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Achieving Transparency, Accountability and Quality in Medicaid Managed Care: A State and Federal Policy Agenda

At a time when policymakers are looking to address health care efficiency and affordability, policymakers and consumers should have an accurate and transparent accounting of how health care entities spend the tax dollars they receive. Despite $376 billion in Medicaid spending going to managed care organizations, the Centers for Medicare & Medicaid Services (CMS) and states are not using all the levers at their disposal to ensure appropriate oversight of these funds. This policy agenda examines mechanisms to increase transparency and accountability within Medicaid managed care and offers a set of policy proposals designed to give CMS, states, consumers and taxpayers the tools they need to ensure the managed care system lives up to its promise to lower Medicaid costs while delivering high-quality care.

Executive summary

Medicaid is a joint federal-state program that provides comprehensive health care coverage to about 80 million low-income people in the United States.[1] Forty-one states (including the District of Columbia) contract with private Medicaid managed care organizations (MCOs) to deliver services to some or all Medicaid beneficiaries in their state, including children, pregnant women, older adults and individuals with disabilities.[2] Reliance on managed care models is growing as states expand their use of MCOs to serve more medically complex beneficiaries, deliver services beyond acute care (for example, long-term services and supports), and cover additional populations, including adults newly eligible for Medicaid under the Affordable Care Act.[3] Today, MCOs provide health coverage to approximately 66 million people — nearly three-quarters of Medicaid beneficiaries nationwide.[4]

Despite the prominence of the MCO model, state and federal governments largely lack oversight mechanisms to determine whether MCOs efficiently deliver and coordinate quality health care services for Medicaid beneficiaries. Analysis by Families USA — informed by a comprehensive

literature review and a series of roundtable discussions with national policy experts, state advocates and stakeholder organizations — identified substantial gaps across existing state and federal oversight policies and regulations.

This policy agenda outlines state- and federal-level policy proposals aimed at improving three key areas necessary for effective MCO oversight: public transparency, accountability and quality of care:

1. **Public transparency.** Though federal regulations require MCOs to report a variety of information directly to states and to the Centers for Medicare & Medicaid Services, government agencies and MCOs have few requirements to publicly report details regarding the impact of managed care on health care costs and quality.[5] This information gap limits the ability of policymakers to effectively regulate MCO plans to ensure that the people covered by these plans are receiving high-value care. We propose four policies that would enhance transparency within Medicaid managed care. With better transparency tools in place, policymakers can be effective in leveraging models of care coordination and delivery, prevent plans from inappropriately denying services or delaying care, ensure MCOs spend adequately on health care services for their members, issue meaningful sanctions when plans do not meet expectations, and ensure beneficiaries have access to high-quality services.

2. **Accountability.** Given the share of Medicaid dollars going to MCOs — $376 billion, or more than half of all Medicaid spending annually — it is important to hold MCOs accountable for delivering high-quality care to consumers that meets state and federal requirements and improves health outcomes.[6] However, state Medicaid agencies, consumers and other stakeholders have limited mechanisms for ensuring MCO accountability. We propose four policies that would allow states to incentivize high-performing plans, cultivate competition in the MCO market, foster coordination between Medicare and Medicaid for beneficiaries eligible for both programs, enforce systemwide and sector-specific cost growth targets for state health care spending, and promote more meaningful beneficiary engagement.[7]

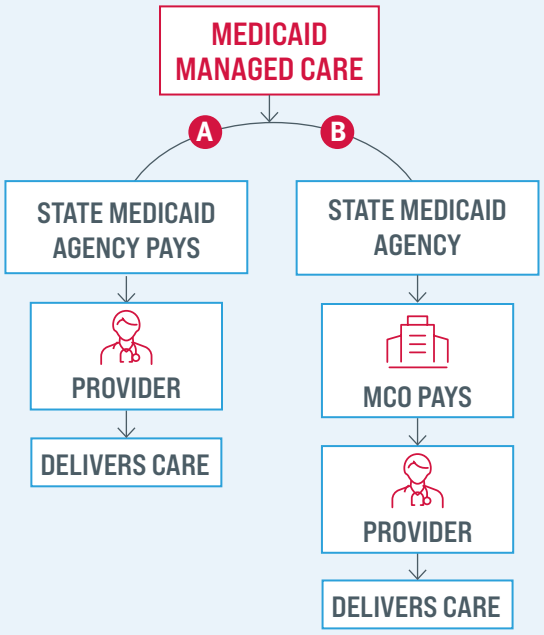
3. **Quality of care.** Medicaid managed care was originally developed with the goal of improving care quality and reducing costs, particularly by improving care coordination among different providers and systems.[8] Though CMS has made many efforts to ensure timely access to high-quality care for MCO enrollees, including through a 2024 Medicaid rule that enhances access to Medicaid services, barriers to care remain, and there is limited evidence that MCOs are improving quality of care for their beneficiaries.[9,10] With appropriate tools in place, policymakers can tackle some of the biggest drivers of poor care quality, including the inaccessibility of fair hearings for consumers denied care, payment inequalities for providers who serve individuals eligible for both Medicare and Medicaid, and inadequate care coordination for medically complex beneficiaries.

