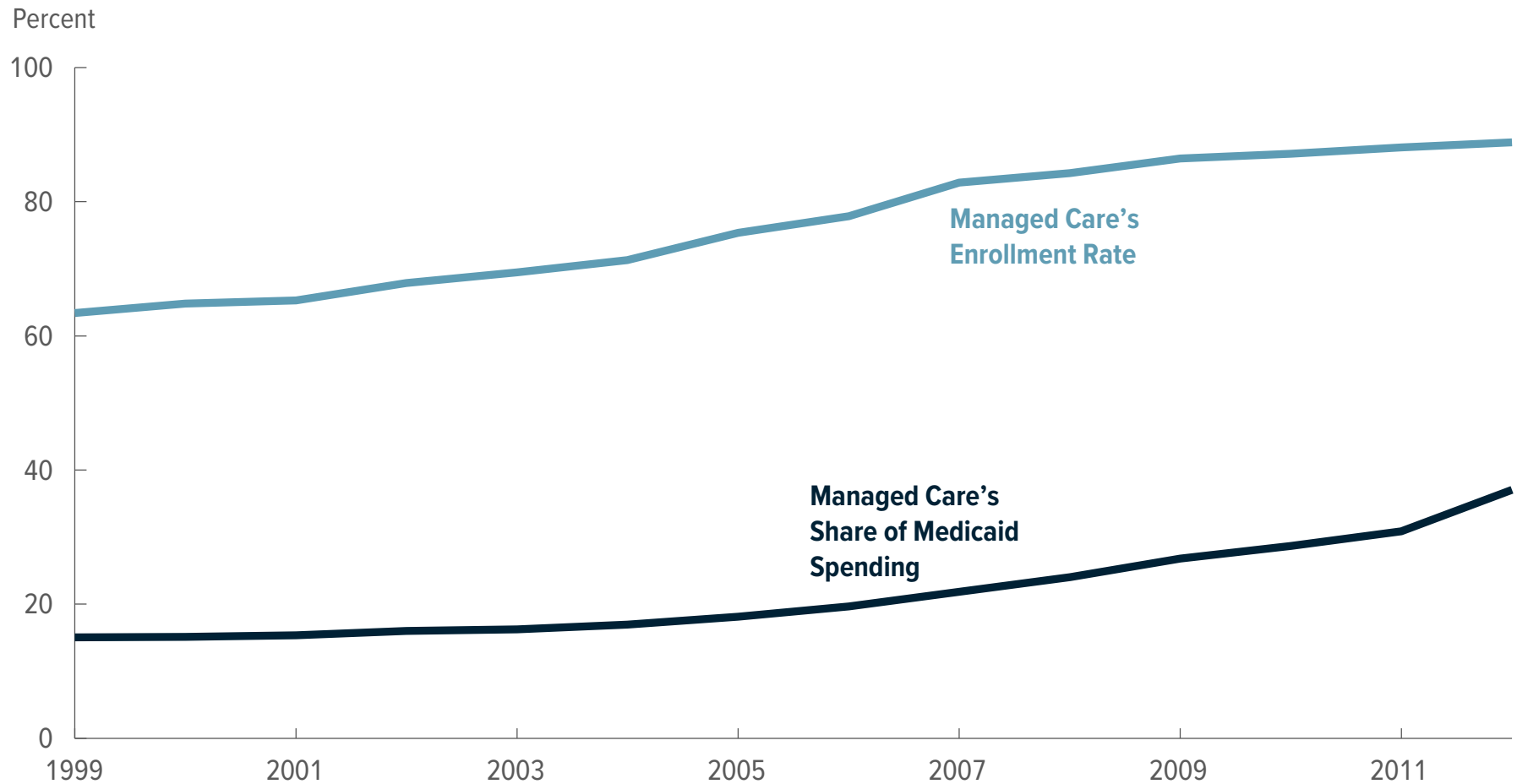


CBO

Exploring the Growth of Medicaid Managed Care



AUGUST 2018

Notes

Numbers in the text and exhibits may not add up to totals because of rounding.

Supplemental data are posted along with this report on CBO's website.



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Exploring the Growth of Medicaid Managed Care

Summary

Medicaid—a joint federal-state program that provides health benefits to over 70 million people with low income—accounted for \$375 billion of federal spending and \$230 billion of state spending in fiscal year 2017. States typically use two types of payment systems to provide those benefits: fee for service and managed care. Under the fee-for-service system, states reimburse health care providers for the services that they deliver to beneficiaries. By contrast, under Medicaid managed care, states pay a fixed per capita fee, or capitation payment, to private health insurance plans or to provider groups, known as managed care organizations (MCOs), that provide services to enrollees. Some MCOs provide those services themselves, but others reimburse health care providers for services that they deliver. The scope of services covered by MCOs ranges from a small subset of services—for example, nonemergency medical transportation or case management (the approving and monitoring of health care services for an individual)—to all health care services that its enrollees might need.

States might implement Medicaid managed care for a variety of reasons. Two of the most often cited are to increase the predictability of spending and to improve the coordination of care. Proponents of managed care suggest that competition between MCOs reduces spending and improves outcomes. To date, however, studies of

managed care have not found consistent evidence to support those claims.¹

This report presents information on managed care's enrollment and spending and analyzes the various factors that affect them. The Congressional Budget Office estimates that between 1999 and 2012 (the most recent year for which data on beneficiaries are available), the portion of all Medicaid beneficiaries who were eligible for full benefits that was enrolled in managed care (that is, the enrollment rate) grew from 63 percent to 89 percent, while the share of total Medicaid spending that went to managed care increased from 15 percent to 37 percent (see the figure on page 2). The high rate of enrollment in managed care prompted the authors of one study to describe it as “the

predominant delivery system for Medicaid.”² Indeed, the large percentage of Medicaid beneficiaries already enrolled in MCOs has led some analysts to speculate that there is limited capacity for further expansion of the program. But managed care's relatively small share of total Medicaid spending suggests that further growth in managed care's share of spending, if not its enrollment, is possible. Thus, analyses, such as this one, of patterns of enrollment in and spending for managed care may aid policymakers considering proposals to change the role of managed care in Medicaid and the analysts charged with evaluating those proposals.

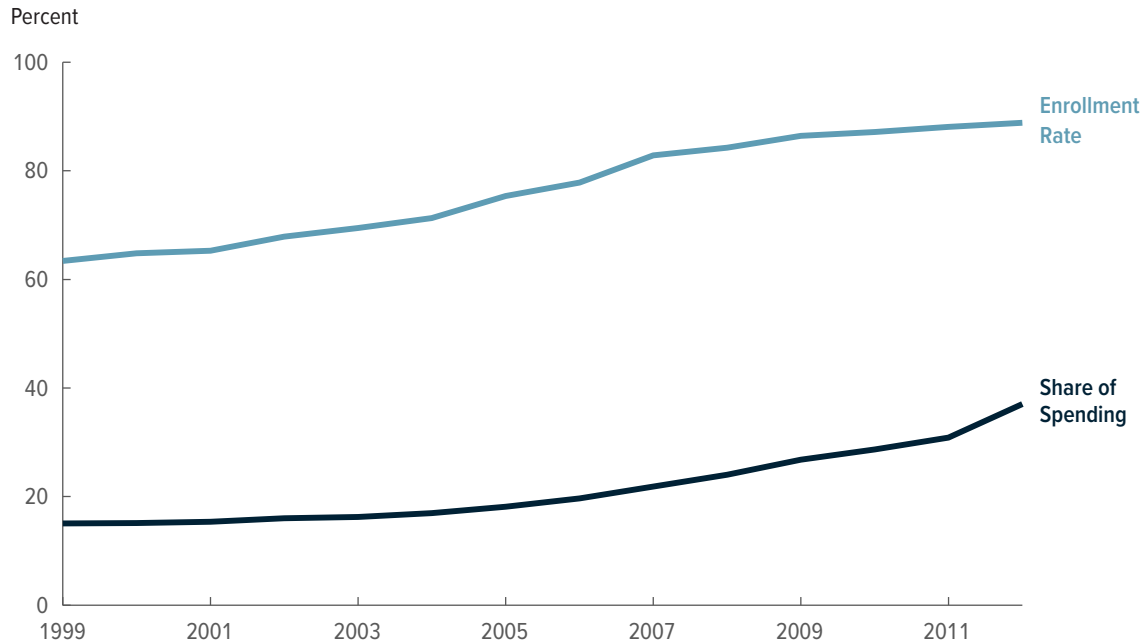
What Types of Medicaid Managed Care Plans Are Beneficiaries Enrolled In?

Medicaid managed care encompasses a wide variety of contractual arrangements between states and MCOs. Some MCOs, often referred to as comprehensive, cover a wide range of services. Other MCOs cover only a narrow set of services, such as dental care, nonemergency transportation, or behavioral health services. (Behavioral health services include treatment for mental health and substance use disorders.) In some cases, all beneficiaries within a given eligibility group—children,

1. See, for example, Kyle J. Caswell and Sharon K. Long, “The Expanding Role of Managed Care in the Medicaid Program: Implications for Health Care Access, Use, and Expenditures for Nonelderly Adults,” *Inquiry: The Journal of Health Care Organization, Provision, and Financing*, vol. 52 (September 2015), pp. 1–17, <http://doi.org/10.1177/0046958015575524>; Bradley Herring and E. Kathleen Adams, “Using HMOs to Serve the Medicaid Population: What Are the Effects on Utilization and Does the Type of HMO Matter?” *Health Economics*, vol. 20, no. 4 (April 2011), pp. 446–460, <http://dx.doi.org/10.1002/hec.1602>; and Marguerite E. Burns, “Medicaid Managed Care and Cost Containment in the Adult Disabled Population,” *Medical Care*, vol. 47, no. 10 (October 2009), pp. 1069–1076, <http://doi.org/10.1097/MLR.0b013e3181a80fef>.

2. Kathleen Gifford and others, *Medicaid Moving Ahead in Uncertain Times: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018* (Kaiser Family Foundation, October 2017), p. 15, <https://tinyurl.com/y7rxuuhf>.

Managed Care's Enrollment Rate and Share of Medicaid Spending for All Beneficiaries



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' Medicaid Analytic eXtracts for 1999 to 2012.

Data were unavailable for Colorado for 2011 and 2012 and for Idaho, Kansas, and Rhode Island for 2012.

for example—enroll in the MCO, but in other cases, only beneficiaries with specific health conditions participate. For example, beneficiaries who are diagnosed with a serious mental illness are often required to enroll in an MCO that covers behavioral health services, whereas beneficiaries who develop a need for nursing home services may enroll in an MCO that covers long-term services and supports. (Long-term services and supports include care provided either in an institution or

in a beneficiary's home or the community that offers assistance with activities of daily living, such as eating and bathing, or instrumental activities of daily living, such as preparing meals and housekeeping.)

CBO found that the majority of Medicaid beneficiaries received benefits through multiple payment arrangements: Some beneficiaries were enrolled in comprehensive and noncomprehensive

MCOs simultaneously, and others received services through fee-for-service Medicaid as well as through MCOs. In 2012, enrollment in managed care—particularly comprehensive managed care—was much more common among nonelderly, non-disabled adults and children than it was among other beneficiaries.

Why Is Spending on Medicaid Managed Care Less Than Spending on Fee-for-Service Medicaid?

Although the vast majority of Medicaid beneficiaries are enrolled in managed care, spending on Medicaid managed care is significantly less than spending on fee-for-service Medicaid. Several factors contribute to that discrepancy:

- Many beneficiaries who are enrolled in a comprehensive MCO still receive benefits through the fee-for-service program. More than 60 percent of beneficiaries were enrolled in a comprehensive MCO in 2012; fee-for-service payments accounted for more than one-quarter of their Medicaid spending. Almost half of such beneficiaries received at least some of their benefits through the fee-for-service program; hospital and physicians' services and long-term services and supports accounted for the largest shares of fee-for-service spending.
- Other beneficiaries are enrolled in MCOs that cover only a narrow range of benefits, and they receive most of their services through fee-for-service Medicaid. More than one-quarter of all Medicaid beneficiaries were enrolled in such

MCOs in 2012, and for those beneficiaries, fee-for-service payments accounted for 95 percent of Medicaid spending.

- Beneficiaries in eligibility groups whose average Medicaid spending is lower (namely, nonelderly, nondisabled adults and children) are more likely than other beneficiaries to be enrolled in comprehensive MCOs. In 2012, average monthly spending for all nonelderly, nondisabled adults and children was less than \$300. By contrast, average monthly spending for beneficiaries who were also enrolled in Medicare and other elderly and disabled beneficiaries was \$1,500. Whereas 69 percent of the lower-cost group was enrolled in comprehensive managed care, only 39 percent of the higher-cost group was.
- Even within an eligibility group, beneficiaries whose Medicaid spending is lower, on average, are more likely to be enrolled in managed care. For example, children in foster care typically have higher behavioral health costs than other children, and states have been less likely to enroll foster care children in managed care than they have been to enroll other children in such programs.

How Have Changes in Spending on Medicaid Managed Care Varied by State?

From 1999 to 2014, the share of Medicaid spending that went to managed care increased in most states.³ During that period, the num-

3. Data on states' Medicaid spending in more recent years are available, but CBO concluded its analysis with 2014

ber of states in which managed care accounted for more than 25 percent of Medicaid spending grew from 5 to 30, and the number of states in which it accounted for more than 50 percent of Medicaid spending grew from 2 to 13. Not all states embraced managed care, however. The share of Medicaid spending that went to managed care *declined* in 6 states over that period, and in 2014, managed care accounted for less than 5 percent of Medicaid spending in 11 states.

