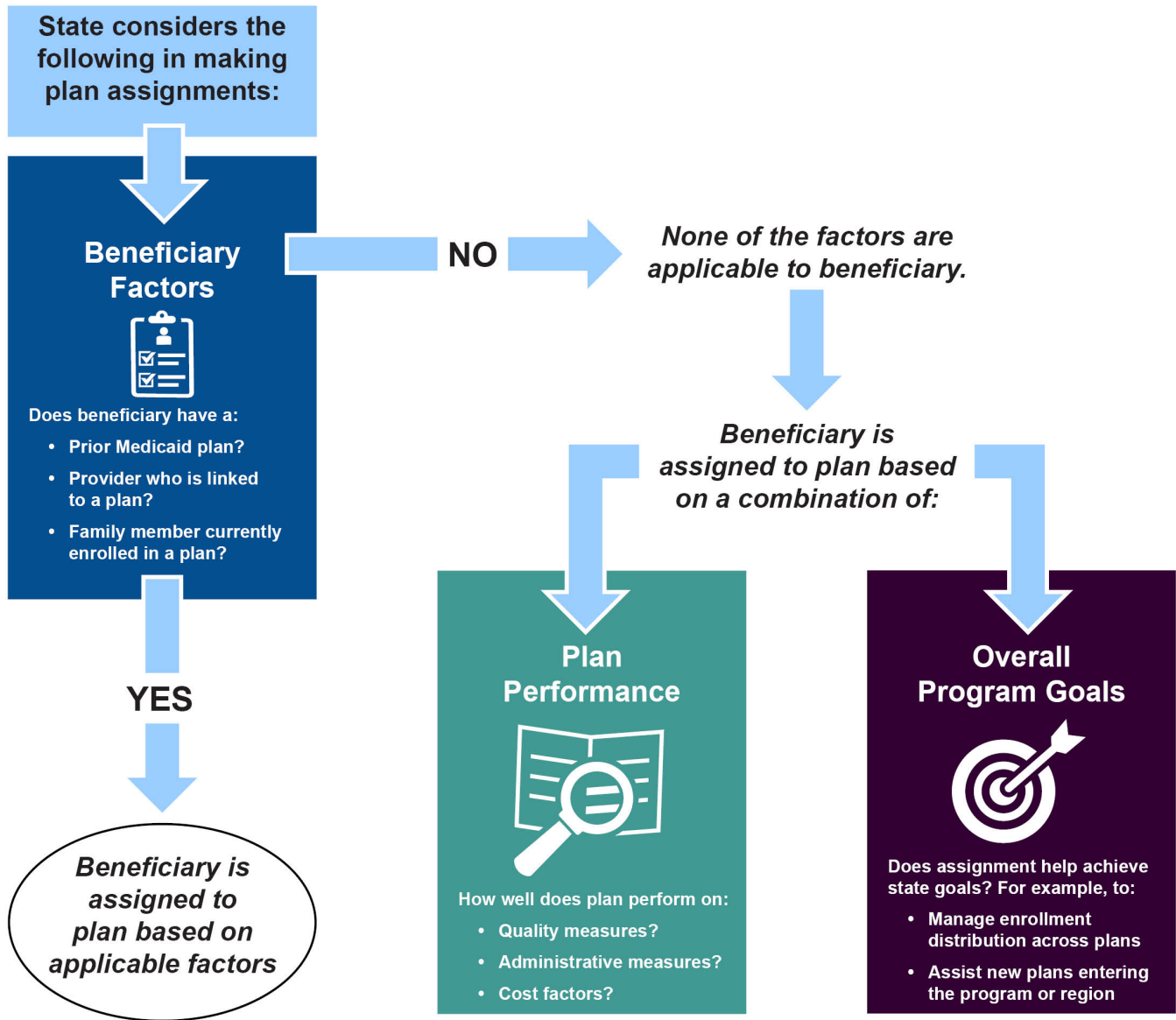


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and overall program goals.) For example, states made auto assignment decisions based on such goals as ensuring plan capacity to serve additional beneficiaries or managing enrollment distributions across plans in certain geographic markets.