These proposals would give CMS, states, consumers and taxpayers the tools they need to determine where managed care plans are effective, where improvement is needed, and whether current and future MCO plans deliver quality care and good health outcomes for the beneficiaries they serve.

What Is Medicaid Managed Care?[11]

Medicaid managed care is a system for health care delivery and payment. Under a typical managed care arrangement, the state Medicaid agency pays a private Medicaid managed care organization (MCO) a set per member per month payment (capitated payment). In return, the MCO agrees to provide covered services to Medicaid recipients enrolled in its plan and handle a range of functions, including establishing provider networks and managing costs, utilization and quality of care.

Alternatively, states can choose to offer Medicaid benefits on a fee-for-service (FFS) basis. In this model, the state pays providers directly for Medicaid-eligible services received by beneficiaries.[12]



Policy proposals to improve public transparency

PROPOSAL 1: CMS should require MCOs to report publicly on prior authorization claims adjudication processes, clinical standards and algorithms, as well as require states to audit prior authorization denials.

Prior authorization is a policy many health plans have in place that requires a patient's provider to obtain approval in advance for certain health care services before the plan agrees to cover them.[13] Insurers impose prior authorization requirements to reduce costs and prevent low-value care. However, prior authorization requirements can also lead to treatment denials or delays in accessing necessary care.[14]

Federal regulations allow MCOs to use prior authorization as a strategy to contain costs. However, beginning in 2026, a new federal rule requires that MCOs must provide a specific reason for denying prior authorization requests.[15,16,17] Additionally, MCOs are directed to report on the percentage of prior authorization requests that were denied and the percentage of denied requests that were overturned upon appeal. Finally, under this rule, CMS requires MCOs to publicly report certain prior authorization metrics annually.

This new rule is intended to facilitate better communication and transparency between payers, providers and patients. In addition, with specific information on why a service or treatment was

denied through the prior authorization process, health care providers will be better prepared to resubmit the prior authorization request, if necessary.

While this new regulation is a good starting point to increase transparency around how MCOs make coverage decisions, there is more work to be done. A report from the Office of the Inspector General (OIG) found that, despite some MCOs having prior authorization denial rates higher than 25%, state Medicaid agencies do not routinely review the appropriateness of MCO denials of prior authorization requests.[18] Additionally, some health plans are using algorithms and artificial intelligence to make prior authorization decisions.[19] Studies have found that some algorithms widely used by health systems and insurers for clinical decision-making use flawed criteria and are prone to racial bias.[20] For example, one common algorithm used by many hospitals and health systems to determine the need for follow-up services routinely identified healthier white patients as requiring these services before sicker Black patients.[21] Use of these algorithms in Medicaid managed care could exacerbate existing racial health disparities, particularly given the disproportionate number of Black people and other people of color enrolled in the Medicaid program.[22]

Proposal 1.1: To mitigate the damage from blanket prior authorization or claims denials, CMS should require MCOs to show how prior authorization and claims decisions are made and disclose whether algorithms are in use.

Proposal 1.2: CMS should require that any final denial decision made by an MCO must be made by a person, not a computer.

Proposal 1.3: CMS should require that states regularly conduct independent audits of MCO prior authorization and claims denials.

PROPOSAL 2: CMS should establish and update a publicly available dashboard to report on MCO sanctions.

Federal regulations allow states to impose sanctions on MCOs for a variety of reasons that range from providing inadequate care to data reporting errors to financial infractions. Sanctions imposed on MCOs fall into three broad categories: taking control of the plan at the administrative level, imposing a corrective action plan or imposing a monetary penalty.[23]

States vary widely in the reasons for which they choose to impose sanctions, the size of the monetary penalties they impose and how much information they share with the public. A 2022 review by the National Health Law Program (NHeLP) of sanctions in nine states found that six states did not publish any public information about MCO sanctions.[24] The remaining three states provided information that diverged significantly in quality and depth, making direct comparison between states challenging.

Despite the lack of public reporting, states and CMS are collecting this data. Per federal regulations, a state must give written notice to CMS within 30 days whenever it imposes or lifts a sanction.[25] The written notice must specify which MCO has been sanctioned, the reason for the sanction and the penalty imposed. CMS does not post this information publicly, and it does not require states to do so either. However, some states do publish robust sanction data. NHeLP's analysis found MCO sanctions information in Arizona and California to be well-documented, organized and easy to find.