How Has States' Use of Medicaid Managed Care Changed Over Time?

Between 1999 and 2014, states' use of comprehensive managed care increased overall, despite the fact that the number of states with comprehensive managed care declined over that period from 45 to 41.

During those years, states made changes to their comprehensive managed care programs that, on the whole, increased the number of people and the types of services covered by those programs.

- Many states expanded their comprehensive managed care programs to cover their entire jurisdiction rather than only certain counties, cities, or regions.
- In general, states made enrollment in comprehensive MCOs mandatory for more

to coincide with its analysis of qualitative data on states' managed care programs. More recent qualitative data are also available, but CBO found discrepancies between sources in that more recent data. See the appendix for further explanation.

Medicaid beneficiaries, especially those who are elderly, disabled, or enrolled in Medicare.

- Many states negotiated contracts with MCOs to increase the scope of services that the MCOs would cover, expanding coverage for long-term services and supports in particular. For example, the number of states that included institutional long-term care (care provided in a nursing facility or similar institution) in a comprehensive managed care program increased from 4 in 1999 to 28 in 2014.

One reason for the expanding scope of managed care coverage was that although many states had established managed care programs by 1999, those programs were still new at the time and tended to cover only certain beneficiaries and services. The managed care model is less controversial and easier to put in place when Medicaid is one payer among many using it. Employment-based insurance typically covers families and acute care (such as hospital and physicians' services), so many states implemented managed care by first covering children and parents and by providing acute care. States were slower to adopt managed care for elderly and disabled beneficiaries and for such services as nursing facility care or specialty behavioral health services because there were few comparable employment-based models. Between 1999 and 2014, many states expanded managed care coverage to include those groups and services.

States were already increasing their use of managed care before the Affordable Care Act (ACA) was enacted, but the ACA accelerated that expansion.

The law gave states the option to expand Medicaid eligibility, and many of the states that chose to do so covered the newly eligible population with managed care. Even in those states that did not expand Medicaid, enrollment in the program rose because of the increased outreach and awareness of Medicaid that resulted from the ACA. Because most of the new enrollees were nonelderly, non-disabled adults for whom enrollment in managed care programs was often mandatory, the increased enrollment was disproportionately in managed care.

Although the general trend was toward increasing the use of comprehensive managed care, a few states eliminated or scaled back their programs between 1999 and 2014. In those cases, the decision to roll back managed care tended to be idiosyncratic and to reflect the unique characteristics of the state's Medicaid program. For example, the largest retrenchment in managed care occurred in Vermont, which replaced a traditional comprehensive managed care program with a public-private partnership. In that model, Medicaid beneficiaries enroll in a public MCO operated by the Department of Vermont Health Access.

How CBO Categorized Beneficiaries

For the analysis of beneficiary-level data, CBO used data from the Medicaid Analytic eXtract for the years 1999 to 2012 published by the Centers for Medicare & Medicaid Services (CMS). For each year, the agency examined data on all states for which information was available (see the appendix for details). CBO examined data for only those beneficiaries who were eligible for full Medicaid benefits. Some beneficiaries are eligible for partial benefits: Medicaid may pay

only their Medicare premiums or out-of-pocket costs, or they may be eligible for only particular types of Medicaid benefits, such as family planning services or emergency care. CBO chose to limit this study to beneficiaries who qualify for full benefits because they are more likely to be enrolled in managed care and because their average Medicaid spending is much higher. As a result of that approach, CBO's estimates of the percentage of Medicaid beneficiaries who are enrolled in managed care are somewhat higher than other published estimates.⁴

People qualify for Medicaid in several different ways. In all states, children, families, and pregnant women with low income may qualify for Medicaid if they meet requirements set by the state. People who have a disability or who are age 65 or older also may qualify if they meet state-specific income and asset requirements. Most people who are age 65 or older, who receive benefits through Social Security's Disability Insurance (DI) program for more than two years, or who have end-stage renal disease are eligible for Medicare, so many elderly and disabled people are enrolled in both Medicare and Medicaid.⁵ Such people—often

called dual-eligible beneficiaries—are referred to here as Medicare-Medicaid beneficiaries. Finally, many low-income adults were made eligible for Medicaid under the insurance coverage provisions of the ACA, which took effect in 2014. As of July 2018, 31 states and the District of Columbia have expanded Medicaid to cover certain low-income adults.⁶ However, because 2012 is the most recent year for which CBO has access to data on beneficiaries, those newly eligible individuals are not included in this analysis.

Medicaid beneficiaries can thus be categorized into groups on the basis of their eligibility, and those groups tend to have different health care needs and patterns of spending. To account for those differences, CBO assigned all Medicaid beneficiaries to one of four mutually exclusive eligibility groups:

- Nonelderly, nondisabled adults,
- Children,

Eligible for Medicare?" (September 11, 2014), <https://go.usa.gov/xnM7D>. Many disabled people under age 65 are enrolled in Medicaid but not Medicare because they do not qualify for DI benefits on the basis of their work history or disabling condition, because their application for DI benefits is pending, or because they have not satisfied the two-year waiting period (which applies to most recipients). See Social Security Administration, "Social Security Benefit Planner: Disability, How You Qualify" (accessed July 26, 2018), www.ssa.gov/planners/disability/qualify.html.

4. CMS, for example, reports that about 80 percent of Medicaid beneficiaries were enrolled in managed care in 2014. See Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics, 2014* (prepared by Mathematica Policy Research, Spring 2016), p. 23, <https://go.usa.gov/xnM79>.
5. Some elderly people are enrolled in Medicaid but not Medicare because neither they nor their spouse met the work history requirement to qualify for Medicare Part A (Hospital Insurance) without paying a premium. See Department of Health and Human Services, "Who Is

6. Not included in that 31 are Maine and Virginia; both states have decided to expand Medicaid, but neither has done so as of the time of this writing.

- Elderly and disabled beneficiaries (who are not enrolled in Medicare), and
- Beneficiaries who are also enrolled in Medicare (Medicare-Medicaid beneficiaries).

Spending for nonelderly, nondisabled adults and children tends to be lower, on average, than spending for elderly and disabled beneficiaries and beneficiaries who are also enrolled in Medicare. Those younger beneficiaries who are not eligible for Medicare typically use more preventive, acute, and routine health care services, whereas elderly and disabled beneficiaries and Medicare-Medicaid beneficiaries are more likely to use long-term services and supports. For children, Medicaid may cover additional services, such as vision and dental care, under the Early and Periodic Screening, Diagnostic, and Treatment benefit, which provides comprehensive and preventive health care services for children under age 21.⁷

Elderly and disabled beneficiaries who are not enrolled in Medicare share many characteristics with Medicare-Medicaid beneficiaries—namely, beneficiaries in both groups are age 65 or older or have disabilities or other chronic health conditions, and thus they are more likely to use long-term services and supports than beneficiaries in other groups. Nevertheless, there are some important differences between Medicaid coverage for Medicare-Medicaid beneficiaries and coverage for other eligibility groups. First, for beneficiaries who

7. See Centers for Medicare & Medicaid Services, “Early and Periodic Screening, Diagnostic, and Treatment” (accessed July 26, 2018), <https://go.usa.gov/xU7UK>.

are enrolled in both programs, Medicare is the primary payer for most acute and postacute care, and Medicaid pays for Medicare premiums and out-of-pocket costs as well as for some services that are not covered by Medicare.⁸ As a result, compared with other eligibility groups, much more of Medicare-Medicaid beneficiaries’ total Medicaid spending goes to long-term services and supports and to specialty behavioral health services.

A second major difference between Medicaid beneficiaries who are enrolled in Medicare and the other eligibility groups is that states have less flexibility to require Medicare-Medicaid beneficiaries to enroll in managed care.⁹ The fact that Medicare-Medicaid beneficiaries are less often required to enroll in managed care—coupled with their spending proportionally more than other groups on long-term services and supports and other services not traditionally covered by

8. See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), www.cbo.gov/publication/44308.

9. To obtain approval from CMS, states may either amend their Medicaid state plan or obtain a waiver of other Medicaid requirements specified in the Social Security Act. Waiver authority provides states with more flexibility in program design but requires periodic renewal. Amendments to state plans do not require renewal, but states may not use that authority to require children with special needs, Medicare-Medicaid beneficiaries, or American Indians to enroll in managed care. See Medicaid and CHIP Payment and Access Commission, *Report to the Congress: The Evolution of Managed Care in Medicaid* (June 2011), pp. 93–95, <https://go.usa.gov/xnV54>.

MCOs—probably contributes to their enrolling in managed care at lower rates than other groups.

How CBO Categorized Managed Care Organizations

To account for the differences between comprehensive and noncomprehensive managed care, CBO assigned all beneficiaries to one of three mutually exclusive enrollment categories each year (see the appendix):

- Comprehensive managed care, which includes all beneficiaries who were enrolled in a comprehensive MCO for at least one month during the year;¹⁰
- Noncomprehensive managed care, which includes beneficiaries who were enrolled in a noncomprehensive MCO for at least one month during the year and who were not enrolled in a comprehensive MCO at any point during the year; and

10. For this analysis, CBO treated beneficiaries who were enrolled in only a comprehensive MCO and beneficiaries who were enrolled in both a comprehensive MCO and at least one other MCO as a single group. The reason for that treatment is that beneficiaries who are enrolled in only a comprehensive MCO may receive as many (or even more) of their services through managed care than those who are enrolled in multiple MCOs simultaneously because of differences in comprehensive MCOs’ scope of coverage. In 2012, for example, 78 percent of Medicaid spending for beneficiaries enrolled in only a comprehensive MCO was for managed care, whereas 66 percent of Medicaid spending for beneficiaries enrolled in a comprehensive MCO and at least one additional MCO went to managed care.

- Fee-for-service Medicaid only, which includes beneficiaries who were not enrolled in an MCO at any point during the year.

In analyzing enrollment, CBO classified beneficiaries by the type of MCO that they were enrolled in, but it could not classify spending in that way because the data on states' payments to MCOs are less detailed than data on beneficiaries' enrollment in MCOs. The analysis of spending thus distinguishes only between payments for managed care and payments for fee-for-service Medicaid.

For this analysis, CBO defined *comprehensive MCO* to include MCOs that meet the federal definition of comprehensive (referred to hereafter as general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE).¹¹

11. To be classified as comprehensive under federal law, an MCO must cover inpatient hospital services and at least

CBO treated MCOs that cover long-term services and supports as comprehensive because beneficiaries who are enrolled in such MCOs generally receive the vast majority of their benefits through providers of long-term services and supports. In 2012, 84 percent of Medicaid spending for beneficiaries who were enrolled in a long-term services and supports MCO but not in a general

one other service from a specified list (outpatient hospital services; rural health clinic services; federally qualified health center services; other laboratory and x-ray services; nursing facility services; early and periodic screening, diagnostic, and treatment services; family planning services; physicians' services; and home health services), or it must cover three or more services from that list. See Medicaid Managed Care Rule, 42 C.F.R. § 438.2 (2016). The definition originates from the definition of a health maintenance organization (HMO) that was provided in the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (2012). In 1976, that law was amended to define MCOs under Medicaid as organizations that met the same qualifications as HMOs in private health insurance markets.

comprehensive MCO went to managed care, whereas for beneficiaries who were enrolled in a general comprehensive MCO but not in an MCO that covered long-term services and supports, only 72 percent of Medicaid spending went to managed care.

PACE is a joint Medicare-Medicaid program that provides home- and community-based services to beneficiaries who need long-term services and supports.¹² CBO treated PACE as a comprehensive MCO because, like MCOs that cover long-term services and supports, PACE organizations provide their enrollees with most of the care that they receive.

12. See Centers for Medicare & Medicaid Services, "PACE" (accessed July 26, 2018), <https://go.usa.gov/xndEU>.



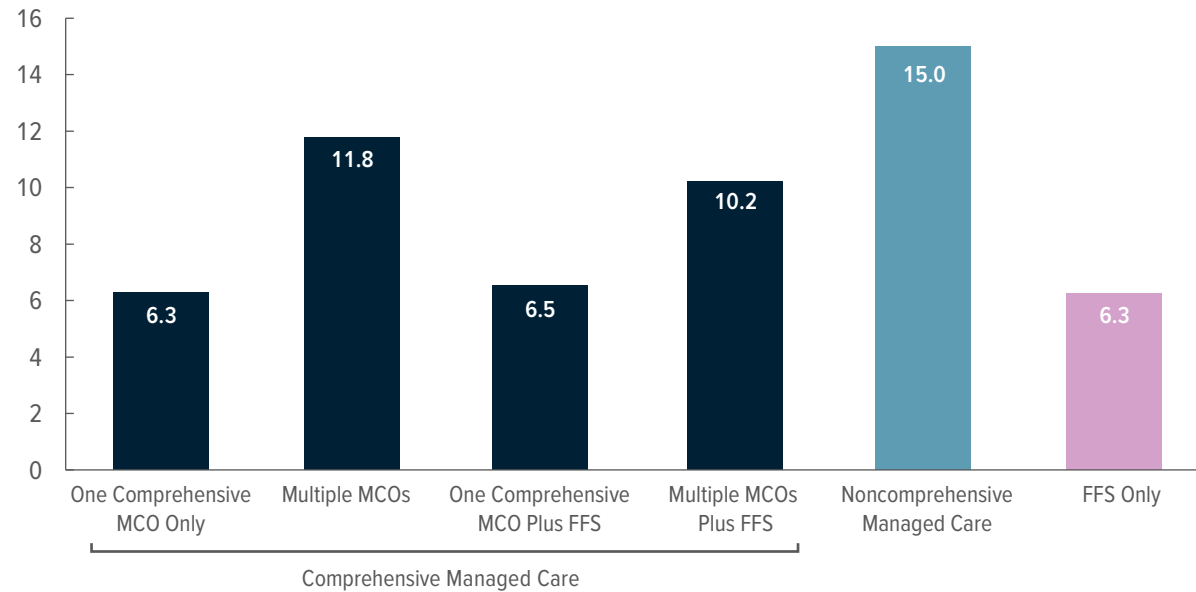
What Types of Medicaid Managed Care Plans Are Beneficiaries Enrolled In?



