FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

March 30, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

Re: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) [CMS-6098-NC]

Dear Administrator Dr. Oz:

Families USA appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) in response to the request for information (RFI) regarding potential regulatory or programmatic changes that the agency could pursue to bring better oversight and accountability to Medicare and Medicaid. We recommend CMS take a targeted approach toward that goal – one that bolsters program integrity to the benefit of low-income families and seniors who need health care services, without employing counterproductive tactics or relying on misleading metrics. We also urge CMS to direct such targeted oversight efforts toward genuine gaps in accountability for plans and providers and we offer specific recommendations as to how greater transparency over Medicaid Managed Care Organizations can achieve better program quality and efficiency.

As the longtime national, non-partisan advocate for health care consumers, dedicated to achieving high-quality, affordable health care and improved health for all, Families USA believes that states and the federal government need proper tools to identify and address instances of fraud and waste to ensure that taxpayer dollars most effectively support the health care needs of all Americans. We appreciate CMS soliciting feedback from stakeholders to ensure appropriate oversight and accountability structures are in place to protect the integrity of key health programs so they can continue to provide crucial care and services. We hope the outcome of CMS' effort in this RFI will be for the agency to refine its approaches to program integrity and to focus on areas in the system where lack of transparency and data mean that current federal and state oversight efforts fall short of holding bad actors accountable.

In the first part of our comments, we recommend that this administration's efforts to address waste, fraud and abuse be targeted to meaningfully ensure accountability in the health care system, without resorting to drastic and destabilizing measures (e.g. after-the-fact Medicaid funding deferrals as recently done in Minnesota) or utilizing counterproductive efforts that misplace their focus on beneficiary use of services or misuse metrics like payment error rates which are not indicative of fraud.

We welcome the opportunity to continue our work with CMS on a broad range of issues related to accountability and oversight over the plans and providers in Medicaid, Medicare, and the Marketplaces

in order to better prevent improper or fraudulent payments before they occur. In this vein, **the second part of our comments provide responses to the RFI focused the need for greater oversight over Medicaid Managed Care Organizations (MCOs) – many of which are massive for-profit health care corporations. We recommend five areas for greater transparency by Medicaid MCOs: prior authorization practices, medical loss ratio reporting, sanctions, contracts, and procurement best practices.** These efforts would help facilitate a more efficient and effective Medicaid program and better highlight specific vulnerabilities to waste, fraud, and abuse in our health care system.

Part I: CMS Fraud Oversight and Prevention Should be Targeted and Not Counterproductive

As part of Families USA's support for the goals of Medicare and Medicaid, we support appropriate and targeted efforts to root out fraud, waste, and abuse – including the many existing federal and state oversight structures to investigate and prosecute fraud, such as the Medicaid Fraud Control Units (MFCUs) run in all states by the U.S. Department of Health and Human Services Office of the Inspector General (HHS OIG), and the work of state and independent auditors.[1,2] Over the last 50 years, these investigators have uncovered and prosecuted many discrete instances of fraud committed against Medicare and state Medicaid programs.

Investigating and addressing systems of fraud within Medicaid can take years of collaborative work between CMS and a state Medicaid agency, as exemplified in the case of Minnesota's recent program integrity efforts.[3] When the Minnesota Department of Human Services (DHS) identified sources of fraud, officials turned it over to the MFCU for prosecution. Since 2020, Minnesota DHS has "conducted over 3,000 investigations and referred over 500 cases to law enforcement" and through these efforts, officials have identified "more than $50 million for recovery."[4] These ongoing program integrity efforts in Minnesota demonstrate the extensive work already underway to detect and address fraud. **As the administration considers additional actions, we urge CMS to ensure that all oversight efforts support and maximize, rather than disrupt, ongoing investigations and existing program integrity structures.**

In seeking an efficient Medicaid and Medicare program, CMS should be similarly efficient in finding fraud without being counterproductive to the core mission of these programs, or to the effort to address fraud. While Minnesota and other states may need more resources or tools to effectively investigate fraud and hold bad actors accountable, blunt actions that strip Medicaid funding from the vulnerable Americans who need it do nothing to support program integrity. For example, CMS' recent deferral of $259.5 million in Medicaid funding to Minnesota risked disrupting the state's ability to sustain home- and community-based services (HCBS). Of course, any bad actors who seek to defraud states and CMS out of HCBS funding need to be identified and prosecuted. However, restricting access to HCBS through blanket, indiscriminate Medicaid funding cuts does not improve care for people in need and does not give states the targeted resources and innovative solutions they need to identify and rectify fraud today or in the future. **Home care is not fraud. Broad funding restrictions that risk disrupting care for beneficiaries do not reduce administrative error or build system capacity to uncover fraud.**