When detailed sanctions data are available to the public, researchers, advocates and policymakers can use these data to drive meaningful changes in policy, including by advocating for sanctions to be imposed for specific infractions. For example, using sanctions data published in California, reporters at the Los Angeles Times uncovered a pattern of severe delays in care for Medicaid beneficiaries enrolled in the L.A. Care Health Plan.[26] This public pressure led the California Department of Health Care Services to impose the largest monetary sanctions in state history.[27]

Public reporting not only results in greater transparency around MCO performance, but also may encourage quality performance from the start. The threat of public reporting on sanctions, and the risk that poses to the MCO plan's reputation, is, in and of itself, a way to hold MCOs accountable for high performance.

> **Proposal 2.1:** CMS should report the MCO sanctions data it collects from states through a publicly available dashboard.
>
> **Proposal 2.2:** State Medicaid agencies should make detailed sanctions data available online. Detailed data includes information on when sanctions are imposed and why, the specifics of penalties imposed, and details about when sanctions are lifted and why.

Sanctions-related information is already collected at the state and federal level, and its availability to the public would fill the information gap that prevents policymakers and other stakeholders from holding MCOs to appropriately high standards.

PROPOSAL 3: CMS should require states to publicly post medical loss ratio (MLR) reports submitted by MCOs.

The medical loss ratio (MLR) compares how much of a health plan's spending goes to paying for health care services and quality improvement activities, as opposed to how much spending goes to profits and administrative expenses. MLR is a mechanism used by states to ensure MCO plans spend most of the capitated payment they receive from the state on services related to the health of their beneficiaries.[28,29]

MCOs are subject to federal MLR requirements, and CMS requires MCOs to submit detailed reports to states annually with the data necessary to calculate MLRs.[30,31] States then take the calculated MLRs into account when setting future capitation rates. These federal regulations require states to annually submit to CMS a summary description of each MCO's MLR report.[32] In addition, states must routinely audit MLR data to ensure reported revenues and expenditures appropriately distinguish between payments for health care services or quality improvement expenses and administrative services, taxes or other activities.[33]

State oversight of MLR reporting is critical to improving transparency into managed care spending and ensuring populations that depend on Medicaid managed care receive high-quality services. However, many MCOs do not submit complete MLR information to states. A 2022 OIG report found that though most managed care plans submitted MLR reports, nearly half of the reports were missing data essential to MLR calculation (for example, data on quality improvement expenses or on taxes and fees).[34] According to OIG, data related to administrative overhead was most often missing. When such data are absent from MLR reports, it is difficult for states to determine whether plans have has accurately accounted for administrative costs in calculating their MLR.

OIG's investigation determined that key data elements were often missing from state MLR reporting templates, leading to incomplete reporting. OIG recommended CMS develop a standardized template, and CMS has since developed the MLR Annual Reporting Form.[35] This is an important step forward to ensure MCOs accurately document to states the services they provide. However, if those MLR reports are not then made accessible to the public, MCOs are not ultimately accountable to policymakers and consumers for how they spend the Medicaid dollars they receive from the government.

> **Proposal 3.1:** To ensure meaningful transparency, CMS should require states to publicly post MLR reports submitted by MCOs on their Medicaid agency websites.

Policymakers, researchers and advocates can use these reports to identify missing or inaccurate data, thereby ensuring that MCOs are not incorrectly calculating rates or misreporting their spending. When policymakers and advocates are aware of plans that do not maintain an adequate MLR or mislead the state and consumers about their true MLR, they can better advise on sanctions (see Proposal 2 above) and procurement contracts (see Proposal 5 below).

PROPOSAL 4: CMS should collect state Medicaid agency contracts from the states or Medicare Advantage plans and post them publicly.

Approximately 12.2 million Medicaid beneficiaries are also covered by Medicare, the primary source of health insurance for people ages 65 and older.[36] These joint Medicare-Medicaid enrollees are known as dual-eligible individuals or "dual-eligibles."[37] In 2023, 5.2 million dual-eligibles were enrolled in an integrated Medicare Advantage plan — called a Dual-Eligible Special Needs Plan (D-SNP) — specifically designed to provide greater care coordination between the two programs.[38]

Every D-SNP must sign a contract with the state, known as the state Medicaid agency contract (SMAC).[39] These contracts outline requirements that the plan must meet to ensure Medicare coverage works smoothly with Medicaid coverage (for example, through care coordination or coordinated reporting requirements), allowing the two programs to feel like one from the consumer's perspective. Where SMACs are constructed to foster effective coordination between Medicare and Medicaid, dual-eligible individuals enrolled in a D-SNP are better able to navigate across the two systems. Contract requirements in SMACs have the potential to enhance member satisfaction, improve outcomes and reduce costs.