Exhibit 1.

Medicaid Beneficiaries, by Type of Enrollment , 2012

Millions of Beneficiaries



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services’ 2012 Medicaid Analytic eXtract.

Beneficiaries were considered to be enrolled in comprehensive managed care if they were enrolled in a comprehensive MCO for at least one month. Beneficiaries were considered to be enrolled in noncomprehensive managed care if they were enrolled in a noncomprehensive MCO for at least one month and not enrolled in a comprehensive MCO at any point during the year. Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE). Noncomprehensive MCOs cover only a narrow set of services, such as behavioral health services, dental care, or nonemergency transportation.

Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

FFS = fee-for-service Medicaid; MCO = managed care organization

Medicaid managed care encompasses a variety of contractual arrangements between states and MCOs. In most states, Medicaid benefits are provided through more than one type of MCO and through fee-for-service Medicaid. Of 56.1 million total beneficiaries in 2012, 6.3 million received services through a single comprehensive MCO, and another 6.3 million, through fee-for-service Medicaid exclusively, CBO estimates.

The remaining three-quarters of beneficiaries received services through multiple Medicaid payment arrangements. More than one-fifth of all beneficiaries, 11.8 million, were enrolled in multiple MCOs during the year—including at least one comprehensive MCO—and received no benefits through fee-for-service Medicaid.

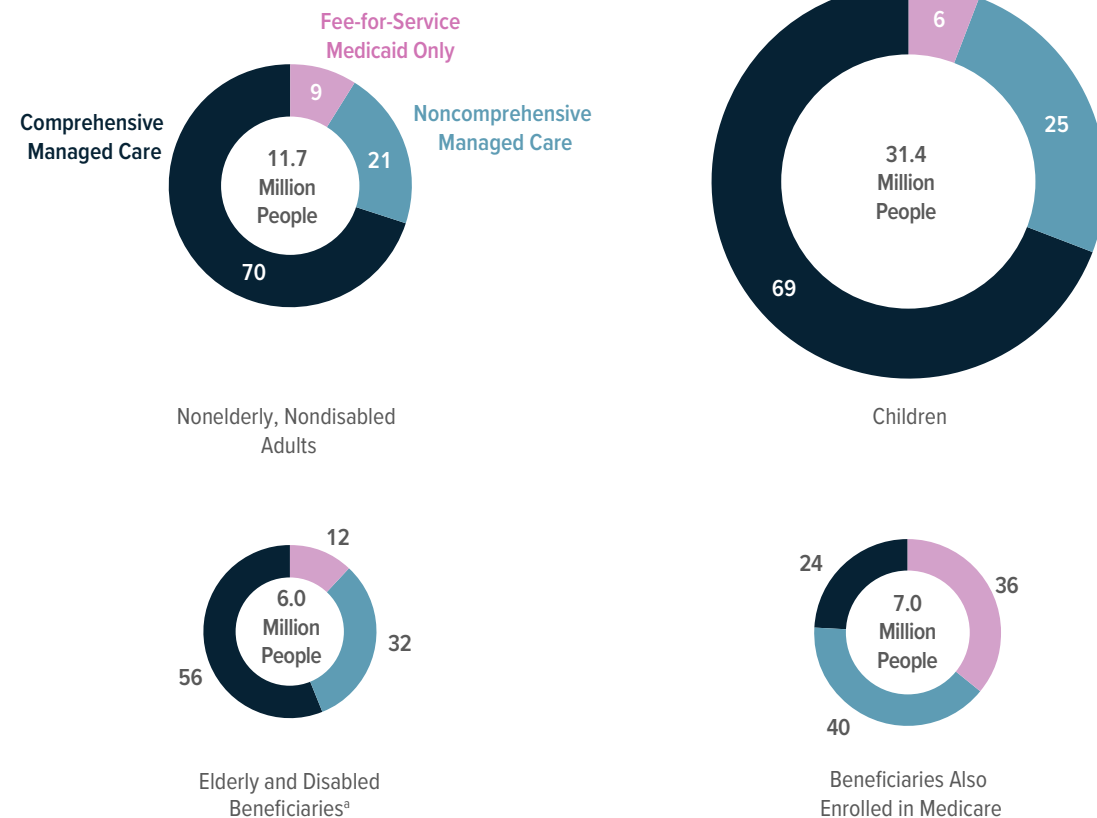
Many states continue to pay for some Medicaid services exclusively on a fee-for-service basis. Under such arrangements, 6.5 million beneficiaries were enrolled in a single comprehensive MCO and received additional services through fee-for-service Medicaid, and 10.2 million beneficiaries were enrolled in multiple MCOs (at least one of them comprehensive) and received additional services through the fee-for-service system. For example, a beneficiary might have been enrolled in a general comprehensive MCO and a behavioral health MCO but still have received prescription drugs through fee-for-service Medicaid.

The remaining 15.0 million beneficiaries—more than one-quarter of all Medicaid beneficiaries in 2012—were enrolled in one or more noncomprehensive MCOs (but no comprehensive MCO). Because a noncomprehensive MCO covers only a small number of benefits, those enrollees had access to a majority of services only through fee-for-service Medicaid.

Exhibit 2.

Rates of Enrollment in Managed Care and Fee-for-Service Medicaid, by Eligibility Group, 2012

Percent



In 2012, enrollment in managed care—particularly comprehensive managed care—was much more common among nonelderly, nondisabled adults and children than it was among other beneficiaries. The rates of enrollment in comprehensive managed care for children—who accounted for more than half of Medicaid beneficiaries that year—and for nonelderly, nondisabled adults were both roughly 70 percent: 21.6 million children and 8.2 million nonelderly, nondisabled adults were enrolled in a comprehensive MCO. Only 56 percent of elderly and disabled beneficiaries who were not enrolled in Medicare (3.4 million people) and 24 percent of Medicaid beneficiaries who were also enrolled in Medicare (1.7 million) were enrolled in a comprehensive MCO.

The rate of enrollment in noncomprehensive managed care that year was highest among Medicare-Medicaid beneficiaries—40 percent (2.8 million). By comparison, 32 percent of elderly and disabled beneficiaries not enrolled in Medicare (1.9 million), 25 percent of children (7.9 million), and 21 percent of nonelderly, nondisabled adults (2.4 million) were enrolled in at least one noncomprehensive MCO.

If this exhibit were updated to incorporate data on enrollment in the years since the expansion of Medicaid that occurred under the Affordable Care Act, the total number of nonelderly, nondisabled adults enrolled in Medicaid would be greater. Enrollment rates in comprehensive managed care, in particular, would be higher because the vast majority of states that chose to expand Medicaid eligibility under the ACA enrolled newly eligible adults in comprehensive MCOs. Unfortunately, data for more recent years were not available when this analysis was conducted.

Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eExtract.

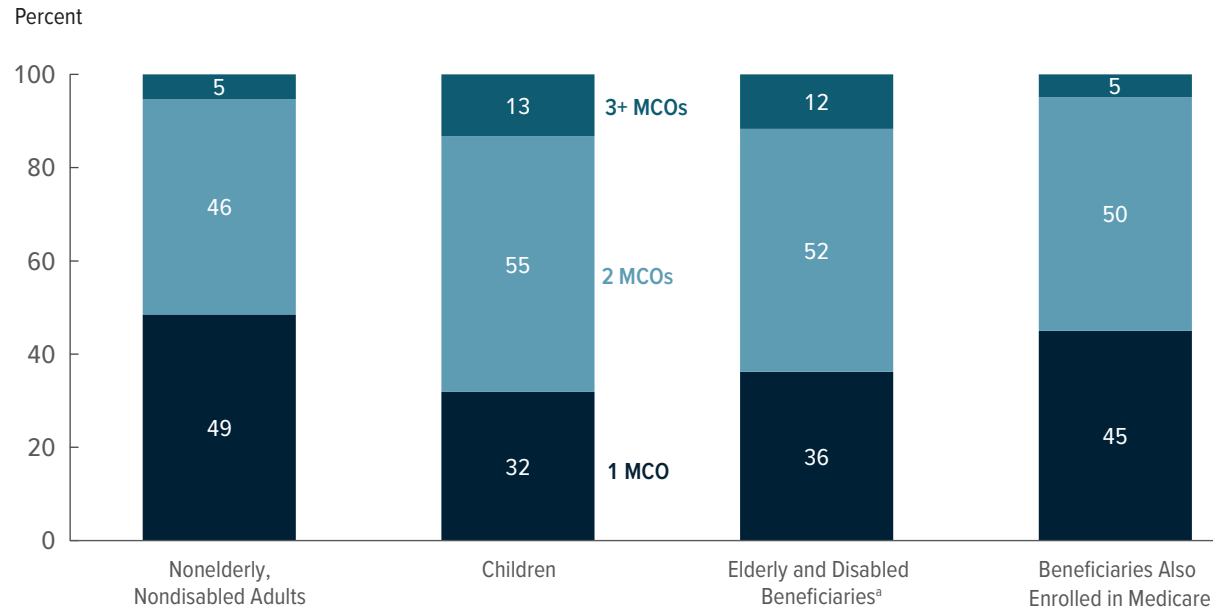
Beneficiaries were considered to be enrolled in comprehensive managed care if they were enrolled in a comprehensive managed care organization (MCO) for at least one month. Beneficiaries were considered to be enrolled in noncomprehensive managed care if they were enrolled in a noncomprehensive MCO for at least one month and not enrolled in a comprehensive MCO at any point during the year. Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE). Noncomprehensive MCOs cover only a narrow set of services, such as behavioral health services, dental care, or nonemergency transportation.

Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

a. Excludes beneficiaries who were enrolled in Medicare.

Exhibit 3.

Number of Managed Care Organizations in Which People Covered by Comprehensive Managed Care Were Enrolled, by Eligibility Group, 2012



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eXtract.

Beneficiaries were considered to be enrolled in comprehensive managed care if they were enrolled in a comprehensive MCO for at least one month. Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE).

Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

MCO = managed care organization.

a. Excludes beneficiaries who were enrolled in Medicare.

The majority of beneficiaries who were enrolled in comprehensive managed care in 2012 were enrolled in more than one MCO during the year; that was true for all Medicaid eligibility groups. Most often, beneficiaries who were enrolled in multiple MCOs were enrolled in both comprehensive and noncomprehensive MCOs, but some beneficiaries were enrolled in multiple comprehensive MCOs (for example, a general comprehensive MCO and PACE).

Rates of enrollment in multiple MCOs were highest for children and for elderly and disabled beneficiaries, largely because more of those beneficiaries were enrolled in dental and behavioral health plans in 2012. Of all children enrolled in a comprehensive MCO, 36 percent were enrolled in a dental plan. For other groups, the percentage of beneficiaries enrolled in both a comprehensive MCO and a dental plan was significantly smaller: 26 percent for beneficiaries who were also enrolled in Medicare, 23 percent for other elderly and disabled beneficiaries, and 20 percent for nonelderly, nondisabled adults. Children receive more extensive dental benefits under Medicaid than other groups do, which probably explains why they were enrolled in dental plans at a higher rate.

Elderly and disabled beneficiaries were more likely than others to be enrolled in a behavioral health plan: 29 percent of elderly and disabled beneficiaries who were enrolled in comprehensive managed care (and not in Medicare) were enrolled in a behavioral health plan. For other groups, the percentage of beneficiaries enrolled in a comprehensive MCO and a behavioral health plan was as follows: 22 percent for children; 19 percent for nonelderly, nondisabled adults; and 17 percent for Medicare-Medicaid beneficiaries. Elderly and disabled beneficiaries' higher rate of enrollment in behavioral health plans reflects the higher prevalence of mental health and substance use disorders among that population.