To be most effective at addressing fraud, CMS must distinguish mechanisms that detect genuine instances of fraud from other kinds of program integrity efforts. For instance, CMS' Payment Error Rate Measurement (PERM) indicates improper payments in Medicaid, such as underpayments or overpayments, but it does not measure fraud.[5] Most Medicaid improper payments result from

documentation or administrative errors rather than fraudulent activity. Recent findings involving Medicaid payments associated with deceased beneficiaries should be viewed in this broader context. Audits by the HHS OIG have identified situations in which capitation payments continued briefly after an enrollee's death due to delays in updating eligibility and death-record data across systems.[6] These audits point to administrative and data coordination challenges, not widespread beneficiary fraud, and represent a very small fraction of total program spending.

These findings suggest that first, states need resources and tools to improve administrative systems to reduce human error and inefficiencies. Second, tackling true fraud in the system will require targeted investments in oversight, auditing, and investigative capacity.[7] **Strengthening eligibility systems, improving data sharing, and modernizing program integrity safeguards are important steps to protect taxpayer dollars and should be advanced.**

Finally, and more broadly, federal oversight findings from HHS OIG, the U.S. Government Accountability Office (GAO), and the U.S. Department of Justice make clear that the most significant threats to Medicare and Medicaid program integrity come from organized provider fraud and market-based schemes, not from individual beneficiaries. These investigations have uncovered networks in which marketers, brokers, telemedicine platforms, laboratories, and equipment suppliers collaborate to generate medically unnecessary claims.[8,9] These examples provide compelling evidence that **the misaligned financial incentives of our health care payment and delivery system are a far greater vulnerability for fraudulent billing schemes than the concern that low-income families and seniors might improperly receive health insurance coverage.** In that vein, we offer comments below as to how transparency in Medicaid managed care could be much more meaningful in making Medicaid more efficient and effective.

Part II: Responses to RFI Questions on Program Integrity, Recommending Transparency of Medicaid MCOs

As CMS explores ways to improve Medicaid program integrity, Families USA recommends that the agency focus on an area in need of improved oversight and accountability: Medicaid Managed Care Organizations (MCOs). MCOs are responsible for delivering and managing the care of more than three-quarters of Medicaid beneficiaries across 42 states, accounting for more than half (53%) of federal and state Medicaid spending.[10] As it stands, CMS and states largely lack information, tools and resources needed to determine whether MCOs efficiently and effectively deliver and coordinate quality health care services for the Medicaid beneficiaries they serve.[11]

Families USA strongly believes that more meaningful oversight in managed care would come from better arming state Medicaid officials with up-to-date information about how MCOs in their state operate, along with comparative information about managed care plans in other states. Such information would enable officials to better understand MCO performance and hold low performing plans to account.

Several federal analyses confirm the need for greater CMS oversight and accountability over Medicaid MCOs:

- A March 2026 report by the Medicaid and CHIP Payment and Access Commission (MACPAC) concludes that states "struggle to access and use multiple sources of plan performance data effectively," and need more complete MCO performance information in an "accessible, understandable format" concerning plans within their state and plans across state lines.[12]

- HHS OIG's March 2025 strategic plan highlights the problems states run into when they oversee MCOs without complete information and calls for system-wide improvements so states can make data-driven decisions that ensure integrity within Medicaid managed care.[13]

With this in mind, our comments primarily focus on the questions found in Section K of the RFI, titled *Medicaid and CHIP*. Those questions include:

- *What tools or technologies can CMS or states use to enhance program integrity in Medicaid, CHIP managed care, and fee-for-service programs?*
- *What tools or guidance can CMS give to states to enhance program integrity in the Medicaid and CHIP managed care and fee-for-service programs?*
- *What data or information should be made publicly available that would allow for transparency in Medicaid by states, health plans, and providers?*

In response to these questions, **Families USA makes the following recommendations across five key domains related to Medicaid managed care:**

1. **Transparency in MCO Prior Authorization Practices.** CMS should require MCOs to publicly report on prior authorization processes and require states to audit prior authorization denials.
2. **Transparency in Medical Loss Ratio Reporting.** CMS should require states to publicly post Medical Loss Ratio (MLR) reports submitted by MCOs and obligate MCOs to pay remittances to the state when they do not meet minimum MLR requirements.
3. **Transparency in MCO Sanctions.** CMS should require all states to publicly report MCO sanctions data and establish a publicly available dashboard to make data on state MCO sanctions easily accessible.
4. **Transparency in MCO Contracts.** CMS should publicly post approved state contracts with MCOs.
5. **Guidance on MCO Procurement Best Practices.** CMS should develop best practices for states to adopt managed care procurement policies that incentivize high-performing plans and cultivate greater competition in the managed care market.