However, states have varied success in executing SMACs. SMACs in some states go beyond minimum federal requirements to require greater integration or better tailor how D-SNPs serve dual eligibles. Other states report struggling with how to best use their contracting authority to ensure D-SNPs are responsive to the needs of dual-eligible individuals.[40] Many state Medicaid agencies have limited in-house expertise in Medicare programs and policies.[41] This can make it difficult to effectuate contracts with D-SNPs that have appropriate incentives to promote adequate integration. Publicly available information on SMACs can reduce this information gap.

> **Proposal 4.1:** **To give state Medicaid agencies and other stakeholders the tools to improve effective coordination of care for dual-eligible individuals, CMS should collect SMACs from the states or individual D-SNP plans and post them publicly. At minimum, CMS should create a process that makes it easy for stakeholders to request access to SMACs.**

Making SMACs publicly available will foster greater public transparency regarding how D-SNPs function, allow states to learn from their peers and strengthen the ability of state Medicaid agencies to leverage the D-SNP model to improve care for beneficiaries.

Policy proposals to improve accountability

PROPOSAL 5: States should adopt managed care procurement policies that incentivize high-performing plans and cultivate greater competition in the managed care market.

One way for state Medicaid agencies to ensure MCOs operating in their state meet and exceed federal and state requirements is to contract with high-performing plans. Through the procurement process, states select which MCOs they will contract with and determine contract

requirements (for example, what services the plan must provide, what performance metrics and network adequacy requirements the plan must meet, what reimbursement methods the state will use). The procurement process can be an opportunity for states to use their purchasing power to hold MCOs accountable to deliver good health outcomes for the beneficiaries they serve. Through procurement, state Medicaid agencies can incentivize quality care, impose consequences for poor performance and cultivate greater market competition among plans to improve outcomes and reduce costs.

However, state laws and practices around procurement vary widely, and CMS does not set minimum standards for the MCO procurement process.[42,43] State Medicaid agencies have broad latitude to procure MCO contracts, including determining how many MCOs they will contract with, how long contracts will last, the contract requirements that bidding MCOs will be expected to meet and how proposals will be evaluated.

States also vary in how effectively they use MCO procurement levers to drive plan quality. In some states, procurement standards are highly prescriptive, with detailed specifications on what quality metrics plans must meet, while other states have much less detailed standards.[44] These contracting differences reflect varying priorities that may be guided by political pressures or the views expressed by MCOs and key provider groups within the state.

What can make procurement especially challenging in some states is a lack of plan competition. If too few MCOs plans are available, state Medicaid agencies may have limited choices to weed out substandard plans, even with optimal procurement policies in place. In 2021, 17 states contracted with five or fewer MCO plans.[45] Medicaid managed care enrollment is also heavily concentrated in a small number of national firms, with five Fortune 500 companies accounting for half of MCO enrollment.[46,47] Given the massive market share these companies hold in most geographical areas of the country, states wield limited ability to conduct MCO oversight and impose meaningful consequences.

In addition, because of the amount of state funds at stake and the fact that contracting opportunities happen only once every few years, the MCO procurement process can be highly competitive.[48] This can lead to court battles, interference by lawmakers, prolonged procurement negotiations and instability for consumers.[49,50] For example, Texas' recent MCO procurement contracting has been called into question for giving a potential unfair advantage to one large for-profit bidder while dropping several hospital-affiliated MCOs that largely provide coverage to children and pregnant women.[51,52]

States have several options to increase competition and ensure the procurement process results in MCO plans bringing the greatest value for consumers.

Proposal 5.1: States should design the questions they ask prospective MCOs in their request for proposal (RFP) so that bidders are required to demonstrate plan performance and results, including on metrics related to advancing value-based payment models, integrating service delivery, addressing social determinants of health and improving health equity.

Proposal 5.2: States should ensure the bidding assessment process is rigorous, data-driven and objectively scored by trained evaluators.

Proposal 5.3: States should adopt longer contracting cycles so bidders have more time to design policy innovations and demonstrate results.

Proposal 5.4: To increase market competition, states should give preference to local, nonprofit and provider-led plans. These MCOs experience different financial incentives than the multistate for-profit plans that dominate the managed care market and can bring value to consumers.

Additionally, states can opt to increase public transparency of the procurement process and bring in consumer and beneficiary voices. Opaque and inconsistent procurement policies where MCO bidders with deep pockets may have unfair advantages (such as those reported in the Texas example above) highlight the need for a wide range of stakeholders to have input into the process. Participating stakeholders who do not face political pressures may be better able to ensure smaller nonprofit MCOs have an opportunity to secure a contract if their proposal achieves a high score.

Proposal 5.5: States should engage stakeholders — including consumer advocates and the state's Beneficiary Advisory Council (as described in Proposal 7 below) — early in the procurement cycle to give input about both the questions asked in RFPs and the scoring rubric that will be used to evaluate proposals.