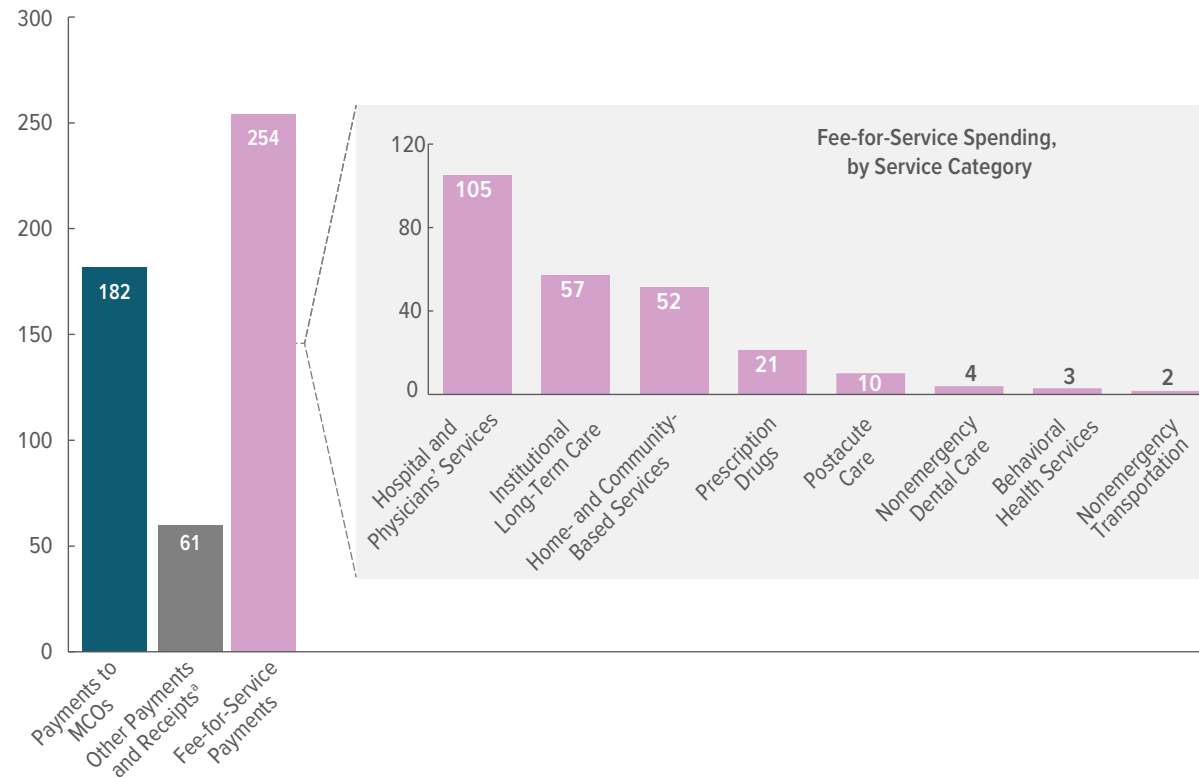
**Why Is Spending on Medicaid Managed Care
Less Than Spending on Fee-for-Service Medicaid?**



Exhibit 4.

Total Medicaid Spending, by Category, 2014

Billions of Dollars



Spending on fee-for-service Medicaid exceeded spending on managed care by roughly 40 percent in 2014. Payments to MCOs accounted for \$182 billion, or 38 percent of total Medicaid spending. But fee-for-service spending, which comprises eight service categories, amounted to \$254 billion, or 54 percent of total Medicaid spending. The remaining 8 percent of spending for Medicaid—\$61 billion—was the net result of other payments and receipts that do not correspond to any particular beneficiary.

The largest category of spending for fee-for-service Medicaid that year was spending on hospital and physicians' services, which accounted for \$105 billion, or 41 percent of all fee-for-service Medicaid spending. However, when the two categories that make up spending on long-term services and supports—institutional long-term care and home- and community-based services—are combined, they account for a total of \$109 billion, or 42 percent of all fee-for-service spending. The next largest category was spending for prescription drugs, which totaled \$21 billion, or 8 percent of all fee-for-service Medicaid spending that year.

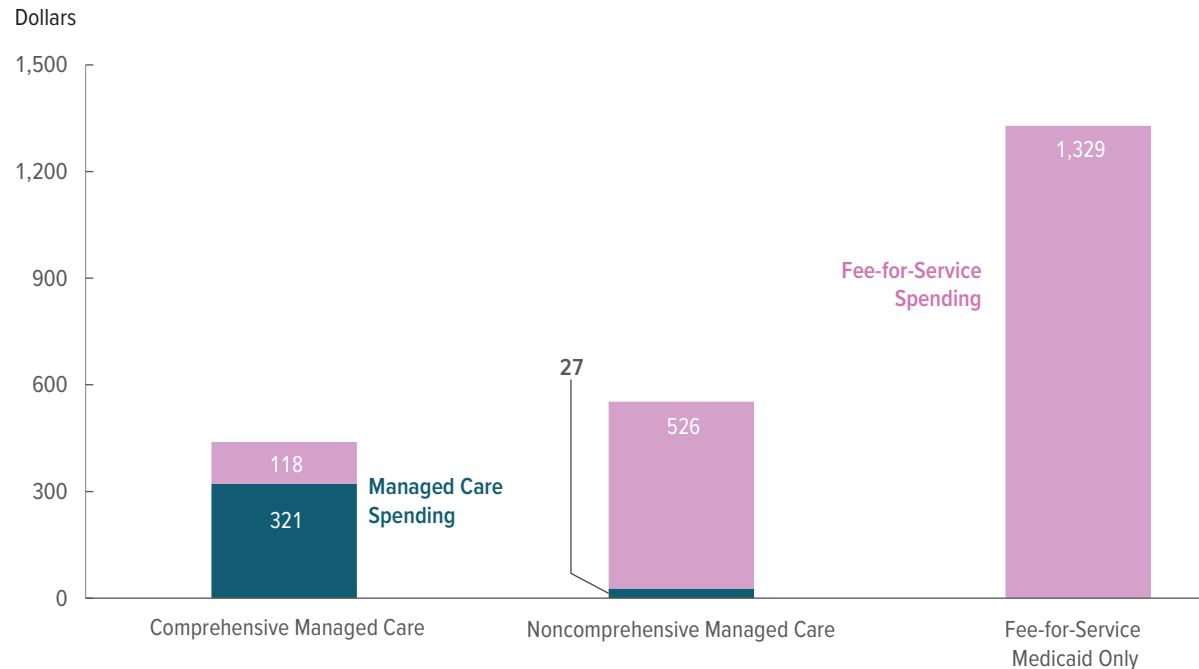
Source: Congressional Budget Office, using data from the expenditure reports from the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (accessed June 10, 2016), <https://go.usa.gov/xnQ7y>.

MCO = managed care organization.

a. Comprises Medicaid spending and rebates that do not correspond to any particular beneficiary—payments made to hospitals that treat a disproportionate share of uninsured and Medicaid patients; payments to teaching hospitals to defray the costs of graduate medical education; other supplemental payments to providers; payments for Medicare premiums, deductibles, and coinsurance; prescription drug rebates; and administrative costs. The Centers for Medicare & Medicaid Services' data on beneficiaries do not include those amounts, so such transactions are excluded from the rest of the analysis in this report.

Exhibit 5.

Average Monthly Spending per Beneficiary on Managed Care and Fee-for-Service Medicaid, by Type of Enrollment, 2012



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eXtract.

Beneficiaries were considered to be enrolled in comprehensive managed care if they were enrolled in a comprehensive managed care organization (MCO) for at least one month. Beneficiaries were considered to be enrolled in noncomprehensive managed care if they were enrolled in a noncomprehensive MCO for at least one month and not enrolled in a comprehensive MCO at any point during the year. Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE). Noncomprehensive MCOs cover only a narrow set of services, such as behavioral health services, dental care, or nonemergency transportation.

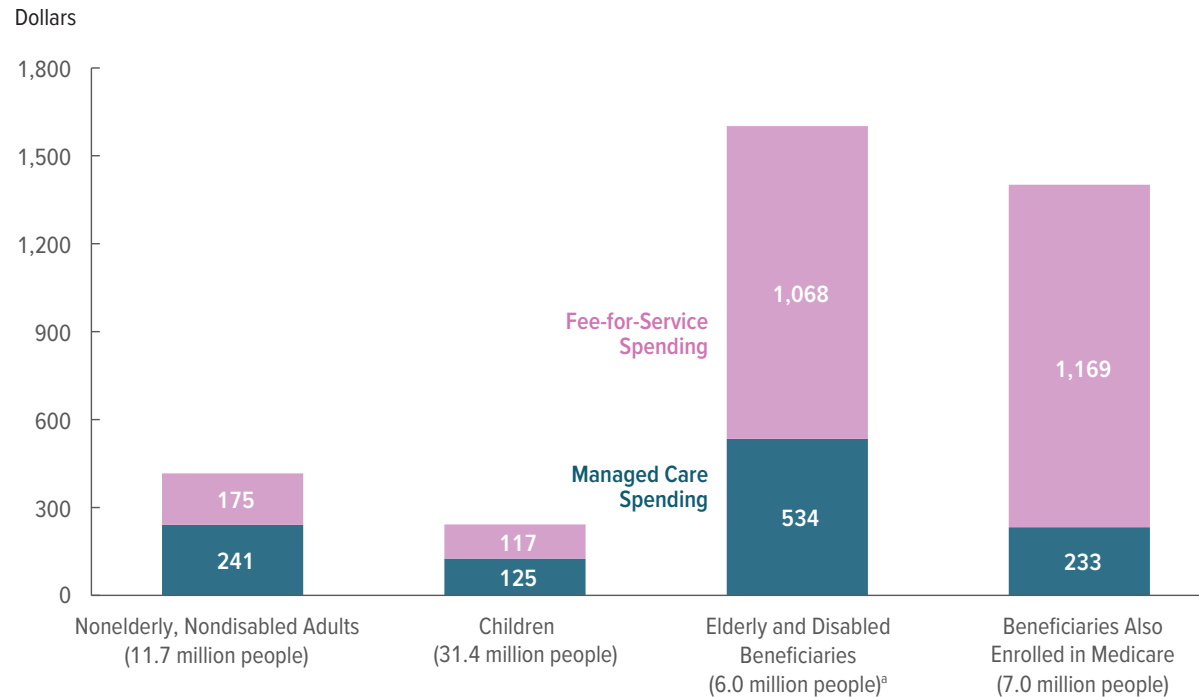
Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

Payments to MCOs account for most Medicaid spending for beneficiaries enrolled in comprehensive managed care but for only a small share of Medicaid spending for beneficiaries enrolled in noncomprehensive managed care. In 2012, 73 percent of average monthly spending for beneficiaries enrolled in comprehensive managed care was for payments to MCOs, whereas only 5 percent of average monthly spending for beneficiaries enrolled in noncomprehensive managed care went to MCOs. The fact that such an overwhelming share of spending for Medicaid beneficiaries enrolled in noncomprehensive managed care—who accounted for more than one-quarter of all Medicaid beneficiaries—goes to fee-for-service Medicaid helps to explain why spending for managed care is so much less than spending for fee-for-service Medicaid despite the high rate of enrollment in managed care.

Although average monthly spending is much lower for beneficiaries enrolled in managed care than it is for those who receive coverage only through fee-for-service Medicaid, that difference only does not mean that managed care saves money. This exhibit does not break down average spending by eligibility group, nor does it account for other characteristics of beneficiaries. Nevertheless, such factors affect Medicaid spending and thus contributed to the differences between average spending for beneficiaries enrolled in managed care and spending for those covered only by fee-for-service Medicaid: As other exhibits illustrate, beneficiaries in eligibility groups with higher average costs are more likely to be covered only by fee-for-service Medicaid.

Exhibit 6.

Average Monthly Spending per Beneficiary on Managed Care and Fee-for-Service Medicaid, by Eligibility Group, 2012



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eXtract.

Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

a. Excludes beneficiaries who were enrolled in Medicare.

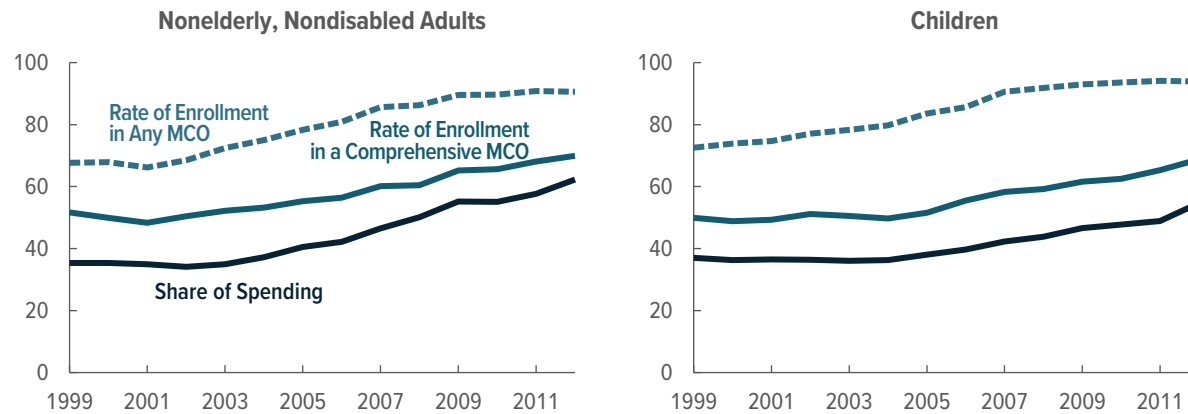
Average monthly Medicaid spending, which is composed of payments to managed care organizations and fees for specific services provided to beneficiaries, is much lower for nonelderly, nondisabled adults and children than it is for elderly and disabled beneficiaries not enrolled in Medicare and for beneficiaries who are enrolled in Medicare. Although 77 percent of Medicaid beneficiaries in 2012 were nonelderly, nondisabled adults or children, they accounted for only 35 percent of Medicaid spending; beneficiaries who were enrolled in Medicare and other elderly and disabled beneficiaries constituted 23 percent of Medicaid beneficiaries but accounted for 65 percent of spending. Average monthly spending that year was \$416 for nonelderly, nondisabled adults and \$242 for children, whereas it was \$1,602 for elderly and disabled beneficiaries not enrolled in Medicare and \$1,402 for Medicare-Medicaid beneficiaries.

In addition, payments to MCOs made up a much larger share of Medicaid spending for nonelderly, nondisabled adults and children than they did of spending for other beneficiaries. In 2012, such payments accounted for more than half of Medicaid spending for nonelderly, nondisabled adults and children (62 percent and 55 percent, respectively) but for only 36 percent of spending for elderly and disabled beneficiaries not enrolled in Medicare and 16 percent of spending for Medicare-Medicaid beneficiaries. One reason that managed care accounts for a significantly larger share of Medicaid spending for nonelderly, nondisabled adults and children is that states are more likely to enroll such beneficiaries in managed care than they are to enroll people in other eligibility groups.

Exhibit 7.