- **Ensuring plan capacity:** Florida, Michigan, and Washington considered plan capacity before auto assigning beneficiaries to plans. For example, beginning in July 2014, Washington plans that received auto assignments must demonstrate that they meet a certain capacity threshold to serve eligible beneficiaries in each of five critical provider types, including primary care and hospitals.
- **Managing distribution across plans:** Pennsylvania divided beneficiaries equally among plans in a certain geographic area, while Louisiana generally did not assign beneficiaries to plans with greater than or equal to 40 percent of total beneficiaries in the state. Arizona's auto assignment methodology had provisions to redistribute auto assignments in certain geographic areas where plans have enrollment greater than or equal to 45 percent of the total beneficiaries.
- **Assisting plans entering the program or a new region:** An Arizona official told us that the state may give preference during auto assignment to new plans entering the market in a particular region. Similarly, California's methodology included specific provisions for new plans, crediting those plans with average performance until the plans could produce performance data.

**Figure 6: Illustration of a State Medicaid Managed Care Auto Assignment Method that Considers Beneficiary Factors, Plan Performance, and Program Goals**



Source: GAO illustration based on state provided documentation. | GAO-16-77

Notes: This illustration assumes that the beneficiary has not selected a plan and the state first considers beneficiary factors. If none of the beneficiary factors apply, the methodology then focuses on plan performance and program goals. Not all states may consider all three factors or consider them in this order.

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The rate of beneficiaries automatically assigned to plans, referred to as the auto assignment rate, varied considerably among states. Selected states' assignment rates ranged from 23 to 61 percent, with three states reporting rates of 30 percent or less and three other states reporting rates of 50 percent or more.<sup>48</sup> Rates may vary by population, geographic area, and the method the state used to calculate the rate.

- **Population:** One state, Arizona, tracked auto assignment rates for its LTSS population and reported a rate about 26 percent lower for this population than for all other populations. An Arizona official noted that there is very little auto assignment among beneficiaries using LTSS because they are typically more engaged in their care and have more outside assistance when initially choosing a plan.
- **Geographic region:** Two states also provided information related to how auto assignments can vary by geographic region. For example, the percentage of total auto assignments for a particular plan in 22 Washington counties ranged from 10 percent to 98 percent. Florida officials also told us that rates vary by region, with Miami having a much lower auto assignment rate than other parts of the state.
- **Calculation method:** Variation in auto assignment rates among states was likely due, in part, to states not having a common method for calculating the rates. For example, Pennsylvania, a state with a lower auto assignment rate, excluded eligible beneficiaries who did not make a plan selection, but were able to be assigned to the same plan as another active family member. In contrast, Louisiana, a state with a higher auto assignment rate, included such assignments in its calculation.

Differences in state enrollment policies, such as the length of time that beneficiaries have to choose a plan before auto assignment, may also contribute to the variation in auto assignment rates. Michigan, for example, reported giving beneficiaries 26 days to select a plan before being auto assigned by the state, while Washington, a state with a higher auto assignment rate, automatically assigned beneficiaries to a managed

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<sup>48</sup>Arizona, California, Florida, Louisiana, Michigan, Pennsylvania, and Washington reported that they tracked these rates, generally for state fiscal year 2014. Tennessee officials told us that the state does not track auto assignment rates, although they estimated that the auto assignment rate would be quite high.

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care plan at the time of enrollment, but gave beneficiaries the option to change plans monthly.<sup>49</sup> Other states may allow beneficiaries to select a plan at the time of enrollment before being auto assigned. For example, according to Louisiana officials, in February 2015, the state began requiring beneficiaries to choose a managed care plan at the time of enrollment, instead of giving beneficiaries 30 days to choose a plan, in an effort to phase out FFS claims processing by the state.<sup>50</sup>

Interviews with state officials indicated that states may adjust auto assignment methods. Specifically, officials from three states told us about future plans to change their auto assignment methods. For example, Arizona reviewed its auto assignment percentages at least annually, and indicated that the state may adjust its method to recognize plan performance on quality and administrative measures, such as those related to claims processing and grievances. Tennessee officials said the state plans to incorporate plan quality and cost performance into its auto assignment process.<sup>51</sup>

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## Agency Comments

We provided a draft of this report to the Department of Health and Human Services for comment. The Department had no comments.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

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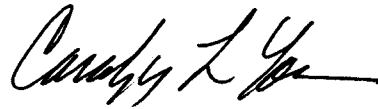
<sup>49</sup>Washington officials estimated that approximately 1 to 3 percent of beneficiaries switched plans. State officials told us that the state changed its policy in May 2015 to give its Medicaid beneficiaries time to choose a plan before being auto assigned to a state-selected managed care plan. Other states in our sample reported that beneficiaries could switch plans within a range of 30 to 90 days, depending on the state.