Proposal 5.6: States should engage consumer advocates and other stakeholders to serve as evaluators to assess which proposals provide the greatest value for consumers.

Proposal 5.7: States are required to have a state Medicaid Advisory Committee (MAC) to advise the state on Medicaid issues and can require their MAC to provide input throughout the MCO procurement process.

On the federal level, CMS can develop resources and provide technical assistance to states to promote more effective procurement processes. CMS can also develop additional federal procurement process requirements, including public engagement requirements and additional contract review standards.

PROPOSAL 6: States should establish state health care cost commissions to create greater accountability around health care spending, including spending by Medicaid managed care plans.

Health care cost commissions are state agencies or independent entities that work to develop enforceable systemwide and sector-specific cost growth targets for state health care spending.[53] As of 2022, nine states have established health care cost commissions. These commissions vary widely in how they are governed, but most consist of local health care leaders, advocates and other stakeholders.[54] Commission activities generally include collecting data to measure cost growth on the payer level, using expert input to set cost growth targets, analyzing cost drivers across the delivery system (such as poor quality care or anti-competitive practices) and implementing strategies to enforce targets.[55]

As Medicaid agencies struggle with workforce vacancies that limit their capacity to effectively oversee the managed care market, health care cost commissions could prove a potent tool for states to hold MCOs accountable. In some states, health care cost commissions have limited ability to enforce their cost growth targets and largely use public transparency as their primary enforcement strategy. However, states are increasingly establishing additional authorities. For example, the Massachusetts Health Policy Commission can require performance improvement plans from entities exceeding the cost growth target, and Oregon's Health Care Cost Growth Target Program can enforce financial penalties for repeated unjustified growth above a set target.[56,57]

Proposal 6.1: States should establish health care cost commissions that develop cost growth targets at the payer level and develop strategies to enforce these targets, including through public reporting and financial penalties or performance improvement plans for payers that do not meet targets. Health care cost commissions should include representatives from Medicaid Advisory Committees, Beneficiary Advisory Councils and other Medicaid stakeholders.

Proposal 6.2: States with health care cost commissions should endow them with mechanisms to enforce cost growth targets.

PROPOSAL 7: States should use MACs (Medicaid Advisory Committees) to promote meaningful beneficiary engagement.

Since the inception of the Medicaid program, federal regulations have required every state to have a Medicaid Advisory Committee (MAC)[58] to advise the state Medicaid agency.[59] Until recently, regulations imposed few requirements regarding timing of meetings, public notice and beneficiary engagement. In its final Medicaid managed care access rule, released in April 2024, CMS made multiple updates to its regulations to set new expectations for states to engage Medicaid enrollees and other stakeholders.[60] Effective July 9, 2025, states are required to create a Beneficiary Advisory

Council (BAC) — composed of current and former Medicaid enrollees, their family members, and paid and unpaid caregivers — that meets separately from the MAC. The rule specifies that the MAC must be comprised of a diverse array of stakeholders, including community-based organizations, local advocacy groups, clinical providers, managed care organizations (as applicable to the state's plan design), state agencies and members drawn from the BAC.

The new regulations allow the MAC and BAC to advise on both health and medical services (as before), as well as additional areas, with a minimum of the following topics: changes to services; care coordination; service quality; eligibility, enrollment and renewal processes; beneficiary and provider communications; and cultural competency issues. Finally, the rule requires the MAC and BAC to meet at least once a quarter (with at least two MAC meetings per year open to the public), and information on MAC and BAC activities must be publicly findable.

To date, few states have sought to engage Medicaid enrollees or other stakeholders in Medicaid program decision-making.[61] These new requirements will prompt states to build and maintain connections to the community served by the Medicaid program, and for the first time in most states, community members now have a pathway to offer feedback to policymakers.

As states implement the new federal changes there are a few issues they should consider:

Proposal 7.1: States should prioritize inclusion and diversity in MAC/BAC member recruitment, for example, by ensuring that membership includes people from different racial and ethnic backgrounds, non-native English speakers, LGBTQ+ individuals, parents of young children, young adults, people with disabilities, individuals with behavioral health conditions, and residents across different geographic regions.

Proposal 7.2: States should implement culturally and linguistically appropriate outreach strategies.

Proposal 7.3: States should require equitable compensation for BAC and MAC members, compensating participating stakeholders for their time and knowledge just as they would other professionals involved in informing program and policy design decisions.

CMS has a role in offering guidance and technical assistance to states to ensure MACs and BACs are structured to promote genuine stakeholder and beneficiary engagement. For example, thoughtful design of compensation for MAC/BAC members acknowledges their contributions without impacting their taxable income, and guidance from CMS can help states strike the balance so they can effectively recruit MAC/BAC members without jeopardizing their eligibility for Medicaid.[62,63]

PROPOSAL 8: States should use SMACs to develop enhanced care coordination requirements for dual-eligible beneficiaries.