Managed Care’s Enrollment Rate and Share of Medicaid Spending for Nonelderly, Nondisabled Adults and Children, 1999 to 2012

Percent



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services’ Medicaid Analytic eXtracts for 1999 to 2012.

Beneficiaries were considered to be enrolled in comprehensive managed care if they were enrolled in a comprehensive managed care organization (MCO) for at least one month. Beneficiaries were considered to be enrolled in noncomprehensive managed care if they were enrolled in a noncomprehensive MCO for at least one month and not enrolled in a comprehensive MCO at any point during the year. Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE). Noncomprehensive MCOs cover only a narrow set of services, such as behavioral health services, dental care, or nonemergency transportation.

Data were unavailable for Colorado for 2011 and 2012 and for Idaho, Kansas, and Rhode Island for 2012.

The percentage of Medicaid spending that goes to managed care is much smaller than the percentage of Medicaid beneficiaries who are enrolled in managed care. Of nonelderly, nondisabled adults, for example, 91 percent were enrolled in some type of managed care in 2012, but payments to MCOs accounted for only 62 percent of their Medicaid spending. That gap is much narrower when enrollment is defined to include only those beneficiaries enrolled in a comprehensive MCO. In 2012, 70 percent of nonelderly, nondisabled adults covered by Medicaid were enrolled in comprehensive managed care, and 62 percent of Medicaid spending for nonelderly, nondisabled adults was accounted for by managed care, resulting in a gap of just 8 percentage points between the enrollment and spending measures.

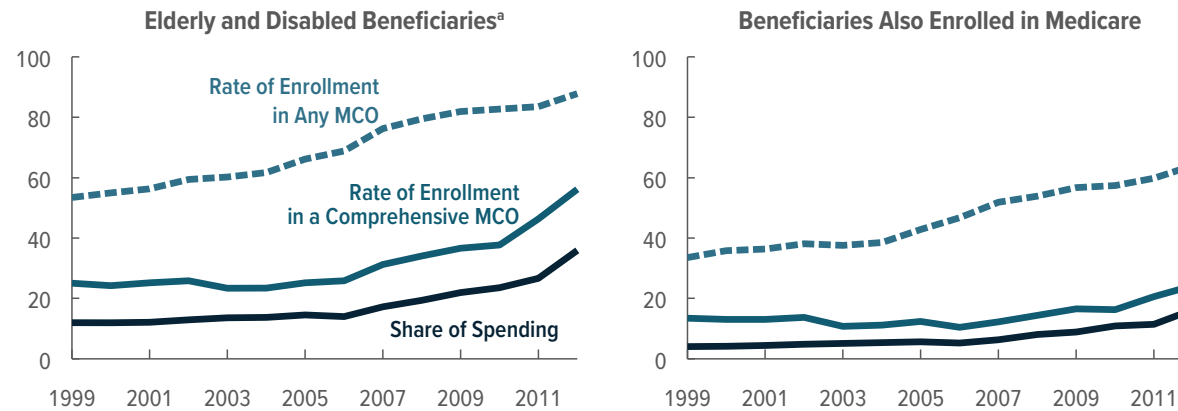
For children, the gap was larger, but again, defining enrollment to include only those beneficiaries enrolled in comprehensive managed care narrows it. The difference between the enrollment and spending measures in 2012, for example, falls from 39 percentage points to 14 percentage points.

Over time, the gap between the rate of enrollment in comprehensive managed care and the share of spending attributable to managed care narrowed for nonelderly, nondisabled adults but not for children. For nonelderly, nondisabled adults, the gap was 16 percentage points in 1999 and declined to 8 percentage points in 2012. For children, the gap was 13 percentage points in 1999 and remained between 13 and 16 percentage points over the entire period. The changes that states made to the types of services that they covered through comprehensive managed care programs probably explain those differing trends.

Exhibit 8.

Managed Care’s Enrollment Rate and Share of Medicaid Spending for Elderly and Disabled Beneficiaries and Beneficiaries Also Enrolled in Medicare, 1999 to 2012

Percent



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services’ Medicaid Analytic eXtracts for 1999 to 2012.

Beneficiaries were considered to be enrolled in comprehensive managed care if they were enrolled in a comprehensive managed care organization (MCO) for at least one month. Beneficiaries were considered to be enrolled in noncomprehensive managed care if they were enrolled in a noncomprehensive MCO for at least one month and not enrolled in a comprehensive MCO at any point during the year. Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE). Noncomprehensive MCOs cover only a narrow set of services, such as behavioral health services, dental care, or nonemergency transportation.

Data were unavailable for Colorado for 2011 and 2012 and for Idaho, Kansas, and Rhode Island for 2012.

a. Excludes beneficiaries who were enrolled in Medicare.

For elderly and disabled beneficiaries who are not enrolled in Medicare and beneficiaries who are enrolled in both Medicare and Medicaid, the gap between their rate of enrollment in managed care and the share of their Medicaid spending attributable to managed care is much narrower when enrollment is defined to include only those beneficiaries enrolled in comprehensive managed care. In 2012, 56 percent of the elderly and disabled beneficiaries who were not enrolled in Medicare were enrolled in a comprehensive MCO, and 36 percent of Medicaid spending for them was accounted for by managed care, resulting in a gap of 20 percentage points between the enrollment and spending measures. By comparison, when enrollment in managed care is defined to include elderly and disabled beneficiaries enrolled in any type of MCO, that gap is 52 percentage points.

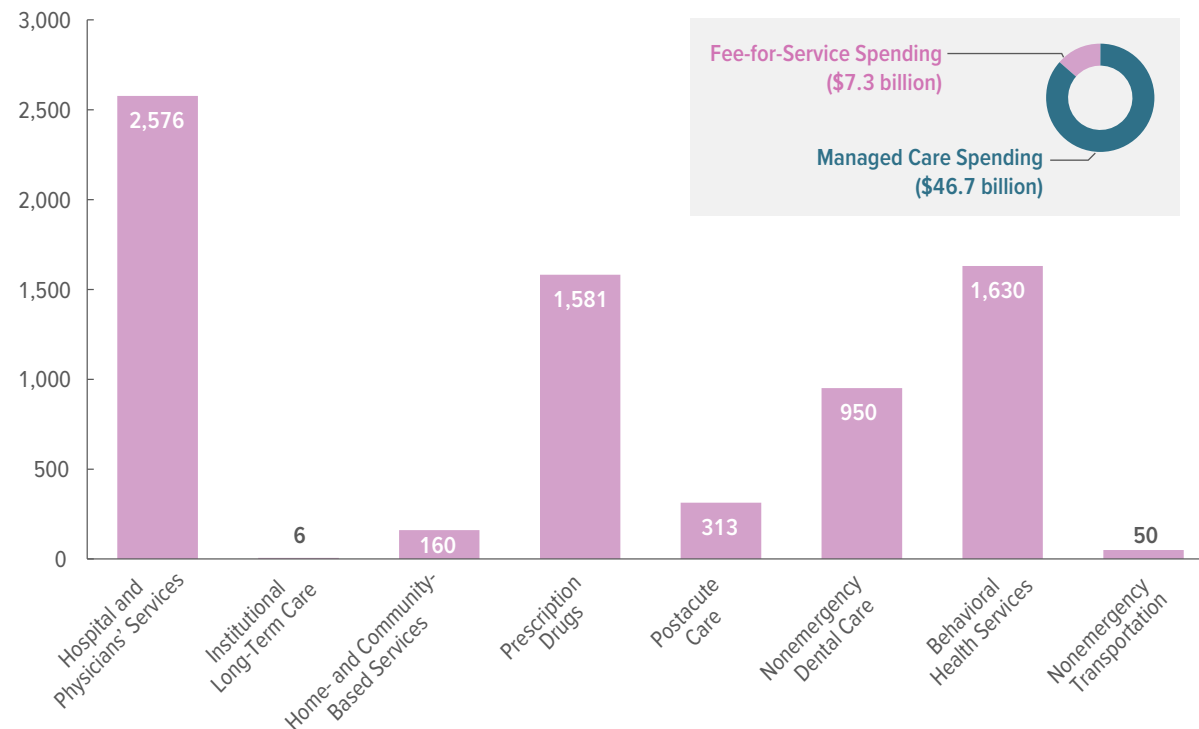
For Medicare-Medicaid beneficiaries, the gap between the rate of enrollment in comprehensive managed care and the share of the group’s spending attributable to managed care was relatively narrow: 8 percentage points in 2012. However, that gap widens to 48 percentage points when enrollment in managed care is defined to include beneficiaries enrolled in any type of MCO.

Over time, the gap between the rate of enrollment in comprehensive managed care and the share of spending attributable to managed care widened for elderly and disabled beneficiaries who were not enrolled in Medicare. Although the difference dropped from 13 percentage points in 1999 to 10 percentage points between 2003 and 2004, it began to increase in 2005. For Medicare-Medicaid beneficiaries, the gap was between 5 percentage points and 9 percentage points from 1999 to 2012.

Exhibit 9.

Fee-for-Service Medicaid Spending for Nonelderly, Nondisabled Adults and Children Who Were Covered by Comprehensive Managed Care for Their Entire Period of Eligibility, by Type of Service, 2012

Millions of Dollars



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eXtract.

This exhibit includes only those beneficiaries who were enrolled in a comprehensive managed care organization (MCO) for their entire period of eligibility in 2012: 5.1 million nonelderly, nondisabled adults (62 percent of all nonelderly, nondisabled adults who were enrolled in a comprehensive MCO for at least one month that year) and 14.3 million children (66 percent of all children who were enrolled in a comprehensive MCO for at least one month that year). Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs) and MCOs that cover long-term services and supports.

Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

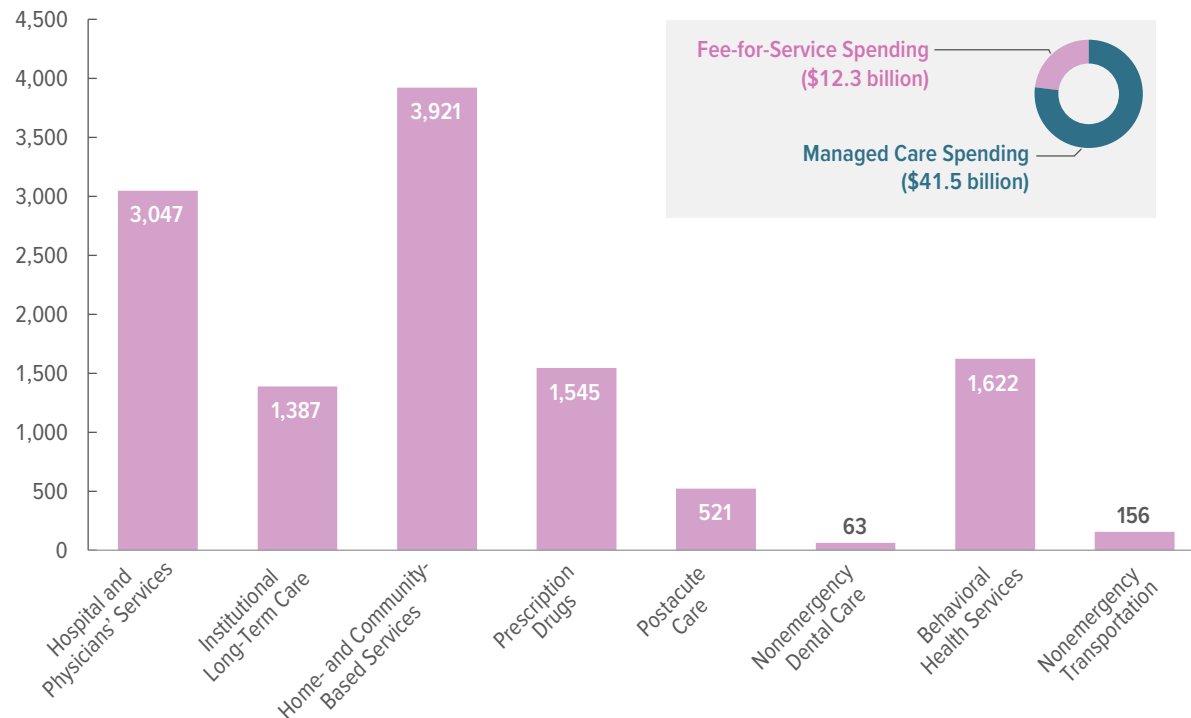
A majority of the nonelderly, nondisabled adults and children who were enrolled in a comprehensive MCO for at least one month in 2012 (and thus categorized as enrolled in comprehensive managed care in previous exhibits) were, in fact, enrolled in such an organization for their *entire* period of Medicaid eligibility that year. For 68 percent of those adults and 61 percent of those children, no fee-for-service spending was reported in 2012. Overall, fee-for-service spending accounted for only 13 percent of total Medicaid spending for nonelderly, nondisabled adults and children who were covered by comprehensive managed care for their entire eligibility period.

For those people, hospital and physicians' services accounted for the largest portion of fee-for-service spending, reflecting both the broad scope of services included in that category and the arrangements that states have made with MCOs to share financial risk for beneficiaries with very high costs. Although risk-sharing arrangements take a variety of forms, they often include provisions that assign states responsibility for very high-cost beneficiaries. The next largest shares of fee-for-service spending were for behavioral health services, prescription drugs, and nonemergency dental care: Those services are often excluded from states' contracts with MCOs and are instead paid for through fee-for-service Medicaid.

Exhibit 10.

Fee-for-Service Medicaid Spending for Elderly and Disabled Beneficiaries and Beneficiaries Also Enrolled in Medicare Who Were Covered by Comprehensive Managed Care for Their Entire Period of Eligibility, by Type of Service, 2012

Millions of Dollars



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eExtract.

