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Medicaid Managed Care: A Multibillion-Dollar Business With Little Oversight

Introduction

Medicaid managed care organizations (MCOs) are essential to the U.S. health care system and are responsible for delivering health care services through state Medicaid programs to nearly 60 million Americans.[1] As part of their critical role in health care delivery, MCOs are accountable for managing costs, utilization and the quality of care delivered to our nation's families who rely on Medicaid for health insurance.[2] They contract with state Medicaid agencies and receive capitated payments to maintain provider networks that meet the needs of the patients they serve.[3] Over the last 30 years, the role of Medicaid MCOs in the health care system has expanded significantly, with more than 40 states now relying on MCOs to administer Medicaid benefits.[4] Some states are also leveraging MCOs to coordinate and integrate health care services to improve the health of populations with chronic and complex conditions, and to increase accountability for high-quality care.[5]

As the role of Medicaid MCOs has expanded, health care spending has increased. Between 2013 and 2021, health care spending on Medicaid MCOs nearly tripled, from more than $130 billion to $376 billion, now accounting for 55% of total national Medicaid expenditures.[6] Today, five for-profit, publicly traded companies account for 50% of Medicaid MCO enrollment nationally.[7] In 2022, each of these MCOs ranked in the Fortune 500, and four ranked in the top 100 with their total 2022 revenues ranging from $32 billion to $324 billion.[8]

health care spending on Medicaid MCOs

2013 — 2021

$130 BILLION — **$376 BILLION**

Despite all the Medicaid funding that flows through MCOs, there is little insight into how that funding is used to deliver care. In fact, MCOs have come under recent scrutiny by federal regulators due to high rates of denials of prior authorizations as well as a lack of state oversight that has reduced access to care for our nation's families.[9]

Medicaid managed care plan performance is unclear

Families USA conducted a literature review both to better understand whether MCOs are meeting their responsibility to Medicaid beneficiaries and to offer ideas on how to improve the oversight and accountability of Medicaid MCOs through policymaking at the federal and state level. Families USA reviewed over 50 resources, including academic literature, policy white papers, state Medicaid assessments and evaluations, reports from the U.S. Department of Health and Human Services Office of Inspector General, and the Government Accountability Office to assess MCO effectiveness in improving access to and coordination of health care services, particularly for beneficiaries with complex health conditions. Through this this review, Families USA identified two major findings:

1. There is limited evidence assessing MCOs' ability to improve access to health care and improve health care coordination.
2. There is a lack of federal and state tools for effective MCO oversight and accountability.

Below is a summary of those findings.

Limited evidence of improving access to care and care coordination

One of the key functions of MCOs is to deliver and coordinate health care services for Medicaid beneficiaries, thereby improving access to health care, yet there is limited data available to evaluate whether MCOs are largely successful in accomplishing this goal.[10] Reviews of over 140 academic studies, including a review of the academic literature by the Medicaid and CHIP Payment and Access Commission (MACPAC), concluded that there are major gaps in MCO performance data which significantly limit the ability to assess whether MCOs improve health care access or the quality of care.[11,12,13] Among the available data, there is evidence to suggest that the initial transition away from fee-for-service Medicaid to managed care can increase health care access but that MCOs often create structural barriers — such as limited access to in-network primary care providers or an insufficient network of specialists — that limit patients' access to their Medicaid benefits.[14,15,16,17] Furthermore, a recent report from the HHS Office of Inspector General reviewed prior authorization denial rates among the seven largest MCO companies covering nearly 30 million people and found that, in 2019, these MCOs on average denied one out of every eight prior authorization requests for services, with 12 MCO plans having denial rates greater than 25% (for contrast the average denial rate in Medicare Advantage plans is 6%).[18] It is well established that high-rates of prior authorization denials not only significantly reduces patient access to needed health care services but also exacerbates the challenges patients face when trying to navigate an already overly complex health care system.[19]