Dual eligibles are sicker and more likely to have functional limitations, cognitive impairments and health-related social needs than the general Medicaid population.[64] Unfortunately, they often receive fragmented care due to limited coordination of services and misaligned financial incentives between the Medicare and Medicaid programs.

Setting contract requirements in SMACs (described above under Proposal 4) is an opportunity for the state Medicaid agency to hold D-SNPs accountable for fostering coordination between Medicare and Medicaid care for dually eligible beneficiaries. Placing appropriate care coordination requirements in SMACs is important, as increasingly fewer dual eligibles have access to D-SNPs that have any meaningful integration between the two programs. Most dual-eligible individuals are enrolled in coordination-only D-SNPs, wherein the plan provides Medicare-covered services but coordinates with other entities (either the state Medicaid agency or an MCO) to provide Medicaid-covered services. While individuals enrolled in these plans receive some targeted care (for example, individualized care plans for each enrollee), they continue to receive Medicaid services in a nonintegrated manner, as federal regulation does not require these plans to fully integrate and align care between programs.[65]

Through SMACs, many states require D-SNPs to exceed federal care coordination and integration requirements, for example, by requiring the D-SNP to coordinate with the enrollee's Medicaid home and community-based waiver service coordinator.[66]

Proposal 8.1: States should use specific contracting language in SMACs to hold D-SNPs accountable to align and coordinate Medicare and Medicaid services for dual-eligible beneficiaries.

Proposal 8.2: States should set requirements in SMACs for D-SNPs to offer Medicaid MCO plans that include coverage of services that often require significant coordination with Medicare-covered services, including long-term services and supports and behavioral health services. This requirement ensures that the same parent organization is accountable for overseeing and coordinating the major services used by dual eligibles.

Policy proposals to improve quality of care

PROPOSAL 9: States should incorporate provisions into managed care contracts specifically intended to ensure adequate care coordination and access to care for groups that face special challenges in accessing and navigating care.

States are increasingly including populations in their Medicaid managed care programs that were previously covered through FFS Medicaid, such as children and youth with special health care needs (CYSHCN) and beneficiaries receiving long-term services and supports (LTSS).[67,68] These populations often receive services through a patchwork of different systems and payers and encounter special difficulties accessing care. In 2019, for example, over 20% of Medicaid-enrolled families of CYSHCN reported needing extra help coordinating their child's health care in the past 12 months, and almost one-quarter of these families could not get access to care coordination services.[69] Though evidence-based national standards exist for effective care coordination for CYSHCN, few states incorporate detailed requirements for care coordination for this population into their managed care contracts.[70]

Proposal 9.1: States should incorporate provisions relating specifically to care coordination for CYSHCN populations into MCO contracts to ensure this vulnerable population receives improved access to care.

Improved care coordination for individuals receiving LTSS is one of the core goals of the transition to managed care for this population.[71] Some states do incorporate specific requirements related to care coordination for the LTSS population into managed care contracts, including by requiring data-sharing across providers and payers and mandating family and caregiver inclusion in the care coordination process.[72] However, many states do not provide detailed specifications on care coordination in their LTSS managed care contracts.[73] A 2019 analysis stated, "Contracts typically did not contain specific requirements for care coordinator training related to dually eligible beneficiaries, or stakeholder input on care coordination training and practices."[74] The same analysis found that "health plans operating integrated models are not sufficiently collaborating with consumers and the disability community to design and implement person-centered care coordination." For example, plans sometimes did not provide access to interpreters in languages beyond Spanish and did not involve consumers or members of the disability community in the training of care coordinators.

Proposal 9.2: States should engage LTSS beneficiaries and their families (or other caregivers) in the development of person-centered care coordination requirements in LTSS managed care contracts.

As an increasing number of states pursue waivers of the inmate exclusion policy and extend Medicaid coverage to incarcerated individuals during the pre-release period, MCO contracts can be a lever for ensuring adequate care coordination for this high-need population.[75] The 2023 Consolidated Appropriations Act required that youth incarcerated in public institutions receive "in the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services."[76] To ensure that the case management provided in the prerelease and reentry period is effective, states should look to the example of states like Arizona that have developed effective and evidence-based strategies for care coordination for justice-involved populations.[77]

Proposal 9.3: States should employ peer supports to provide targeted care coordination, establish routine care transition processes in the discharge period, improve data exchange processes and develop connections between incarcerated individuals and community providers prior to release.

PROPOSAL 10: CMS should revise regulations to allow consumers to go straight to a fair hearing with the state for benefit decision appeals.