This exhibit includes only those beneficiaries who were enrolled in a comprehensive managed care organization (MCO) for their entire period of eligibility in 2012: 2.4 million elderly and disabled beneficiaries who were not enrolled in Medicare (70 percent of all elderly and disabled beneficiaries not enrolled in Medicare who were enrolled in a comprehensive MCO for at least one month that year) and 1.2 million Medicaid beneficiaries who were also enrolled in Medicare (73 percent of all Medicare-Medicaid beneficiaries who were enrolled in a comprehensive MCO for at least one month that year). Comprehensive MCOs are defined here to include MCOs that meet the federal definition of comprehensive (general comprehensive MCOs), MCOs that cover long-term services and supports, and the Program of All-Inclusive Care for the Elderly (PACE).

Data were unavailable for Colorado, Idaho, Kansas, and Rhode Island.

In 2012, 39 percent of all Medicaid beneficiaries who were also enrolled in Medicare or who were elderly or disabled but not enrolled in Medicare were covered by comprehensive managed care for their entire period of eligibility. Of those people, 64 percent of Medicare-Medicaid beneficiaries and 49 percent of other elderly and disabled beneficiaries had no fee-for-service Medicaid spending. Overall, fee-for-service spending accounted for only 23 percent of total Medicaid spending for people in those categories who were covered by comprehensive managed care for their entire period of eligibility.

For those people, the largest share of fee-for-service spending in 2012—\$3.9 billion, or almost one-third—went to home- and community-based services. Those beneficiaries' other major categories of spending were similar to those of nonelderly, nondisabled adults and children: hospital and physicians' services, behavioral health services, and prescription drugs.

A striking difference between people in those two categories who were covered by comprehensive managed care for their entire period of eligibility and those who were not is the breakdown of their fee-for-service spending on long-term services and supports. For the group covered by comprehensive managed care, 74 percent of such spending paid for home- and community-based services, and 26 percent for institutional long-term care. For the group with only fee-for-service coverage, 30 percent paid for home- and community-based services, and 70 percent for institutional long-term care. It may be that beneficiaries enrolled in a comprehensive MCO who need long-term services and supports are more likely than other beneficiaries to be served outside of institutions. Or perhaps home- and community-based services are more likely than institutional long-term care to be excluded from states' contracts with MCOs (and must therefore be paid for through fee-for-service arrangements).

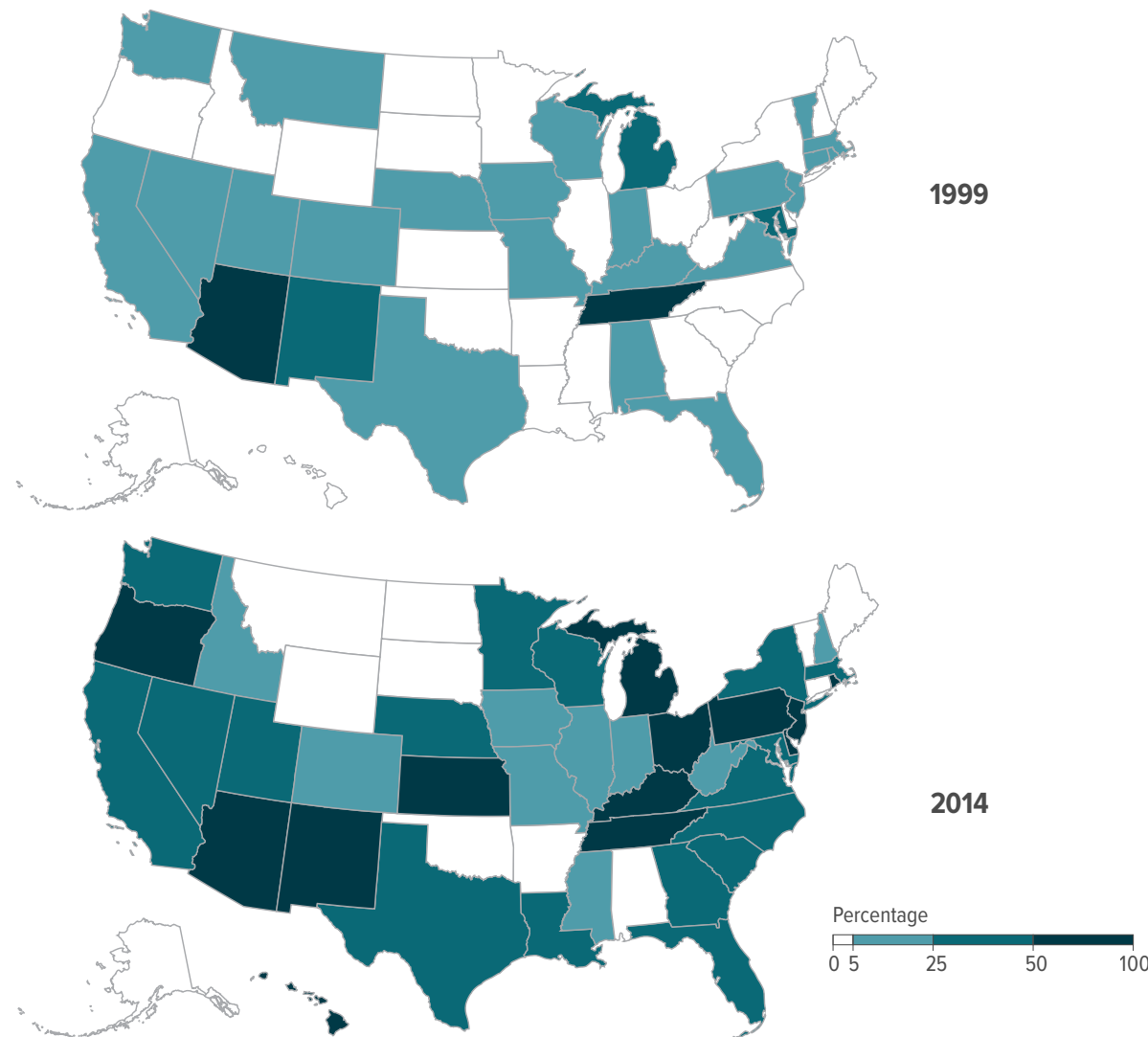


How Have Changes in Spending on Medicaid Managed Care Varied by State?



Exhibit 11.

Share of Medicaid Spending Attributable to Managed Care, by State, 1999 and 2014



In most states, the share of Medicaid spending attributable to managed care increased from 1999 to 2014. Over that period, the number of states in which managed care accounted for more than 25 percent of Medicaid spending grew from 5 to 30, and the number of states in which managed care accounted for more than 50 percent of Medicaid spending grew from 2 to 13. The number of states reporting that less than 5 percent of their Medicaid spending paid for managed care dropped substantially, from 22 in 1999 to 11 in 2014.

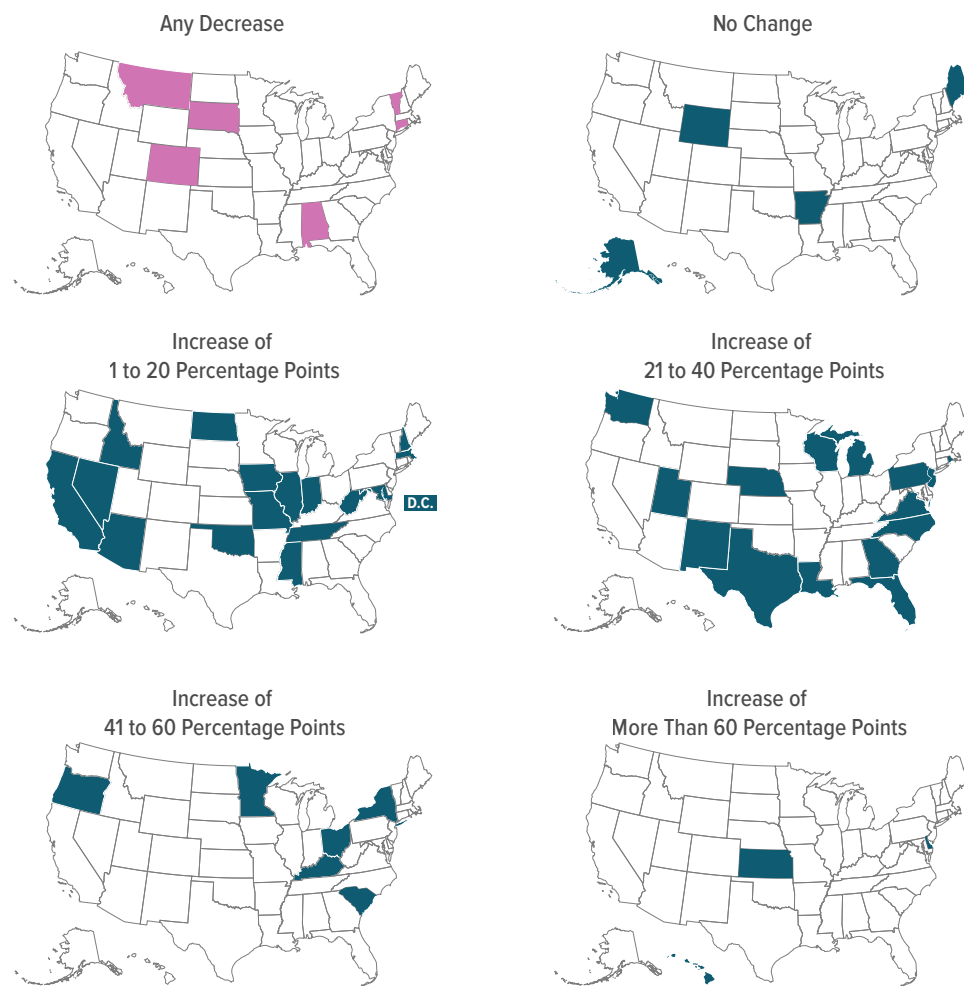
The types of managed care organizations operating in a state are directly related to the share of the state’s Medicaid spending that goes to managed care. All states that reported that more than 50 percent of their Medicaid spending was for managed care had general comprehensive MCOs. In 2014, 4 states reported that payments to MCOs accounted for at least 80 percent of their Medicaid spending. All 4 of those states had general comprehensive MCOs but no noncomprehensive MCOs.

That same year, 11 states with general comprehensive MCOs reported that less than 26 percent of their Medicaid spending was for managed care. There are several possible reasons why managed care accounted for only a small percentage of Medicaid spending in those states: The general comprehensive MCOs may have covered only part of the state, excluded one or more eligibility groups, or excluded costly service categories, or enrollment in the programs may have been voluntary in those states.

Source: Congressional Budget Office, using data from the expenditure reports from the Medicaid Budget and Expenditure System/ State Children’s Health Insurance Program Budget and Expenditure System (accessed July 26, 2018), <https://go.usa.gov/xnQ7y>.

Exhibit 12.

Changes in the Share of Medicaid Spending Attributable to Managed Care, by State, 1999 to 2014



Managed care’s share of Medicaid spending declined in just six states between 1999 and 2014. The state with the largest decline (25 percentage points)—Vermont—uses a model referred to as public managed care. The Department of Vermont Health Access serves as the state’s sole MCO and covers the majority of Medicaid beneficiaries. Although the program is a type of managed care, because it is a public-private partnership, the Centers for Medicare & Medicaid Services classifies spending for it as going to fee-for-service Medicaid. As a result of that treatment, no Medicaid spending is attributed to managed care in the state’s financial reports to CMS even though the state reports operating a comprehensive managed care program.

Three other states reported substantial declines in the share of their Medicaid spending that was attributable to managed care from 1999 to 2014. Alabama’s share declined by 18 percentage points; Connecticut’s, by 15 percentage points; and Montana’s, by 9 percentage points. All three of those states eliminated general comprehensive managed care programs in those years. Two states, Colorado and South Dakota, reported declines of less than 5 percentage points.

For the remaining states (aside from four whose share did not change), managed care’s share of Medicaid spending increased over the period, but the size of those increases varied substantially. Delaware, Kansas, and Hawaii adopted new programs and reported dramatic increases in the share of their Medicaid spending attributable to managed care—increases of 68, 85, and 88 percentage points, respectively. In other states, managed care increased by smaller amounts, which in some cases reflect growth of an existing managed care program and in others establishment of a new one.

Source: Congressional Budget Office, using data from the expenditure reports from the Medicaid Budget and Expenditure System/ State Children’s Health Insurance Program Budget and Expenditure System (accessed July 26, 2018), <https://go.usa.gov/xnQ7y>.