Putting these transparency and accountability levers in place would give states the data and guidance they need to determine where managed care plans are effective, where improvement is needed, and where MCOs are not serving as honest and effective stewards of Medicaid program funding.

1. Transparency in MCO Prior Authorization Practices

Recommendation: CMS should require Medicaid MCOs to publicly report on prior authorization processes and require states to audit prior authorization denials.

Families USA recommends that CMS require states contracting with Medicaid managed care plans or utilization management contractors (specialized third-party vendors focused narrowly on reviewing medical necessity that MCOs or state Medicaid agencies may hire to conduct prior authorization) to publicly report on their prior authorization claims adjudication processes — including the clinical standards, criteria, and decision-support algorithms used to approve or deny prior authorization requests (including algorithms or other criteria used by artificial intelligence). Families USA also recommends that CMS require states to conduct regular audits of prior authorization denials issued by

contracted MCOs or utilization management contractors. When MCOs deny care through opaque or secret algorithmically driven prior authorization processes, the cause of problems related to improper care denials remain hidden and harder to address.

Patients and the Medicaid program are harmed by improper prior authorization denials.

Prior authorization can be one of the most consequential decision points regarding patient care. When functioning well, prior authorization processes can serve as a check on whether care recommended by health professionals will benefit patient needs or whether evidence-based alternatives exist that may serve patients better and at a lower cost. However, improper handling of prior authorization requests by health insurance plans, including MCOs, can be rife with failure for health care consumers, with major consequences for patient health and health system costs.

For many people with low-incomes who are covered by Medicaid, including people with disabilities and those managing complex chronic conditions, a wrongful denial is not just an inconvenience — it can be a life-altering barrier to care.[14] Improper prior authorization denials mean patients go without needed cancer treatments, mental health services, surgical procedures or medications, with steep consequences to their health.[15] Prior authorization denials can be particularly problematic for conditions like diabetes that require access to a range of devices, medications, and other services to ensure individuals can maintain their health and avoid unnecessary hospitalizations.[16]

Improper denials not only worsen health outcomes for individuals, but they also often end up costing the Medicaid program more than if the care had been promptly approved and provided. A recent physician survey found that 29% of prior authorization denials lead to a serious health event, resulting in an expensive hospitalization for a life-threatening issue and/or permanent bodily damage or disability that will require a lifetime of costly care.[17]

Further, improper denials by MCOs mean state Medicaid programs receive less value for their same level of investment. After all, MCOs are paid a fixed capitation rate for each enrollee — meaning they receive payment whether or not their members actually receive needed health care services.[18] When MCOs systematically or even inadvertently deny covered services, they retain capitation payments without delivering the benefits the state contracted them to deliver. Processing inappropriate denials and subsequent beneficiary appeals also costs MCOs additional time and resources, added expenses that increase the administrative costs of running the managed care plan and which factor into higher capitation rates paid by the state.[19] Avoiding these costs wherever appropriate would result in better patient care at a lower cost to CMS.

A lack of transparency regarding the processes that result in improper denials allows bad processes and bad prior authorization decisions to proliferate.

While some Medicaid regulation exists to help ensure prior authorization processes advance the needs of patients and do not result in improper denials, current regulation could be improved. Under 42 C.F.R. § 438.210, MCOs are permitted to limit services based on: (1) criteria identified in a Medicaid state plan, such as medical necessity; or (2) for the purpose of utilization control. Pursuant to the same rule, MCOs must also ensure the consistent application of review criteria and consult with requesting providers when appropriate.

Families USA acknowledges and applauds the additional steps CMS and the administration have taken recently to meaningfully improve transparency around prior authorization processes. For example, the 2024 Interoperability and Prior Authorization Final Rule added provisions to § 438.210 requiring MCOs to publicly post prior authorization metrics, including aggregate approval and denial rates, decision timeframes, and overturn rates. The rule also mandates that MCOs establish a "Prior Authorization Application Programming Interface (API)" that will identify for providers a list of covered items and services that require prior authorization along with documentation requirements.