1 OUT OF EVERY 8

prior authorization service requests are denied by MCOs

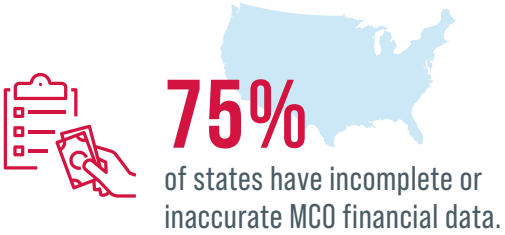
The denial of prior authorizations is particularly problematic for people dually enrolled in Medicare and Medicaid MCOs as it often reduces access to critical preventive services, consequently increasing the use of emergency department services.[20] Ensuring access to preventive services and the timely approval of prior authorization in Medicaid is essential as states transition more adults over age 65 and people with disabilities into Medicaid managed care, and that these populations often require good care coordination to meet their health needs. Today more than 75%

of patients with complex health needs in 16 states rely on MCOs for their benefits.[21,22] Further compounding the high rates of prior authorization denials, the HHS Office of Inspector General report found that most states do not review the medical appropriateness of denials regularly or collect data on denial rates due to the fact that the federal government does not require it.[23] This lack of data collection directly undermines the ability of states and the federal government to conduct meaningful MCO oversight to ensure that people who rely on Medicaid MCOs for health insurance get the care they need.

Importantly, some evidence reviewed suggests that MCOs do improve outcomes for beneficiaries by providing high-quality care coordination.[24] A study analyzing care coordination for people with disabilities found that high-quality care coordination — where the coordinator knew the patient's health history, included patient input, and was engaged with care delivery — was associated with better health outcomes.[25] Other evidence suggests that plans providing lower quality care coordination services such as care management only provided over the phone, have no impact on patient outcomes.[26] In many instances, failing to meet the care coordination needs of patients may even worsen health outcomes.[27] Despite these findings, the overall lack of complete and accurate data on MCO performance is a significant barrier to fully understand how MCOs are meeting the care coordination needs of the patients they serve and limits state oversight of MCOs.[28]

Lack of oversight and accountability tools

State and federal governments largely lack appropriate oversight mechanisms to determine whether Medicaid managed care programs are delivering on their promise to Medicaid enrollees.[29] While states and health plans have broad leeway in designing their MCO benefits, the lack of available data and transparency in MCO performance — including health care costs and outcomes data — prevents researchers, policymakers and consumers from assessing MCO performance and ability to uphold program integrity. Ultimately, this lack of data significantly hinders the ability of policymakers to make informed policy decisions that improve health care access, care coordination and health outcomes of beneficiaries.[30,31]



75%

of states have incomplete or inaccurate MCO financial data.

Despite federal laws requiring MCOs to utilize quality reporting mechanisms, including medical loss ratio reports and external quality review, managed care plans often buck these federal requirements by withholding key data, thereby rendering these tools ineffective. For example, an HHS Office of Inspector General report found that 75% of states had incomplete or inaccurate MCO financial data, including inaccurate data on the amount paid to providers, the amount the plan allowed for the service, or the amount the provider billed to the plan.[32] Another HHS Office of Inspector General report revealed that 50% of the medical loss ratio reports — a measure of the proportion of health care premiums MCOs spend on health care services and improving quality — submitted by MCOs to the HHS secretary lacked at least one of the seven data elements that are required under federal law.[33] The failure of MCOs to comply with federal data reporting requirements and the absence of state oversight of compliance result in gaps in critical performance data, which prevents policymakers from having needed insight into MCO performance. This lack of MCO compliance undermines the ability of state and federal policymakers to ensure Medicaid MCO program integrity that meet the health needs of our nation's families.[34,35]

In the short term, policymakers should focus on improving data reporting requirements and increasing transparency into MCO program integrity around access, costs and health outcomes.

The need for better accountability and oversight

As Medicaid MCOs continue to grow in their role to address the social drivers of health and covering more people with complex conditions, it is critical to implement key policy solutions that ensure people who rely on Medicaid for health insurance receive high-quality health care. The U.S. Congress and the federal administration, as well as leaders in state capitols, need better transparency, oversight and accountability tools. In the short term, policymakers should focus on improving data reporting requirements and increasing transparency into MCO program integrity around access, costs and health outcomes. These policy solutions should focus on making needed improvements and closing loopholes in existing MCO oversight and accountability tools. In the intermediate to long term, policymakers should focus on advancing new oversight and accountability tools, and reorienting health care payment and delivery through Medicaid MCOs to improve the health of people who rely on Medicaid for health insurance, ensure health care is accessible, and that the program is financially sustainable.

Conclusion

Medicaid managed care plans are responsible for delivering health care benefits to two-thirds of the people who rely on Medicaid for health insurance. Yet, there is limited data available to assess fully the quality of care people receive through MCOs. This lack of data is a major barrier for states and the federal government to conduct effective oversight of MCOs and hold managed care plans accountable for delivering high-quality, cost-effective care that improves health outcomes. Ultimately, policymakers will need to act to improve existing oversight and accountability tools, and advance new ones.

Endnotes

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