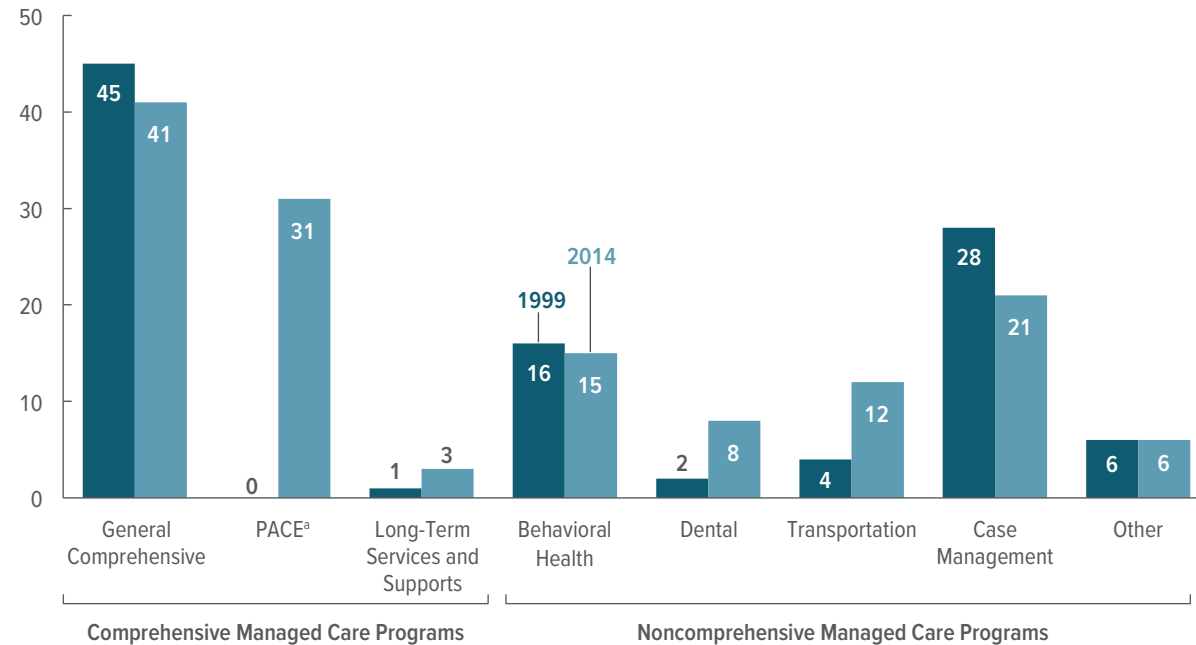


How Has States' Use of Medicaid Managed Care Changed Over Time?



Exhibit 13.

Number of States With Managed Care Programs, by Type of Program, 1999 and 2014



Source: Congressional Budget Office, using the Centers for Medicare & Medicaid Services' descriptions of managed care programs.

Comprehensive managed care programs are defined here to include programs that meet the federal definition of comprehensive (general comprehensive programs), programs that cover long-term services and supports, and PACE. Noncomprehensive managed care programs cover only a narrow set of services, such as behavioral health services, dental care, or nonemergency transportation.

PACE = Program of All-Inclusive Care for the Elderly.

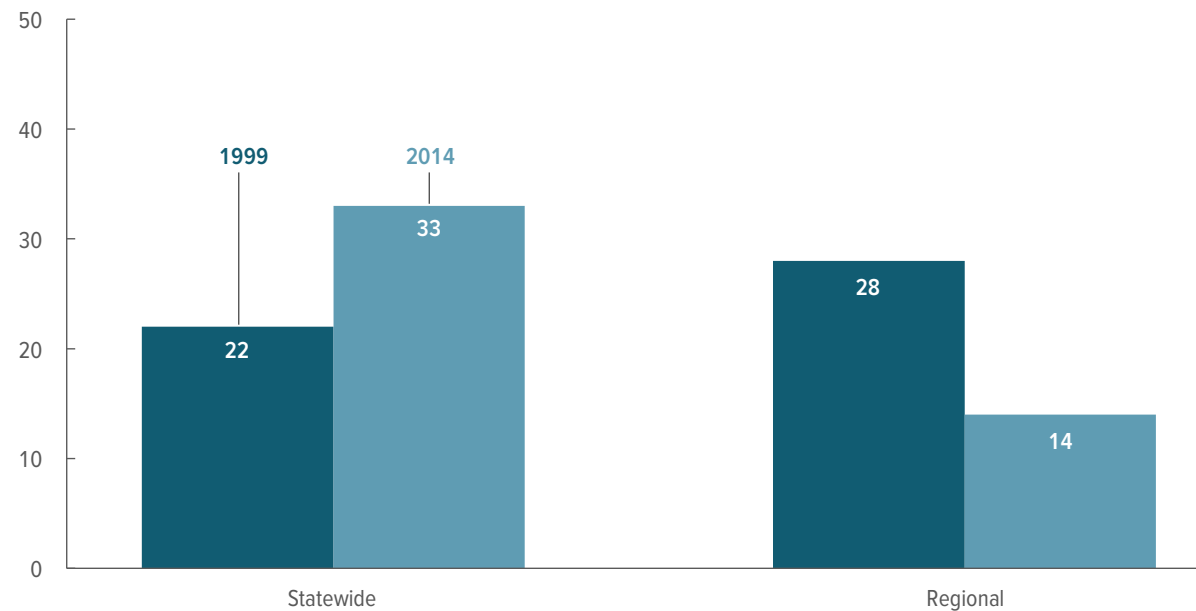
a. PACE was established as a Medicare and Medicaid provider by the Balanced Budget Act of 1997. However, the final regulations governing the programs were not issued until November 2006. The Centers for Medicare & Medicaid Services did not collect data on PACE organizations as part of its tracking of managed care programs in 1999, but it has done so since at least 2005. For more information, see National PACE Association, "What Is PACE?" (accessed July 26, 2018), <http://npaonline.org/pace-you#History>.

Between 1999 and 2014, the number of states with general comprehensive managed care organizations and noncomprehensive MCOs that provide case management services declined while the number of states with PACE organizations and MCOs covering long-term services and supports, dental services, and transportation increased. The largest increase was in the number of states with PACE organizations, but those organizations serve very small populations: a local community of people who are age 55 or older and need the equivalent of nursing home care. Of the other programs, dental and transportation plans tend to cover the most people, so the increase in the number of those programs had a particularly large effect on the total number of enrollees with coverage through a noncomprehensive MCO.

The decline in the number of states offering some types of managed care—especially general comprehensive care—is surprising given the increases in the rates of enrollment in managed care and the shares of Medicaid spending going to MCOs nationally. Although fewer states had general comprehensive managed care programs than had them 15 years earlier, in 2014 general comprehensive MCOs were more likely to cover the entire state, and they tended to provide coverage for more eligibility groups and for a wider array of services. Furthermore, in 2014, states were more likely than they were in 1999 to make enrollment in general comprehensive MCOs mandatory for all eligibility groups.

Exhibit 14.

Number of States With General Comprehensive Managed Care Programs, by Coverage Area, 1999 and 2014



Source: Congressional Budget Office, using the Centers for Medicare & Medicaid Services' descriptions of managed care programs.

General comprehensive managed care programs are those that meet the federal definition of comprehensive. In 1999, 45 states had some type of general comprehensive managed care program; by 2014, that number had fallen to 41. In both years, that number is less than the sum of the number of states with statewide programs and the number of states with regional programs because some states had both statewide and regional general comprehensive managed care programs.

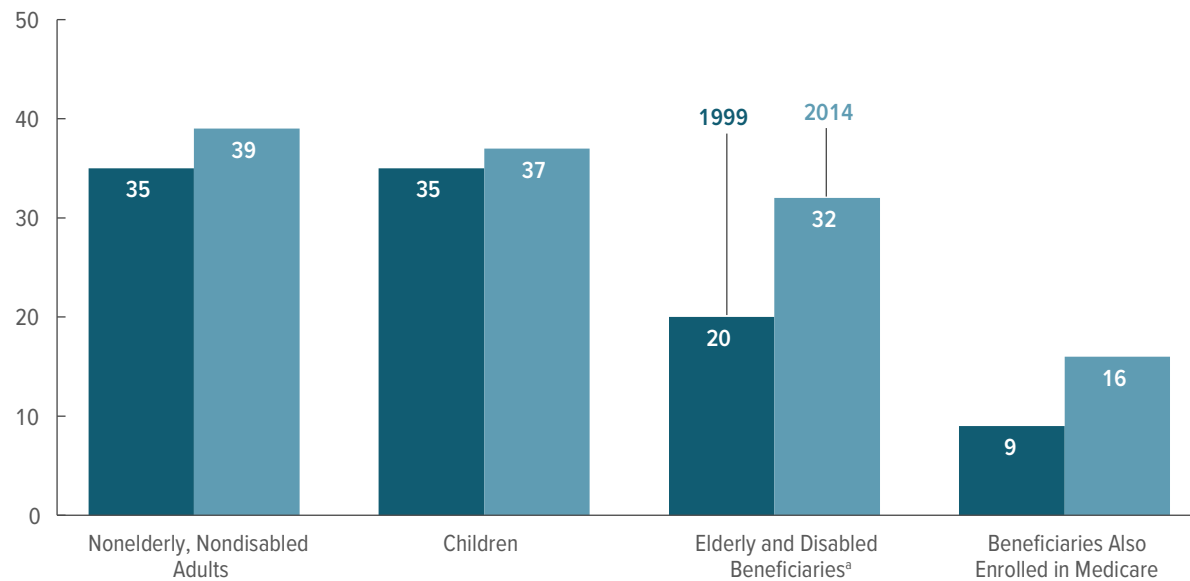
States may implement general comprehensive managed care programs that cover either the entire state or only selected regions within the state. States that had general comprehensive managed care programs were much more likely to provide statewide coverage through those programs in 2014 than they had been in 1999. Although this analysis did not explore the reasons behind states' decisions to implement, expand, or discontinue programs, it is possible that many states adopted small managed care programs initially and later expanded those programs statewide. Similarly, the movement from regional to statewide managed care may reflect MCOs' growing and increasing their capacity to enroll beneficiaries and to contract with health care providers.

In the case of regional managed care, regions may be limited to a single county, several neighboring counties, or selected counties across the state (all urban counties, for example). Further, states might have multiple managed care programs that span overlapping areas in which much of the state's population resides, so even a state without a single statewide program might have general comprehensive managed care available to most of the state's Medicaid beneficiaries. That was the case in Illinois, for example, which had three general comprehensive managed care programs. Those three programs covered only 50 of the state's 102 counties, but 90 percent of its population lived in those counties in 2014.

Some states have both statewide and regional managed care programs. Texas, for example, had one general comprehensive managed care program that covers the entire state and a second general comprehensive managed care program that provides long-term services and supports in 10 counties.

Exhibit 15.

Number of States With Mandatory Enrollment in General Comprehensive Managed Care Programs, by Eligibility Group, 1999 and 2014



Source: Congressional Budget Office, using the Centers for Medicare & Medicaid Services' descriptions of managed care programs.

General comprehensive managed care programs are those that meet the federal definition of comprehensive. In 1999, 45 states had some type of general comprehensive managed care program; by 2014, that number had fallen to 41.

CBO treated a state as having mandatory enrollment if the state required any subset of the eligibility group to enroll in general comprehensive managed care.

a. Excludes beneficiaries who were enrolled in Medicare.

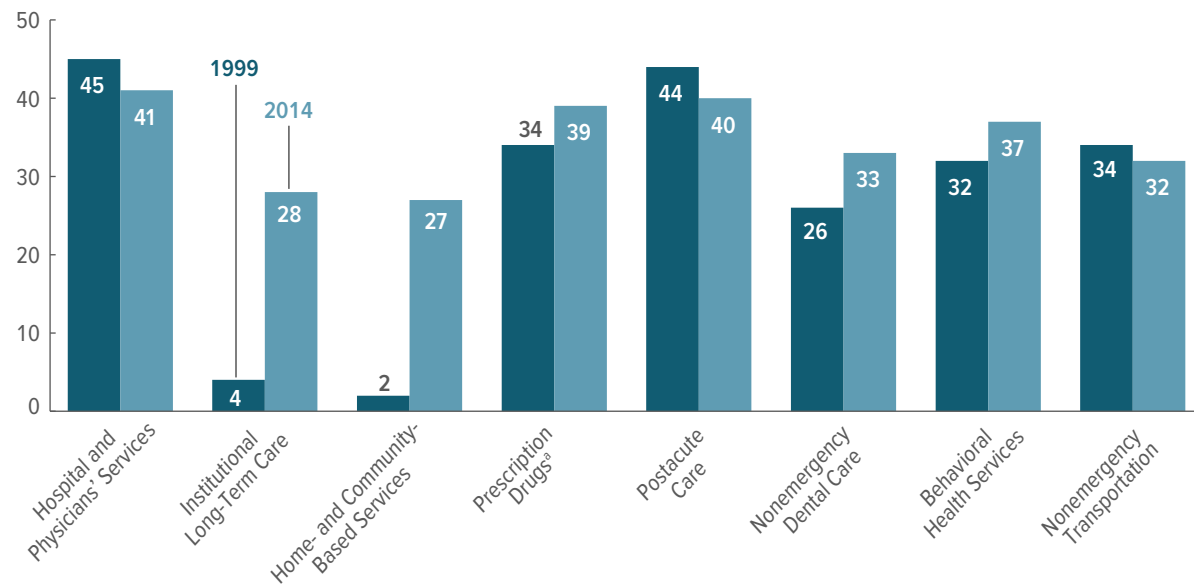
Between 1999 and 2014, the number of states that required Medicaid beneficiaries to enroll in a general comprehensive MCO increased for all eligibility groups. The increase in mandatory enrollment in managed care was particularly significant for beneficiaries who were also enrolled in Medicare and for other elderly and disabled beneficiaries. At least two factors contributed to that development: MCOs increased their capacity to serve a larger number and a wider range of beneficiaries, and states decided to expand voluntary programs by making them mandatory.

Voluntary enrollment poses challenges that states are able to mitigate by shifting to mandatory enrollment. With voluntary enrollment, if beneficiaries who choose to enroll in managed care have health characteristics that distinguish them from other beneficiaries, it can be difficult for states to establish payment rates that accurately reflect enrollees' costs. Moreover, voluntary enrollment requires states to have the administrative capacity to maintain two systems—fee for service and managed care—for a given eligibility group.

States are less likely to mandate enrollment in managed care for Medicaid beneficiaries who are enrolled in Medicare. Federal policy restricts states' authority to mandate enrollment for those beneficiaries more than it does for other groups. Furthermore, for Medicare-Medicaid beneficiaries, Medicare is the primary payer for most acute and postacute care, so Medicaid is the secondary payer for many of the services, such as inpatient hospital care, that account for most of the other groups' Medicaid spending. Most of the Medicaid spending for Medicare-Medicaid beneficiaries goes to long-term services and supports, which are less frequently covered through managed care.

