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State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations: Interview Findings

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Overview

- Background
- Oversight requirements
- Themes from stakeholder interviews
- Analysis of Managed Care Program Annual Reports (MCPARs)
- Next steps

Background

- 41 states and the District of Columbia contract with comprehensive, risk-based managed care organizations (MCOs)
- Almost three-quarters (73 percent) of beneficiaries enrolled in managed care, and managed care is more than half (56 percent) of Medicaid benefit spending
- States contract with MCOs through a competitive procurement (Request for Proposal or RFP) or a non-competitive application

MACPAC Managed Care Accountability Work

- Procurement
  - 2022 study found CMS defers to state Medicaid agencies to procure MCOs but opportunities do exist to assist states and MCOs during readiness review
- External Quality Review (EQR)
  - 2022-2024 study included 60 stakeholder interviews and analysis of 2024 managed care final rule
  - Commission made three recommendations to improve the usability and transparency of EQR findings
- Denials and appeals
  - 2023 study examined monitoring, oversight, and beneficiary experience
  - Commission made seven recommendations that include requiring external medical review of denials, conducting clinical audits of denials, and making denials and appeals data publicly available

Policy Questions

- What tools (e.g., sanctions or incentives) are available to states to ensure MCOs comply with contract requirements and meet performance expectations?
- What tools do states actually use? Do states need additional tools?
- What tools are available to CMS to ensure state managed care programs and their contracted MCOs comply with regulatory requirements and meet performance expectations?
- What tools does CMS use? Does CMS need additional tools?

Oversight requirements

Requirements for federal oversight

- Oversight of procurement is limited to conflict of interest safeguards and verifying contractors are eligible for at-risk contracts
- CMS must approve state-MCO contracts and actuarial rate certifications
- CMS has the authority to deny federal match on capitation payments for non-compliance with federal requirements and can deny federal match for new enrollees upon recommendation from the state Medicaid agency
- CMS may refer to the Office of the Inspector General (OIG) for additional civil monetary penalties

Federal requirements for state oversight

- States may not enter into contracts with MCOs unless the state has established intermediate sanctions
- States must establish intermediate sanctions for specific instances in which the MCO acts or fails to act
- Imposing sanctions is discretionary; states can impose additional sanctions under state law

Intermediate sanctions states can impose on Medicaid MCOs

Intermediate sanction types (42 CFR 438.702(a))	Reasons for the sanction (42 CFR 438.700) and civil money penalty amount, if applicable (42 CFR 438.704)
Civil monetary penalties	• Failure to provide medically necessary services that the plan is required to provide to enrollees covered under the contract ($25,000). • Imposing premiums or charges that are more than what is allowed under the Medicaid program (maximum amount is $25,000 or double the amount of the excess charges, whichever is greater. State must deduct from the penalty the amount of overcharge and return it to the affected enrollees). • Discriminating on the basis of health status or need for health care services. Includes termination of enrollment or refusal to reenroll an enrollee (except as allowed under the Medicaid program), or any practice that would reasonably be expected to discourage enrollment by enrollees whose medical condition or history indicates probably need for substantial future medical services ($100,000 for each determination; $15,000 for each enrollee subject to an overall limit of $100,000). • Misrepresenting or falsifying information provided to CMS or the state ($100,000 for each determination). • Misrepresenting or falsifying information provided to an enrollee, potential enrollee, or health care provider ($25,000). • Failing to comply with physician incentive plan requirements at (42 CFR 422.208 and 210) ($25,000). • A state determines that the MCO has distributed marketing materials that have not been approved by the state or contain false or misleading information ($25,000). • A state determines an MCO has violated any requirements in sections 1903(m) [MCO requirements] or 1932 of the Social Security Act [provisions related to using managed care in a state] or any implementing regulations.
Appointment of temporary management of an MCO	
Granting enrollees the right to terminate enrollment without cause and notifying them of their right to disenroll	
Suspension of new enrollment	
Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the state is satisfied the sanction is no longer required	

Incentive payments

- Total payment under incentive arrangements may not exceed 105 percent of the capitation rate under actuarial soundness standards
- Contracts must provide that the incentive arrangement is:
  - For a fixed period of time and performance is measured during the applicable rating period
  - Not renewed automatically
  - Made available to contractors under the same terms of performance and not conditioned on the plan entering into an intergovernmental transfer
  - Support initiatives under the state's quality strategy