<sup>50</sup>While eligible beneficiaries are selecting a plan, they may be enrolled in FFS or managed care. Florida officials told us the state plans to phase out the time period where beneficiaries are covered by FFS. Beneficiaries would still have a chance to choose their plan, but the state would enroll them in plans more quickly.

<sup>51</sup>CMS's proposed rule would also make changes to state auto assignment methods, for example, by specifying additional factors that states may take into account when auto assigning.

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If you or your staffs have any questions about this report, please contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Selected States' Comprehensive Risk-Based Managed Care Programs

State	Enrollment as of July, 2013	Contract period	Description of managed care programs
Arizona	1,072,628	October 1, 2014 – September 30, 2015	<p>Arizona Health Care Cost Containment System: Mandatory program for aged, disabled (children and adults), children, low-income adults, those dually eligible for Medicare and Medicaid (dual eligibles), and foster care children.</p> <p>Arizona Long Term Care System: Mandatory program for aged, disabled (children and adults), and dual eligibles, all of whom are in need of a nursing home level of care.</p>
California <sup>a</sup>	5,686,453	January 1, 2014 – December 31, 2016	<p>Two-Plan model: Mandatory and voluntary program in select counties for disabled (children and adults), children, and foster care children.</p> <p>Geographic Managed Care: mandatory and voluntary program in select counties for aged, disabled (children and adults), children, low-income adults, certain dual eligibles, and foster care children.</p> <p>County Organized Health Systems: Mandatory program in select counties for aged, disabled (children and adults), children, low-income adults, certain dual eligibles, foster care children, and American Indians/Alaskan Natives.</p>
Florida	1,516,233	September 1, 2012 – August 31, 2015	Managed Medical Assistance: Mandatory and voluntary statewide program for aged, disabled (children and adults) children, low-income adults, dual eligibles, foster care children, and American Indians/Alaskan Natives.
Louisiana	427,713	February 1, 2015 – January 31, 2018	Bayou Health: Mandatory statewide program for disabled (children and adults), children, parents, breast and cervical cancer program population (under 65), low-income adults, foster care children, pregnant women, and aged, blind and disabled adults.
Michigan	1,290,847	October 1, 2013 – September 30, 2014	Comprehensive Health Care Program: Mandatory statewide program for aged, disabled (children and adults), children, low-income adults, and foster care children.
Pennsylvania	1,621,687	July 1, 2013 – June 30, 2014	HealthChoices: Mandatory statewide program for aged, disabled (children and adults), children, low-income adults, certain dual eligibles, and foster care children.
Tennessee	3,030,664	January 1, 2014 – December 31, 2016	TennCare: Mandatory statewide program for aged, disabled (children and adults), children, low-income adults, certain dual eligibles, and foster care children.
Washington	780,675	January 1, 2014 – December 31, 2014	Apple Health: Mandatory statewide program for aged, disabled (children and adults), children, and low-income adults.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data and documentation | GAO-16-77

Notes: Descriptions of state managed care programs are based on CMS information as of August 2014 and October 2014. This information is compiled by CMS staff and updated throughout the year, according to CMS. Contract periods are for the state contract with managed care organizations that were most recently approved or reviewed by CMS generally as of March 2015.

<sup>a</sup>California has additional managed care programs, which represent expansions of these programs into additional counties.

# Appendix II: Federal Expenditures on Managed Care as Percent of Total Medicaid Expenditures, Fiscal Years 2004 and 2014