Exhibit 16.

Number of States With General Comprehensive Managed Care Programs That Covered Selected Services, 1999 and 2014



Source: Congressional Budget Office, using the Centers for Medicare & Medicaid Services' descriptions of managed care programs.

General comprehensive managed care programs are those that meet the federal definition of comprehensive. In 1999, 45 states had some type of general comprehensive managed care program; by 2014, that number had fallen to 41.

a. For information on how prescription drug coverage changed as a result of the Affordable Care Act, see Brian Bruen and Katherine Young, *Paying for Prescribed Drugs in Medicaid: Current Policy and Upcoming Changes* (Kaiser Family Foundation, May 2014), <https://tinyurl.com/yblntnpj>.

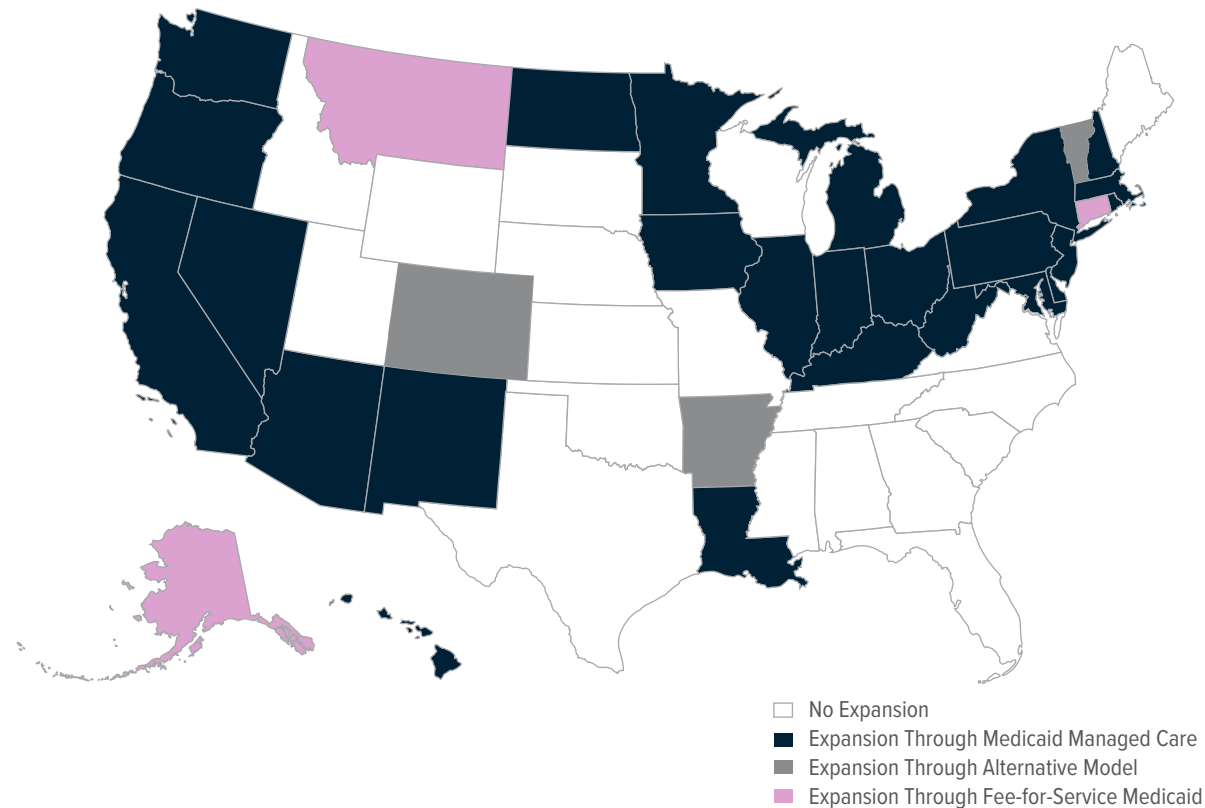
Between 1999 and 2014, the scope of states' general comprehensive managed care programs increased to cover a wider range of services. Although the number of states with comprehensive MCOs declined, the number of states that covered a particular type of service increased for most service categories.

The most significant increases over the period were for long-term services and supports. The number of states with general comprehensive MCOs that covered institutional long-term care increased from 4 to 28; for home- and community-based services, the increase was from 2 to 27. Those increases reflect changes not only in managed care but also in Medicaid more generally. Between 1999 and 2014, states dramatically increased the home- and community-based services they provided through Medicaid for all eligibility groups, and they tried to move from providing long-term services and supports in institutional settings to providing such services in community settings. States often included both types of services in their contracts with MCOs to achieve those objectives.

Coverage of prescription drugs increased in response to the Affordable Care Act, which required drug manufacturers to pay rebates to MCOs similar to those they were already paying to states; previously, states often excluded prescription drugs from their contracts with MCOs to obtain higher rebates. States may have added other services to their MCO contracts as insurers in the private market expanded their coverage to include those services. It is generally easier to add coverage for a service when employers and other payers are already covering it.

Exhibit 17.

States That Expanded Medicaid Under the Affordable Care Act, by Payment System Used to Cover the Newly Eligible Population, as of July 2018



Source: Congressional Budget Office, using data from the Kaiser Family Foundation and the Centers for Medicare & Medicaid Services.

Maine and Virginia have decided to expand Medicaid, but they have not yet done so.

The ACA authorized states to expand Medicaid to nonelderly, nondisabled adults with income less than or equal to 138 percent of the federal poverty guidelines (commonly referred to as the poverty level). The ACA specified a benefit package for people made eligible for Medicaid by the expansion that differed from the benefits that Medicaid traditionally provided. The new package (often referred to as a benchmark benefit or benchmark-equivalent benefit) included the same benefits as those provided by the health insurance plans available through the marketplaces that the legislation established. The newly eligible population's benefits are thus very similar to the benefits provided under private health insurance plans.

Perhaps because of that requirement, most states that expanded Medicaid chose to cover the newly eligible population through managed care. Of the 31 states (plus the District of Columbia) that had expanded Medicaid as of July 2018, only 3—Alaska, Connecticut, and Montana—covered the newly eligible population using a fee-for-service system exclusively. Three states expanded Medicaid using an alternative approach to cover newly eligible beneficiaries: Arkansas provided subsidies to newly eligible adults that they could use to purchase nongroup coverage through the marketplace, a health care model that has been referred to as the private option. Colorado expanded Medicaid through its Accountable Care Collaborative program, which is a primary care case management program that uses a network of regional care collaborative organizations to coordinate acute, primary, and specialty care; pharmacy benefits; and some behavioral health services. Through a public-private partnership, Vermont established a program, operated by the Department of Vermont Health Access, that delivers services using a model similar to managed care.

Appendix: Data and Methods

To explore the growth of enrollment in and spending for Medicaid managed care—and the reasons that managed care’s enrollment rate is much higher than its share of Medicaid spending—this document integrates detailed quantitative data on beneficiaries, data on states’ aggregate spending, and qualitative data on the characteristics of Medicaid managed care programs. Integrating the various types of data allowed the Congressional Budget Office to provide new information on enrollment and spending trends as well as on changes in states’ use of managed care.

Pulling such data together, however, presented some challenges. States submit various sources of Medicaid data to the Centers for Medicare & Medicaid Services (CMS), but the time between when those data are submitted and when they are available for researchers to use varies among data sources. The lag times are most significant for data on beneficiaries—which, as of July 2018, were available only through 2012 for most states.¹ As a result, CBO limited its analysis of the data on beneficiaries to the years 1999 to 2012. Further,

1. For more information on the file, see Research Data Assistance Center, “MAX Personal Summary File” (accessed July 26, 2018), www.resdac.org/cms-data/files/max-ps; and Centers for Medicare & Medicaid Services, “Medicaid Analytic eXtract (MAX) General Information” (updated March 2, 2018), <https://go.usa.gov/xnGwE>.

those data exclude some states in some years: Data were unavailable for Colorado for 2011 and 2012 and for Idaho, Kansas, and Rhode Island for 2012, but the missing data did not affect comparisons over time.²

CBO supplemented the data on beneficiaries with data on states’ aggregate spending from the CMS Expenditure Reports and qualitative data on states’ Medicaid managed care programs. The CMS expenditure data are publicly available through 2016.³ The program descriptions are also available through 2016, but CBO discovered discrepancies between information in those files and data from other sources starting with the data for 2015.⁴ As a result, CBO limited its analysis of states’ managed care programs to the years 1999 to 2014. Because comparing states’ spending with information on

2. Time series that exclude Colorado, Idaho, Kansas, and Rhode Island from all years are posted along with this report on CBO’s website (www.cbo.gov/publication/54235).
3. See Centers for Medicare & Medicaid Services, “Expenditure Reports From MBES/CBES” (accessed July 26, 2018), <https://go.usa.gov/xnQ7y>.
4. Program descriptions were obtained from a variety of sources including the Centers for Medicare & Medicaid Services, “Medicaid Managed Care Enrollment Report” (accessed July 26, 2018), <https://go.usa.gov/xnGGh>, and personal communications with CMS.

their managed care programs was central to this analysis, CBO limited its analysis of the spending data to those same years.

States’ Medicaid managed care programs vary considerably in terms of the number and types of services covered. Whereas some programs provide comprehensive coverage, others cover only a single type of service. To simplify the analysis presented here, CBO categorized managed care programs as either comprehensive or noncomprehensive (see the table on page 29).

One challenge with those definitions is that federal law permits states significant leeway in categorizing a managed care organization (MCO) as a general comprehensive MCO on the basis of the services it covers. Most research on Medicaid managed care has defined managed care programs to include either any type of MCO or only MCOs that meet the federal definition of *general comprehensive*, despite the fact that the programs that have met that definition have varied significantly in terms of services covered, both from state to state and over time. Although quantitative data on Medicaid managed care provide some information on which beneficiaries were enrolled in general comprehensive MCOs and how much Medicaid spent on them, determining precisely which

Types of Medicaid Managed Care Organizations

Type	Services Covered	2012 Enrollment (In millions)
Comprehensive Managed Care		
General Comprehensive	Either inpatient hospital services and at least one other service from a specified list of services (outpatient hospital services; rural health clinic services; federally qualified health center services; other laboratory and x-ray services; nursing facility services; early and periodic screening, diagnostic, and treatment services; family planning services; physicians' services; and home health services), or three or more services from that same list ^a	34.6
Long-Term Services and Supports	Nursing home care and community-based long-term services and supports, as well as supports for beneficiaries with a demonstrated need for such services	0.2
Program of All-Inclusive Care for the Elderly (PACE)	Medical and social services in an adult day health care center supplemented by in-home and referral services according to beneficiaries' needs; serves only beneficiaries age 55 or older who need a nursing home level of care and live in a PACE organization service area	0.1
Noncomprehensive Managed Care		
Dental	Dental care	13.9
Behavioral Health	Services to treat mental health conditions or substance use disorders for beneficiaries with a qualifying diagnosis	11.6
Case Management (Primary care case management)	Case management services; may also include any of the following: intensive telephonic or face-to-face case management, development of enrollee care plans, execution of contracts with or oversight of fee-for-service providers, payments to fee-for service providers on behalf of a state, outreach and education activities, customer service call centers, review of providers' claims and of their use and practice patterns, quality improvement activities, coordination with behavioral health systems, and coordination with systems providing long-term services and supports ^a	9.9
Other	Plans not meeting any of the other definitions; examples include managed care organizations that cover only nonemergency medical transportation, bariatric surgery, medical-only prepaid ambulatory care, or inpatient hospital services	11.7

Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services' 2012 Medicaid Analytic eXtract. The 2012 data are the most recent data available for most states, but Colorado, Idaho, Kansas, and Rhode Island did not provide data for that year.

a. As specified by the Medicaid Managed Care Rule, 42 C.F.R. § 438.2 (2016).

services general comprehensive MCOs covered on the basis of those data is not possible.

To address that limitation with the data, CBO developed a method for analyzing the qualitative descriptions of MCOs that involves extracting key characteristics from the program descriptions and compiling them into a Microsoft Excel database. The key data included which states had various types of MCOs and, for states that had general comprehensive MCOs, whether those programs were statewide or regional and which eligibility groups and services the programs covered. The resulting data allowed CBO to analyze how Medicaid managed care programs have varied among states and how they have changed over time.

To the best of CBO's knowledge, no other researchers have compiled a data set that lends itself to such analysis over an extended period of time. The data that the agency compiled on states' Medicaid managed care programs include not only the characteristics of the programs that were derived from the descriptions but also other measures aggregated from the data on Medicaid beneficiaries that CMS compiles. That data set is published as a supplement to this report on CBO's website (www.cbo.gov/publication/54235).



About This Document

This report was prepared at the request of the Chairman of the House Committee on Energy and Commerce. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the report makes no recommendations.

Alice Burns and Benjamin Layton (formerly of CBO) prepared the report with guidance from Lyle Nelson. Jessica Banthin, Chad Chirico, Noelia Duchovny, Sebastien Gay, Tamara Hayford, Leo Lex, Andrea Noda, Lisa Ramirez-Branum, John Skeen, and David Weaver of CBO provided useful comments. Justin Lee handled all the fact-checking.

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Jeffrey Kling and Robert Sunshine reviewed the report, Bo Peery edited it, and Jorge Salazar and Casey Labrack prepared it for publication. An electronic version of the report is available on CBO's website (www.cbo.gov/publication/54235).

Keith Hall
Director
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