Yet, while these requirements help physicians know where prior authorization is needed for their patients and help policymakers and researchers understand how often and how quickly plans make prior authorization decisions — current federal rules do not advance transparency into *why* various prior authorizations are required in the first place and *why* and *how* an MCO has made the decision to deny care (e.g., what criteria was used and whether the criteria being applied are evidence-based or meet clinical standards, etc.). In addition, rules regulating the API patients use to access prior authorization information do not require plans to give patients the same level of information as their health care providers (for example, the patient API is not required to include prior authorization documentation requirements for covered items and services).

Critically, none of the federal regulatory improvements to date require independent public examination or consumer oversight, or state and federal government oversight of prior authorization criteria, standards, or decision-support algorithms (including those used by artificial intelligence).[20] This means that MCOs and third-party utilization management contractors can continue to make repeated, systemic improper denials without external checks on whether criteria, standards, or decision-support algorithms used are appropriate. The lack of transparency to those with the greatest vested interest – patients who are denied necessary care and Medicaid departments that pay for care even when it is not delivered – make it extraordinarily difficult to assess whether prior authorization determinations are appropriate and evidence-based or driven by financial incentives to deny care.

A number of states have seen value in requiring private individual and group health plans to publicly report more information about their prior authorization requirements. The National Association of Insurance Commissioners recently published a white paper identifying a range of state requirements, including a North Dakota law that requires public disclosure of prior authorization clinical criteria by prior authorization review organizations.[21] The white paper also highlights various American Medical Association principles related to prior authorization, including among other items: (1) utilization management entities should publicly disclose patient-specific prior authorization requirements in a searchable electronic format, and (2) that any clinical criteria used to deny prior authorization requests should be publicly available. Federal Medicaid regulation is lagging behind these principles and advances in state law.

While the administration, like Families USA, has been in conversations with the health insurance industry to secure more cooperation and collaboration in improving prior authorization processes and transparency, **we urge CMS to build on its current foundations to hold MCOs accountable to states and consumers for their prior authorization processes. CMS should:**

- **Require full public disclosure of MCO criteria, standards, and decision-support algorithms that plans use in their prior authorization process.** CMS could require plans to list this information on their websites and state Medicaid agencies to provide links to this information on their websites.

- **Require plans to disclose MCO criteria standards and decision-support algorithms to consumers through the patient API.**
- **Require states to obtain independent audits to ensure that prior authorization denials comply with contractual obligations and all other applicable standards**.[6]

These requirements would give CMS, states, consumers, and advocates the data needed to identify MCOs that are systematically denying services on improper grounds and would create meaningful accountability for plans that fail to deliver on their obligations to Medicaid consumers. Consumers would also be able to explore what the prior authorization criteria are for their care and be in a better position to coordinate with their providers as to whether sufficient documentation or information exists to support the prior authorization request. Mandatory public reporting and state auditing would also benefit patients and providers, who currently have limited ability and capacity to fully and systemically evaluate the criteria against which their authorization requests are being judged. Transparency regarding prior authorization adjudication would therefore bring the entire Medicaid managed care system into better alignment and understanding to support delivery of timely, appropriate care.

2. Transparency in Medical Loss Ratio Reporting

Recommendation: CMS should require states to publicly post Medical Loss Ratio (MLR) reports submitted by MCOs and obligate MCOs to pay remittances to the state when they do not meet minimum MLR requirements.

Families USA strongly urges CMS to require states to publicly post MLR reports submitted by MCOs, along with any remittances paid by plans when their MLR does not meet state minimum standards. CMS has already taken meaningful steps to reduce the administrative burden of calculating MLRs, making the public posting of these reports a low-lift, high-reward action. Requiring this transparency is a straightforward mechanism to ensure meaningful public accountability over how MCOs spend the federal and state dollars entrusted to them. In addition, as the federal government is entitled to the federal share of any state Medicaid recoveries of overpayment, CMS should require states to recoup any excess revenue between the state's minimum MLR threshold and what the plan actually spent on health care.

MLR reports offer critical insight into MCO plan spending; Medicaid programs and the public are harmed when plans waste Medicaid dollars on administrative inefficiencies and high corporate profits.