Medicaid managed care beneficiaries are allowed to file an appeal with their managed care plan in response to an adverse benefit determination (such as when the plan denies a requested service).[78] If plans uphold their original decision on appeal, beneficiaries can request a fair hearing with the state in which a state hearing official decides whether to uphold or overturn the plan's decision.[79]

Under the current setup, Medicaid beneficiaries are afforded a fair hearing only after they exhaust their MCO's appeal process. Prior to rule changes put into place in 2016, beneficiaries were allowed to go straight to a hearing without the added step of the plan-level appeals process. The current process adds burdensome administrative processes for patients to navigate, and patients may get discouraged. Though Medicaid appeals data is fragmentary in some states, making it difficult to draw conclusions, according to the Government Accountability Office (GAO) only about 9,000 appeals were taken to the state for a fair hearing in 2022, a tiny fraction of the hundreds of thousands of appeals that were filed. Additionally, appeal rates vary widely across states, indicating inequities across the system as beneficiaries in some areas may have more challenges accessing needed services.[80]

Furthermore, moving the initial appeals process from an independent state official to a process internal to the MCO means that plans can obscure bad coverage policies by adjusting blanket denials on a one-off basis as consumers appeal, without having to change underlying plan policies that deny beneficiaries' necessary care. An OIG report found that, in 2019, only 11% of beneficiaries appealed MCO prior authorization denials.[81] Of that small number of initial appeals, when the MCO upheld the denial (64% of the time) only 2% continued with their appeal and received a fair hearing with the state. These statistics show how beneficiaries may lack information and resources to bring an appeal to their MCO in the first place and to continue with that appeal through the fair hearing stage.

Proposal 10.1: To make the fair hearing process more accessible and the underlying policies motivating denials more transparent, CMS should allow consumers to directly access a state fair hearing without going through internal plan appeal processes.

PROPOSAL 11: States should eliminate "lesser-of" payment policies for dual eligibles to pay providers full Medicare rates.

Providers are often paid less to treat dual-eligible beneficiaries than Medicare-only beneficiaries due to state-level "lesser-of" payment policies.[82] Lesser-of payment policies essentially require that when an individual has both Medicare and Medicaid, the state will pay the lower cost-sharing amount for a given service, between Medicaid and Medicare rates. States can adopt lesser-of payment policies for some or all provider types. As Medicaid rates are typically lower than Medicare rates (establishing low provider payment rates is a common Medicaid cost containment approach), the lesser-of policy typically means the state pays the Medicaid cost-sharing rate to providers. These policies can mean that primary care providers are paid up to 20% less to treat dual-eligible beneficiaries compared with Medicare beneficiaries who do not have Medicaid.[83]

Lesser-of policies are widespread — as of 2018, only seven states paid the full Medicare cost-sharing amount for primary care services — and they create disincentives for providers to treat dual-eligible populations.[84] A 2023 Congressional Budget Office (CBO) analysis found that dual-eligible beneficiaries experience reduced access to care, particularly to primary care providers, due to reduced payments from lesser-of payment policies.[85]

Proposal 11.1: To increase access to care for dual-eligible individuals, states should eliminate lesser-of payment policies to ensure that providers receive the full Medicare cost-sharing rate for treating this population.

Conclusion

CMS, states, consumers and taxpayers have remarkably little insight into what $376 billion in Medicaid managed care costs yields in terms of improved health outcomes. People served by MCOs deserve better oversight and accountability.

This policy agenda describes 11 categories of policy proposals (see Appendix on page 17 for table of proposals) that, if put into place, can help policymakers ensure MCOs deliver on their promises to improve access to care, manage utilization of services and promote health care quality. The various key areas these policy proposals fit into — transparency, accountability and quality of care — do not stand on their own. To achieve accountability, transparency is essential; to achieve quality of care, accountability is an imperative. Shaping future managed care policy with a constellation of these state and federal policy levers is important for achieving appropriate oversight.

As lawmakers increasingly look to managed care in efforts to constrain Medicaid spending, understanding whether and how these care delivery system arrangements bring value should be a high priority. CMS and states can move quickly to use the levers identified in this agenda to bring transparency, accountability and better value to the Medicaid managed care system. When policymakers fully leverage the tools available under current authority, they can both push MCOs to operate at their best and better pinpoint problems and identify solutions so that managed care systems realize their promise to bring quality care to Medicaid beneficiaries.

As lawmakers increasingly look to managed care in efforts to constrain Medicaid spending, understanding whether and how these care delivery system arrangements bring value should be a high priority.