State	2004			2014		
	Total Medicaid expenditures (millions)	Expenditures for managed care (millions)	Percent of Medicaid spending for managed care	Total Medicaid expenditures (millions)	Expenditures for managed care (millions)	Percent of Medicaid spending for managed care
Alabama	3,237.5	23.1	0.7	3,599.5	0.0	0.0
Alaska	711.9	0.0	0.0	832.1	0.0	0.0
Arizona	4,279.3	3,489.2	81.5	6,565.2	4,513.1	68.7
Arkansas	2,433.7	0.0	0.0	3,615.4	0.0	0.0
California	19,771.8	2,985.0	15.1	35,755.6	14,324.3	40.1
Colorado	1,690.5	228.7	13.5	3,334.8	66.6	2.0
Connecticut	2,477.2	417.8	16.9	3,878.7	0.0	0.0
Delaware	507.4	0.0	0.0	1,003.7	727.0	72.4
District of Columbia	1,016.6	233.6	23.0	1,720.8	605.4	35.2
Florida	9,552.4	1,095.9	11.5	12,151.3	4,632.4	38.1
Georgia	5,336.9	0.0	0.0	6,347.4	2,279.5	35.9
Hawaii	677.9	215.2	31.8	1,125.4	961.2	85.4
Idaho	838.2	0.0	0.0	1,137.3	0.0	0.0
Illinois	6,394.4	127.3	2.0	8,940.5	1,439.7	16.1
Indiana	3,859.8	358.7	9.3	6,144.6	1,274.5	20.7
Iowa	1,810.8	67.0	3.7	2,459.7	69.6	2.8
Kansas	1,371.5	70.6	5.2	1,562.4	1,382.6	88.5
Kentucky	3,613.5	398.4	11.0	5,934.8	3,960.1	66.7
Louisiana	4,427.3	0.0	0.0	4,408.4	981.4	22.3
Maine	1,689.7	0.1	0.0	1,470.7	0.0	0.0
Maryland	2,935.8	840.3	28.6	5,255.2	2,541.4	48.4
Massachusetts	5,579.1	1,006.8	18.1	7,321.5	2,508.5	34.3
Michigan	5,842.9	1,251.7	21.4	9,269.8	3,816.1	41.2
Minnesota	3,557.1	0.0	0.0	5,480.6	2,846.7	51.9
Mississippi	3,178.3	0.0	0.0	3,584.9	602.5	16.8
Missouri	4,721.2	735.1	15.6	5,545.2	675.9	12.2
Montana	620.7	0.0	0.0	729.2	12.3 <sup>a</sup>	1.7
Nebraska	1,088.7	48.9	4.5	979.1	261.7	26.7
Nevada	725.2	107.3	14.8	1,588.7	548.8	34.5
New Hampshire	727.5	0.0	0.0	678.1	122.9	18.1
New Jersey	5,042.0	654.8	13.0	7,099.4	3,534.2	49.8

**Appendix II: Federal Expenditures on Managed  
Care as Percent of Total Medicaid  
Expenditures, Fiscal Years 2004 and 2014**

State	2004			2014		
	Total Medicaid expenditures (millions)	Expenditures for managed care (millions)	Percent of Medicaid spending for managed care	Total Medicaid expenditures (millions)	Expenditures for managed care (millions)	Percent of Medicaid spending for managed care
New Mexico	2,103.0	940.0	44.7	3,139.9	2,463.0	78.4
New York	26,095.4	3,255.7	12.5	27,621.9	12,832.8	46.5
North Carolina	6,326.0	0.0	0.0	7,945.4	0.0	0.0
North Dakota	417.3	1.1	0.3	206.5	5.8	2.8
Ohio	8,655.6	699.9	8.1	13,067.9	6,523.3	49.9
Oklahoma <sup>b</sup>	2,243.8	153.9	6.9	3,037.7	29.5	1.0
Oregon	2,025.0	647.8	32.0	4,952.0	2,918.1	58.9
Pennsylvania	9,785.3	2,569.7	26.3	12,704.5	5,532.0	43.5
Rhode Island	1,172.5	195.6	16.7	1,409.8	771.4	54.7
South Carolina	3,388.2	58.5	1.7	3,770.7	1,565.3	41.5
South Dakota	483.0	0.0	0.0	454.9	0.0	0.0
Tennessee	5,741.5	460.8	8.0	6,064.0	4,054.1	66.9
Texas	12,254.9	1,396.9	11.4	18,790.1	8,068.0	42.9
Utah	1,119.3	148.7	13.3	1,458.8	595.4	40.8
Vermont	627.6	25.7	4.1	901.2	0.0	0.0
Virginia	2,462.8	556.0	22.6	3,843.1	1,314.5	34.2
Washington	3,317.4	603.0	18.2	6,433.9	3,291.8	51.2
West Virginia	1,833.5	132.6	7.2	2,453.9	429.3	17.5
Wisconsin	3,279.2	516.2	15.7	4,447.8	1,064.6	23.9
Wyoming	284.8	0.0	0.0	276.1	0.0	0.0

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-77

Notes: Expenditures for 2004 were adjusted using the gross domestic product price index to 2014 dollars. Expenditures include only the federal share of spending and do not include the state share. Expenditures were for comprehensive risk-based managed care.