The MLR illustrates how much of a health plan's spending goes toward health care services and quality improvement activities, versus profits and administrative expenses.[22] In the Medicaid context, MLR is a critical mechanism for states to ensure MCOs direct most of their capitated payments towards services that benefit the health of their members, helping the state determine whether it is paying for excessive health plan administrative expenses or profits so it can make adjustments to the capitated rate in future years.

A high MLR indicates an MCO is spending less on administrative costs and more on covered services that Medicaid enrollees need. Federal law encourages, but does not require, State Medicaid programs to hold MCOs to a minimum MLR of 85% (42 CFR 438.8(c)); most states have adopted this minimum, and a few have set their minimum MLR higher for some or all Medicaid plans (up to 90%).[23] Currently, each MCO must submit an annual MLR report to their state, and states must compile and submit MLR

information to CMS when they seek approval for proposed capitation rates.[24] Federal law does not require state Medicaid agencies to post MLR reports publicly, therefore few do.[25]
In addition, unlike for Medicare Advantage and private plans, federal law does not require Medicaid MCOs to issue rebates to enrollees or to the state if they do not meet their state's MLR standard. However, states are allowed to recoup any excess payment between the state's minimum MLR threshold and the amount each plan actually spends on health care services and quality improvement activities; as of July 2024, 34 states report they always require remittance payments when an MCO does not meet minimum MLR requirements.[26]

Accuracy and transparency in MLR reporting is critical for the public to know whether MCOs are engaging in abusive and wasteful profiteering and whether states are holding them accountable.

Strong state oversight of MLR is essential to improving transparency in managed care spending, ensuring Medicaid beneficiaries receive high-quality care and ultimately holding MCOs accountable for how they spend the Medicaid dollars they receive from the government.[27] However, many MCOs do not submit complete MLR information to states. A 2022 HHS OIG report found that nearly half of MLR reports submitted by managed care plans to their state were inaccurate or incomplete, undermining the very oversight mechanism MLR is designed to provide.[28]

CMS has taken important steps recently to improve the accuracy of MLR reporting, including the customizable MLR Plan-to-State Reporting template released on July 28, 2025 that will make it easier for states to obtain accurate and complete MLR data from MCOs.[29] In addition, new federal regulations require states to submit more detailed MLR information for each plan in their state to CMS, rather than just an annual MLR summary.[30] These reporting requirements will help CMS better understand how individual plans are spending public dollars, including how provider incentive and bonus payments are counted in the MLR calculation. **We applaud these efforts but urge CMS to go further to bring this transparency to the public. CMS should:**

- **Require states to publicly post MLR reports submitted by MCOs on their Medicaid agency websites**.
- **Require all states to obligate MCOs to pay remittances to the state when they do not meet minimum MLR requirements and require states to report those remittances to the public.**

Without public access to this information, policymakers and advocates cannot effectively hold MCOs accountable for how they spend the Medicaid dollars they receive. Public reporting would enable stakeholders to identify missing or inaccurate information, flag plans that misrepresent data and pursue appropriate accountability measures (including sanctions, remittance payments and procurement decisions) against plans that fail to meet MLR standards. Transparency is not an end in and of itself but is the foundation upon which meaningful accountability and the rooting out of wasteful spending stands.

3. Transparency in MCO Sanctions

Recommendation: CMS should require all states to publicly report MCO sanctions data and establish a publicly available dashboard to make data on state MCO sanctions easily accessible.

Families USA urges CMS to require all states to publicly report MCO sanction data. While states already submit this data to CMS, the absence of public transparency significantly undermines the impact

sanctions can have on MCO performance. Public reporting is a low-cost, high-reward lever with a proven track record that drives meaningful accountability and lasting change.

Sanctions are among the most powerful tools available to ensure that MCOs steward Medicaid dollars efficiently and honestly and deliver high-quality care to beneficiaries.

Federal regulations permit states to impose sanctions for a wide range of violations, from inadequate care and data reporting failures to financial infractions. For example, a sanction could be appropriate when an MCO is inappropriately and systematically denying services through harmful prior authorization practices or is not honestly reporting administrative expenses and profit on its MLR report (both described above).

MCO sanctions fall into three broad categories: administrative takeover of the plan, requiring a corrective action plan, or imposing a monetary penalty.[31] Yet how states use their sanction authority varies enormously and is ripe for improvement. States differ significantly in what triggers a sanction, the size of the monetary penalties they impose and how transparently they communicate their actions to the public. A 2022 review of nine states found that six published no public information about MCO sanctions whatsoever.[32] The three that did disclose information varied so widely in quality and depth that meaningful comparison was nearly impossible.