Appendix:
Policies To Improve Transparency, Accountability and Quality for CMS and States

Proposal number	CMS
	POLICY PROPOSALS TO IMPROVE PUBLIC TRANSPARENCY
1.1	To mitigate the damage from blanket prior authorization or claims denials, CMS should require MCOs to show how prior authorization and claims decisions are made and disclose whether algorithms are in use.
1.2	CMS should require that any final denial decision made by an MCO must be made by a person, not a computer.
1.3	CMS should require that states regularly conduct independent audits of MCO prior authorization and claims denials.
2.1	CMS should report the MCO sanctions data it collects from states through a publicly available dashboard.
3.1	To ensure meaningful transparency, CMS should require states to publicly post MLR reports submitted by MCOs on their Medicaid agency websites.
	POLICY PROPOSALS TO IMPROVE QUALITY OF CARE
10.1	To make the fair hearing process more accessible and the underlying policies motivating denials more transparent, CMS should allow consumers to directly access a state fair hearing without going through internal plan appeal processes.

Proposal number	STATES
	POLICY PROPOSALS TO IMPROVE PUBLIC TRANSPARENCY
2.2	State Medicaid agencies should make detailed sanctions data available online. Detailed data includes information on when sanctions are imposed and why, the specifics of penalties imposed, and details about when sanctions are lifted and why.
4.1	To give state Medicaid agencies and other stakeholders the tools to improve effective coordination of care for dual-eligible individuals, CMS should collect SMACs from the states or individual D-SNP plans and post them publicly. At minimum, CMS should create a process that makes it easy for stakeholders to request access to SMACs.

Appendix:
Policies To Improve Transparency, Accountability and Quality for CMS and States

Proposal number	STATES
	POLICY PROPOSALS TO IMPROVE ACCOUNTABILITY
5.1	States should design the questions they ask prospective MCOs in their request for proposal (RFP) so that bidders are required to demonstrate plan performance and results, including on metrics related to advancing value-based payment models, integrating service delivery, addressing social determinants of health and improving health equity.
5.2	States should ensure the bidding assessment process is rigorous, data-driven and objectively scored by trained evaluators.
5.3	States should adopt longer contracting cycles so bidders have more time to design policy innovations and demonstrate results.
5.4	To increase market competition, states should give preference to local, nonprofit and provider-led plans. These MCOs experience different financial incentives than the multistate for-profit plans that dominate the managed care market and can bring value to consumers.
5.5	States should engage stakeholders — including consumer advocates and the state's Beneficiary Advisory Council (as described in Proposal 7, page 10) — early in the procurement cycle to give input about both the questions asked in RFPs and the scoring rubric that will be used to evaluate proposals.
5.6	States should engage consumer advocates and other stakeholders to serve as evaluators to assess which proposals provide the greatest value for consumers.
5.7	States are required to have a state Medicaid Advisory Committee (MAC) to advise the state on Medicaid issues and can require their MAC to provide input throughout the MCO procurement process.
6.1	States should establish health care cost commissions that develop cost growth targets at the payer level and develop strategies to enforce these targets, including through public reporting and financial penalties or performance improvement plans for payers that do not meet targets. Health care cost commissions should include representatives from Medicaid Advisory Committees, Beneficiary Advisory Councils and other Medicaid stakeholders.
6.2	States with health care cost commissions should endow them with mechanisms to enforce cost growth targets.
7.1	States should prioritize inclusion and diversity in MAC/BAC member recruitment, for example, by ensuring that membership includes people from different racial and ethnic backgrounds, non-native English speakers, LGBTQ+ individuals, parents of young children, young adults, people with disabilities, individuals with behavioral health conditions, and residents across different geographic regions.

Appendix:
Policies To Improve Transparency, Accountability and Quality for CMS and States

Proposal number	STATES
7.2	States should implement culturally and linguistically appropriate outreach strategies.
7.3	States should require equitable compensation for BAC and MAC members, compensating participating stakeholders for their time and knowledge just as they would other professionals involved in informing program and policy design decisions.
8.1	States should use specific contracting language in SMACs to hold D-SNPs accountable to align and coordinate Medicare and Medicaid services for dual-eligible beneficiaries.
8.2	States should set requirements in SMACs for D-SNPs to offer Medicaid MCO plans that include coverage of services that often require significant coordination with Medicare-covered services, including long-term services and supports and behavioral health services. This requirement ensures that the same parent organization is accountable for overseeing and coordinating the major services used by dual eligibles.
POLICY PROPOSALS TO IMPROVE QUALITY OF CARE	
9.1	States should incorporate provisions relating specifically to care coordination for CYSHCN populations into MCO contracts to ensure this vulnerable population receives improved access to care.
9.2	States should engage LTSS beneficiaries and their families (or other caregivers) in the development of person-centered care coordination requirements in LTSS managed care contracts.
9.3	States should employ peer supports to provide targeted care coordination, establish routine care transition processes in the discharge period, improve data exchange processes and develop connections between incarcerated individuals and community providers prior to release.
11.1	To increase access to care for dual-eligible individuals, states should eliminate lesser-of payment policies to ensure that providers receive the full Medicare cost-sharing rate for treating this population.

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