<sup>a</sup>Montana reported expenditures for managed care in 2014; however, CMS officials told us that the state did not operate a managed care program in that year and therefore reported expenditures were likely an error.

<sup>b</sup>Oklahoma reported expenditures for managed care in both 2004 and 2014; however, CMS officials told us that the state did not operate a managed care program in either year and therefore reported expenditures were likely an error.



# Appendix III: Selected States' Methods for Overseeing Quality in Medicaid Managed Care

Our eight selected states (Arizona, California, Florida, Louisiana, Michigan, Pennsylvania, Tennessee, and Washington) varied in the methods used to oversee the quality of care provided by contracted managed care organizations (MCOs). See the table below and the discussion that follows for information on the types of quality measures, sanctions, incentives, and accreditation requirements states used and how those methods fit into each state's broader quality framework.

**Table 5: Methods for Overseeing Quality of Care Provided by Medicaid Managed Care Organizations (MCOs) in Selected States**

State	Required reporting of HEDIS measures <sup>a</sup>	Required reporting on other measures	Sanctions tied to certain performance measures	Sanction types for performance on certain quality standards		Incentives for performance on certain measures <sup>c</sup>	Accreditation required? <sup>d</sup>
				Corrective Action Plans	Financial <sup>b</sup>		
Arizona	Some	Y	Y	✓	✓	Y	No
California	All	Y	Y	✓	✓	N	No
Florida	Some	Y	Y	✓	✓	Y	NCQA or Other
Louisiana	Some	Y	Y	✓	✓	Y	NCQA
Michigan	All	Y	Y	✓	✓	Y	NCQA or Other
Pennsylvania	All	Y	Y	✓	✓	Y	NCQA or Other
Tennessee	All	Y	Y	✓	✓	Y	NCQA
Washington	Some	Y	N	N/A	N/A	N	NCQA

Legend: HEDIS = Healthcare Effectiveness Data and Information Set; Y = yes; N = no; NCQA = National Committee on Quality Assurance; and N/A = not applicable.

Source: GAO analysis of state contracts with MCOs, state quality documentation, and interviews with state officials. | GAO-16-77.

Notes: The information presented reflects requirements outlined in the state contract with MCOs that was most recently approved or reviewed by CMS, generally, as of March 2015. Five states' contracts—Arizona, California, Florida, Louisiana, and Tennessee—were effective as of August 2015. Pennsylvania's contract ended at the end of June 2014 and Washington's at the end of December 2014. Michigan's contract ended at the end of September 2014.

<sup>a</sup>For the states that required reporting on all HEDIS measures, we are referring to the measures that are relevant to Medicaid. These states may not require reporting on the subset of those requirements focused on dental care.

<sup>b</sup>Financial sanctions may be monetary penalties for failure to meet minimum performance targets or payment reductions for performance below the median.

<sup>c</sup>Incentives could include bonuses or an increase in the number of beneficiaries who are automatically assigned to a plan offered by the MCO.

<sup>d</sup>State required accreditation by NCQA or other accrediting bodies.

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## Quality Performance Measures

All eight selected states used a combination of Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS measures to assess quality performance of their participating MCOs. HEDIS is a tool used by health plans to measure performance on various dimensions of care and service, including effectiveness of care, access and availability of care, experience of care, utilization and risk adjusted utilization, and relative resource use. In the 2015 HEDIS, 68 of the 83 measures are applicable to Medicaid.

- With regard to HEDIS measures, all selected states required their participating MCOs to report at least some HEDIS measures that are applicable to Medicaid. Four of the states required MCOs to report all of the Medicaid-applicable HEDIS measures.
- All selected states either required MCOs to report on specific non-HEDIS measures, or their contracts allowed states to develop non-HEDIS measures that MCOs may have to report. The non-HEDIS measures states required varied. For example, Arizona listed two non-HEDIS measures related to flu shots for adults above the age of 50, while Florida listed 10 non-HEDIS measures, including but not limited to, the provision of annual lipid profiles, the frequency of human immunodeficiency virus disease monitoring lab tests, and transportation timeliness.
- Non-HEDIS measures may capture similar issues as the HEDIS measures, but in a slightly different manner. For example, there is an adult flu shot HEDIS measure applicable to Medicaid that captures the provision of flu shots for those aged 18 to 64. However, there is no adult flu shot measure applicable to Medicaid that is for ages 65 and older, and no way within the existing HEDIS measure to distinguish older adults. As such, to capture older adults, Arizona uses two non-HEDIS measures in their Medicaid managed care program: flu shots for adults aged 50-64, and flu shots for adults aged 65 and older. Other types of non-HEDIS measures that states are requiring MCOs to report include: Children's Health Insurance Program Reauthorization Act child and adult core set measures; over- and under-utilization monitoring measures; Agency for Healthcare Research and Quality prevention quality indicators; and other state-defined measures.