This opacity is not a data problem but a policy choice, as states and CMS are already collecting ample sanctions data. Federal regulations require states to notify CMS in writing within 30 days of imposing or lifting any sanction, specifying which MCO was sanctioned, the reason for the sanction and the penalty applied.[33] CMS does not post this information publicly, and states do not consistently publish sanctions-related data because they are not required to do so.

However, when detailed sanctions data are publicly available, researchers, advocates and policymakers can use this information to push for meaningful reforms that bring bad actors to account. In California (one of two states highlighted in the 2022 review as having well-documented and easy-to-find MCO sanction data[34]), reporters at the Los Angeles Times used the state's published sanctions data to expose a pattern of severe care delays for Medicaid beneficiaries enrolled in the L.A. Care Health Plan.[35] The public scrutiny prompted the California Department of Health Care Services to issue the largest monetary sanctions in state history.[36]

Public reporting of MCO sanctions does more than create accountability after the fact: it can prevent poor performance from occurring in the first place.

Most MCOs operate as for-profit companies, which means that financial penalties, theoretically, should drive better care and future compliance.[37] In practice, however, the fines issued that are publicly known are often negligible relative to company profits, raising serious doubts about whether MCO sanctions, as currently structured, are serving as a meaningful deterrent to effectuate industry change. However, if MCOs fear that the specific details of their inappropriate actions will be reported publicly, the reputational risk from bad publicity may be a stronger motivator for positive change than monetary penalties on their own. While financial fines can be absorbed as a "cost of doing business," negative publicity erodes public trust, damages the brand, and can jeopardize the ability of plans to retain valuable contracts with their state (or with other states in which they operate).

Massachusetts offers a compelling proof of concept: the state's Health Policy Commission used public reporting to successfully slow health care spending growth for years in a highly concentrated market that might otherwise have gone unchecked. No health system wanted to be the first to face the public scrutiny and reputational consequences of exceeding cost growth targets. Stakeholders credit the state's elevated level of transparency with motivating health systems to hold the line on costs.[38] The same principle applies to MCOs and sanctions data.

CMS has stated in its RFI that it wants states to be "proactive in crushing fraudulent activities." Public reporting of actions so wrongful that they have risen to the level of requiring sanctions is a clear way CMS and states can deter future bad actors and stop fraud before it starts. **We urge CMS to better utilize the MCO sanctions data it already collects. CMS should:**

- **Require all states to publicly report on the state Medicaid agency website detailed MCO sanctions data, including which MCO was sanctioned, the specific reason for the sanction (with supporting details) and the penalty applied.**
- **Establish and continually update a publicly available dashboard to make data on state MCO sanctions easily accessible across state lines.** We note that MACPAC has recommended CMS issue better guidance to states to improve their sanctions reporting on the Managed Care Program Annual Report (MCPAR) pursuant to 42 CFR 438.66(e)(2)(viii).[39] However, rather than sanctions data be tucked away on a federal form that may be hard for consumers to find and use, we urge CMS to establish a specific webpage that spotlights sanctions across all managed care states.

By making better use of the sanctions data they already have, CMS and states have the opportunity to close a critical information gap and give policymakers, advocates, and the public the tools they need to hold MCOs to the standards that consumers deserve.

4. Public Posting of State Contracts with Medicaid Managed Care Organizations

Recommendation: CMS should publicly post state contracts with Medicaid managed care organizations.

Families USA recommends that CMS publicly post state contracts with Medicaid managed care organizations, as transparency in contracting serves important program integrity functions as well as provides a vehicle for quality improvement. Publicly posting contracts allows parties external to the contracting process to independently evaluate whether Medicaid spending is appropriate by determining whether contract terms are being met or are effective. Additionally, when states and other stakeholders can see how high-performing states are contracting for things like better maternal health outcomes, lower rates of avoidable hospitalizations, or stronger chronic disease management, they are better equipped to demand improvements. Therefore, as CMS endeavors to ensure that Medicaid dollars are well spent, it should look to improve the public availability of Medicaid managed care contracts.

Evaluating Medicaid managed care effectiveness is inhibited by decentralized posting of Medicaid managed care organization contracts.

Pursuant to 42 C.F.R. § 438.3, CMS must review and approve all MCO contracts, as well as any contract amendments.[40] However, CMS does not currently publicly post the contracts and amendments it

approves. And while 42 C.F.R. § 438.602 requires states to post the contracts on a state website, locating Medicaid managed care contracts on websites for the more than forty states with Medicaid managed care programs poses multiple challenges for stakeholders interested in evaluating the effectiveness of MCO contract provisions. For example, the names and types of state agencies that host the contracts can vary.[41] In some states the contracts are posted by the state's Medicaid agency, while in other states they are posted by a state's administrative services agency.[42] Medicaid agencies at the state level also have different names, organizational structures, and sometimes multiple websites.[43] States may also change which agencies are responsible for posting the contracts and the websites that host the contracts over time. This all makes searching for and finding the contracts, and keeping up with changes, an unnecessarily burdensome task.

Public posting by CMS would enable cross-state learning and drive better outcomes.

Eliminating the onerous time and effort involved in searching for and finding MCO contracts would allow stakeholders to devote more resources toward analyzing the effectiveness of the contracts. State Medicaid agencies would have better visibility into how their peers structure contractual requirements, allowing them to learn from each other to improve their accountability provisions, quality standards, and corrective action mechanisms to achieve better health outcomes. For example, if a state is struggling with high rates of avoidable emergency department use among its Medicaid managed care enrollees, it could examine contracts from states that have successfully reduced avoidable emergency department utilization to identify what performance metrics, care coordination requirements, or financial incentives they embedded in their MCO contracts to drive improvement. Or if a state is concerned about MCO behavioral health network adequacy, it could look to states that have strong network adequacy standards for mental health and substance use disorder providers as a model for strengthening its own contracts. This kind of practical, evidence-based cross-state learning can be difficult without streamlined access to actual contract language. CMS posting the contracts it already has would change that immediately.

Similarly, if researchers and health advocates had access to a centralized public repository of MCO contracts they could also assist CMS and state Medicaid agencies in evaluating the efficacy of contract provisions to improve quality of care and achieve better health outcomes for consumers. For example, researchers could track and analyze how Medicaid managed care contract provisions changed over time and what the impact was on health outcomes. Researchers could also compare changes to contract provisions and health outcomes across states and share their findings with policymakers. Better access to specific performance metrics and access standards in Medicaid managed care contracts would also help health advocates identify gaps between contractual promises and actual performance, file more informed complaints with state agencies, and push for stronger contract terms in future procurements.

For these reasons, **Families USA recommends that CMS should:**

- **Publicly post on its website all approved MCO contracts and amendments in a searchable format.**

5. Guidance on MCO Procurement Best Practices

Recommendation: CMS should develop best practices for states to adopt managed care procurement policies that incentivize high-performing plans and cultivate greater competition to improve health outcomes.

Families USA recommends that CMS develop and disseminate best practices guidance to help states adopt Medicaid managed care procurement policies that incentivize competition to drive improved health outcomes for Medicaid consumers. Current federal regulation regarding procurement for Medicaid managed care plans is minimal and procurement processes at the state level are subject to gaming by entrenched plans whose underperformance may not be considered during state procurement processes.[44] Improving procurement is essential to ensuring funding for MCOs is spent on the best available plans that deliver quality care and excellent health outcomes.

Federal standards are minimal, and states need more federal oversight.

The federal regulatory floor for Medicaid managed care procurement is remarkably low. Federal regulations only require that states must: (a) have a conflict-of-interest policy in place that is at least effective as safeguards found in federal procurement standards;[45] and (b) follow the same policies and procedures used for other state procurements.[46] CMS does not have any other minimum standards for state MCO procurement.[47] This means current regulations only afford CMS review and approval of MCO contracts and capitation rates that result after procurement already takes place, rather than providing opportunity for CMS to ensure procurement is conducted in ways that protect consumers, maximize competition, and hold low-performing plans accountable in advance of or during procurement.

State procurement laws are sometimes inadequate and state procurement processes are subject to political gaming by MCOs.

The gap in oversight over procurement of MCOs is significant, and the consequences have major financial impacts. In fiscal year 2024 alone, managed care plans received $458 billion in Medicaid funding.[48] Individual state managed care procurements can be worth billions of dollars annually and run for multiple years, making them among the largest contracts any state undertakes.[49] Unfortunately, many states have insufficient or problematic procurement policies when it comes to Medicaid managed care. In 2025, MACPAC found that while procurement is an important opportunity for states to identify high-performing plans and set performance expectations, some state procurement policies actively limit the use of MCO past performance data, or outright prohibit the use of publicly available information from other states to validate self-reported information from MCOs.[50] Accordingly, consumers would benefit from increased engagement from CMS on state procurement of MCOs. Missing this opportunity allows low-performing and non-compliant MCOs to continue receiving multi-year, multi-billion-dollar contracts with little consequence for their failure to deliver quality care.