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## Sanctions for Not Meeting Required Targets on Quality Measures

All but one of our eight selected states set specific standards for performance on one or more quality measures that, if not met, could result in sanctions for MCOs. Sanctions could include requiring MCOs to take corrective actions, financial penalties, or both.

- Six states—Arizona, California, Florida, Michigan, Pennsylvania, and Tennessee—specified in their contracts that there are minimum requirements for outcomes on performance measures that each MCO was required to meet. These states specified that MCOs that do not meet the requirements may be subject to corrective action plans, financial sanctions, or other types of sanctions.
- The final state that set standards for performance on quality measures, Louisiana, required MCOs to demonstrate improvement on performance measures and linked sanctions to failure to meet such improvement.
- The remaining state, Washington, did not include any sanctions that were specifically imposed for failing to meet required performance measure outcomes, though the state could impose sanctions for failure to meet contract terms more generally.

With regard to imposing sanctions, generally, states describe a measured, hierarchical approach, starting first with corrective action plans and imposing more severe sanctions if the MCO does not come into compliance with the corrective action plan. Financial penalties may be imposed along with corrective action plans or as a more severe sanction after the corrective action plan. Financial penalties may be structured such that failure to meet a certain threshold percentage on a performance measure will require that the MCO pay a certain amount for each percent difference between the standard and the percentage it reported. For example, Tennessee set a 5 percent threshold for unanswered calls for its MCOs' nurse triage and advice lines. The state will charge MCOs \$25,000 for each full percentage point above 5 percent per month. Some states linked failure to meet certain standards on performance measures to intermediate sanctions as outlined in federal regulations. These sanctions allow for appointing temporary management of the MCO; freezing new enrollments, including auto enrollment; allowing

beneficiaries to terminate enrollment; and suspending payment for beneficiaries enrolled after the effective date of the sanction.<sup>1</sup>

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## Incentives for Performance on Quality Measures

While there was no consistent method of measuring quality across states, most of the selected states used financial incentives as rewards for MCOs meeting performance standards on certain quality measures. Specifically, six of the eight states established incentives for MCOs performing above a certain benchmark or for improving in performance on selected measures, as shown in the following examples.

- Pennsylvania allocated incentive dollars to each of nine performance measures, and MCOs earn incentives by meeting benchmark performance and improvement targets. In addition, if the MCO performs above the 50th percentile benchmark on diabetes bundle measures the state will award a diabetes bundle performance payout.
- Tennessee focused its incentives on performance improvement by offering a bonus payment to MCOs for each HEDIS measure for which it demonstrated significant improvement.
- Two of the six states that offered incentives—Arizona and Florida—specified that the incentives may be competitive.
  - Arizona assesses MCOs relative to minimum performance standards. A bonus is awarded to one or more MCOs for their performance on certain quality measures.
  - Florida's managed care contract indicated that the state may decide to offer incentives to all high performing MCOs or to make the high performing MCOs compete for them. The state may also decide not to offer incentives to its MCOs each year.

States offering incentives often financed them using capitation payment withholds where the state retains a relatively small percentage of the monthly or annual capitation payments (for example, 1 or 2 percent), and

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<sup>1</sup>42 C.F.R. § 438.702 (2014).

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uses it later to reward MCOs that performed well on certain performance measures.<sup>2</sup>

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## Accreditation Requirements

Six of the eight selected states required participating MCOs to be accredited by a nationally recognized organization that provides an independent assessment of the quality of care provided by the MCO. MCOs that are accredited by these organizations meet quality standards related to various aspects such as consumer protection, case management, and quality improvement activities.