State procurement processes are also often bogged down by MCOs engaging in highly political tactics and drawn-out litigation strategies that make MCO procurement difficult for state Medicaid agencies to manage. For example, states often have to restart procurement processes one or more times because of legal challenges from health plans.[51] Even straightforward, one-time procurement processes can take one or two years; delayed and interrupted processes can take a half a decade or more.[52] Other procurement disputes result in sparring between the legislature and governors over whether to delay procurement proceedings or extend existing contracts through statutory changes to avoid new decisions.[53] Federal requirements could help curtail the ability of health plans to disrupt the procurement process, particularly if CMS could provide states with more tools to help prioritize selection of MCOs with better outcomes.

These limitations on state procurement processes present a significant structural flaw when contracting with Medicaid managed care plans. Without federal support, some states will not be able to effectively hold plans accountable through their own current procurement processes. **Therefore, CMS should help states by driving managed care plan improvement through procurement. Families USA recommends that CMS:**

- **Develop best practices guidance addressing performance-based request for proposal (RFP) evaluation criteria that states could use to improve their state procurement practices**. This could include incorporating MCO quality performance and compliance history, including publicly available performance data from other states.

Best practice recommendations like these will help drive higher quality care, better health outcomes, and meaningful access for the tens of millions of low-income Americans who need Medicaid to be at its best.

Conclusion

Families USA appreciates CMS taking steps to refine their practices for assessing and tackling program integrity issues where they may exist in the Medicaid program. To that end, we urge CMS to consider ways to improve transparency and accountability in the Medicaid managed care system.

For contracts worth literally billions of dollars, Medicaid managed care plans promise to deliver better access and higher value care to Medicaid beneficiaries. Reliance on managed care in Medicaid is only growing as states expand their use of MCOs to serve more medically complex beneficiaries and as lawmakers increasingly look to managed care to constrain Medicaid spending. However, states and the federal government often lack sufficient information to provide the oversight necessary to hold managed care plans accountable for the services they deliver.

By making data and information transparent and available through the mechanisms Families USA has identified here, states and CMS can better understand where MCOs are bringing value to Medicaid (in terms of higher quality of care, improved access, and reduced Medicaid spending), where MCOs are lagging behind and need performance improvement, and where MCOs are potentially operating wastefully or fraudulently. **We recommend that CMS:**

- **Require MCOs to report publicly on prior authorization processes and require states to audit prior authorization denials.**
- **Require states to publicly post MLR reports submitted by MCOs and obligate MCOs to pay remittances to the state when they do not meet minimum MLR requirements.**
- **Require all states to publicly report MCO sanctions data and establish a publicly available dashboard to make data on state MCO sanctions easily accessible.**
- **Publicly post all approved state Medicaid contracts with MCOs.**
- **Develop best practice guidance for states to adopt managed care procurement policies that incentivize high-performing plans and cultivate greater competition in the managed care market.**

While each of these mechanisms on their own provide an important level of transparency and advance CMS' goals of efficiency in the Medicaid system, a combination would form the basis for meaningful and

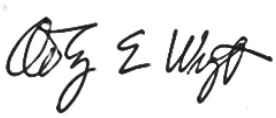
lasting change. For example, having transparency on both prior authorization and MLR can help CMS, states and consumers understand whether improper denials of care are inappropriately driving up plan profits at the expense of care for beneficiaries. Knowledge of inappropriate prior authorization practices and improper MLR reporting can support states in issuing sanctions. In turn, transparent sanctions data can drive quality procurement decision-making if states know about the bad practices of plans who operate in multiple states. Importantly, public reporting through all of these mechanisms can deter MCOs from problematic practices in the first place.

We believe with better transparency tools in place, CMS and states can prevent plans from inappropriately denying services or delaying care, ensure MCOs spend adequately on health care services for their members and ensure beneficiaries have access to the high-quality services CMS and taxpayers should expect from the Medicaid program.

For questions or comments regarding the recommendations made in this letter, please reach out to Mary-Beth Malcarney, Senior Advisor on Medicaid Policy, Families USA at: mmalcarney@familiesusa.org.

Thank you for your time and consideration.

Sincerely,



Anthony Wright
Executive Director

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