- The National Committee on Quality Assurance (NCQA) was the most commonly used accrediting organization in the selected states. All six states either named NCQA as a preferred accreditation body or only allowed NCQA accreditation. States also may have allowed MCOs to be accredited through another accrediting organization, such as URAC or the Accreditation Association for Ambulatory Health Care.
- In discussions with some states, one reason cited for requiring accreditation was that it facilitated the comparison of MCOs because of consistency of data requirements.
- The two states that did not require accreditation explained that they were concerned about the financial burden on the MCOs associated with the accreditation process.<sup>3</sup>

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## Other Quality Oversight Activities

All of the selected states had a written quality strategy for Medicaid managed care that they submitted to the Centers for Medicare & Medicaid Services (CMS) per a federal requirement to do so.<sup>4</sup> The state quality strategy must include a discussion of performance measures, performance improvement projects, and state quality oversight plans.

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<sup>2</sup>Arizona's, Louisiana's, and Michigan's contracts indicated that performance incentives may be financed by withholding a certain percentage of the capitation payment made to each MCO. Arizona and Louisiana withhold 1 and 2 percent of the monthly capitation payment, respectively, while Michigan withholds less than 1 percent annually.

<sup>3</sup>However, officials from one state told us that accreditation expenses can be incorporated into the payment rates, and, as such, be a part of the costs that the state and federal government incur to fund the program.

<sup>4</sup>42 C.F.R. § 438.202(e) (2014).

States are required to submit a revised strategy to CMS whenever significant changes are made.

CMS reviews states' quality strategy documents as submitted and does not require them to be updated within a specified timeframe. CMS is proposing to change this; its proposed rule would require states to update their quality strategy documents at least once every 3 years.<sup>5</sup> According to a CMS quality strategy tracking document, some states submit their quality strategy document to CMS annually, while others have not submitted them to CMS for 3 or more years.

- Among our eight selected states, five had submitted updated versions of their quality strategy to CMS between 2012 and 2014, with three of these five states submitting to CMS annually.
- The remaining three selected states had not submitted an updated version of their quality strategies to CMS in the last 4 to 8 years, according to CMS's tracking document.<sup>6</sup>

Nationally, the tracking document indicates that 8 of the 39 states with comprehensive, risk-based managed care have not submitted updated quality strategy documents to CMS in the last 3 years.

As required by federal law, all of our selected states completed an external quality review report in 2014.<sup>7</sup> In an external quality review, an independent organization specializing in external quality reviews evaluates the quality, timeliness, and access to health care services provided by MCOs to their Medicaid beneficiaries. External quality review

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<sup>5</sup>Under the proposed rule, all states would need to update their quality strategies because CMS is also proposing that the quality strategy documents cover their entire Medicaid program, not just the managed care portions. As such, states that did not previously submit quality strategy documents because they did not offer managed care in their Medicaid programs would need to submit a quality strategy document for their overall Medicaid program to CMS. Furthermore, CMS has proposed to change the method through which the quality strategies are submitted. Instead of requiring states to send the agency the quality strategy, CMS is proposing that states make them available to the agency and the public via their Medicaid websites.

<sup>6</sup>If these states had not made significant changes to their strategies, then no updated copies would have been required. According to agency officials, two of these states submitted draft quality statement documents to CMS in 2014; however, they have yet to submit finalized versions.

<sup>7</sup>42 U.S.C. § 1396u-2(c)(2); 42 C.F.R. § 438.350(a) (2014).

reports include discussions of MCO's strengths, areas for improvement, and recommendations, as shown in the examples below.

- An external quality review report for one of our selected states indicated that the strengths of the MCOs participating in the state's managed care program were that they demonstrated high levels of compliance with contractual requirements and that they improved in their performance on quality measures from previous years. As an opportunity for improvement, this report also mentioned that MCOs could work to improve performance on certain HEDIS measures for which they were performing below the 50th percentile.
- Another state's external quality review report recommended MCOs identify barriers that affect access to care for children's services after the performance measures assessment showed poor performance in well-child and dental visits. The report recommended increased transportation coordination and expanded office hours, as well as educational efforts to increase beneficiary awareness and understanding of available services.

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# Appendix IV: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

Carolyn L. Yocom, (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff Acknowledgments

In addition to the contacts named above, Susan Barnidge, Assistant Director; George Bogart; Shamonda Braithwaite; Laura Sutton Elsberg; Giselle Hicks; Drew Long; and Vikki Porter made key contributions to this report.



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