Themes from stakeholder interviews

Stakeholder interviews

- Findings from 18 stakeholder interviews conducted between December 2024 and May 2025
- Stakeholder groups:
  - State Medicaid agency officials
  - MCO representatives
  - Medicaid health plan trade associations
  - Relevant federal agencies
  - National experts/organizations
- Findings across three areas:
  - Procurement and contract requirements
  - Use of accountability tools
  - CMS oversight and guidance

Procurement and contract requirements

- The procurement process is an early opportunity for states to identify high-performing plans and establish performance expectations
- States use past performance as part of the bid evaluation to identify patterns of contract violations and screen for poor performance
  - Some state procurement rules limit the use of MCOs' past performance or forbid the use of publicly available information from other states to validate MCO self-reports
- Past performance can be used to inform monitoring provisions
  - One interviewed state added a monthly reporting and tracking process for service denials after bidder disclosures of prior performance issues

Use of accountability tools

- States frequently address issues through informal channels with MCOs before escalating to formal sanctions
- States vary the use of accountability tools based on the severity and duration of the contract violation or performance issue
  - All six states interviewed set thresholds that automatically impose a serious penalty (e.g., fine or enrollment suspension) for violations or performance issues that have immediate consequences for enrollees
  - The interviewed states varied in how and when they impose formal sanctions, and some lacked documented criteria and policies as to what triggers escalation
- Stakeholders preferred incentives over penalties for motivating improvement in MCO performance and behavior change
  - Incentives (e.g., bonus payments, auto-assignment, capitation withholds) foster competition and motivate MCOs to achieve targets
  - Monetary penalties are often small compared to the level of capitation payments

Use of accountability tools, cont.

- States use sanctions, but they can be more challenging to administer
  - MCOs frequently appeal enforcement actions, lengthening the time to resolution
  - MCOs have lobbied the state legislature or Governor's office to obtain relief from sanctions
- Public reporting of corrective action plans (CAP) and other sanctions is an accountability tool that promotes transparency
  - Four of six interviewed states post CAPs and monetary penalties on state websites; the other two publish quality measure performance only
  - Two interviewed states plan to include requirements for public reporting in future MCO contracts

CMS oversight and guidance

- While CMS has broad authority to ensure that state Medicaid managed care programs are structured to be compliant with federal requirements, it has fewer tools to directly address specific MCO deficiencies
  - CMS can defer federal matching funds only for the entire amount of the capitation payment made to the plan
  - CMS lacks some of the oversight tools available in fee for service (e.g., imposing formal CAPs on states, deferring a share of the federal match for capitation payments in proportion to the severity of non-compliance)
- Some stakeholders thought CMS could provide states with additional guidance and resources on effective procurement practices and sanction policies
  - Several interviewees suggested that CMS could help states by developing a national publicly available database of MCO contract violations and sanctions

MCPAR analysis

MCPARs

- States are required to post MCPARs on their state Medicaid website, and CMS posts MCPARs from states in a central repository on Medicaid.gov
- We reviewed and analyzed MCPARs submitted for performance year 2023 (September 2023 through August 2024) from 34 states
- We categorized the topics reported into reasons for intervention:
  - Beneficiary rights and communications
  - Data, reporting, and performance
  - Networks and payments
  - Services and benefits
- Our analysis focused on types of sanctions, amount of financial penalties, reported reasons for the intervention, and time to remediation

Themes from MCPAR analysis

- States are more likely to take intermediate steps before escalating to monetary penalties:
  - 359 CAPs sanctions from 25 states
  - 19 CAPs and liquidated damages from 2 states
  - 106 civil monetary penalty sanctions from 11 states
  - 187 liquidated damages sanctions from 10 states
  - 66 compliance letter sanctions from 8 states
- Only 12 of 359 CAPs (3.3 percent) had an associated financial penalty
- The amount of financial sanctions imposed can vary, but the most common value reported was less than $5,000

Themes from MCPAR analysis

- Average sanction amounts vary by intervention topic, with sanctions related to beneficiary rights and communications as the least costly for MCOs
- The majority of reported sanctions (54.8 percent) were remediated within 90 days, and only 3 percent took longer than 360 days to resolve

Key takeaways

- Stakeholder interviews indicated that states generally have sufficient tools through sanctions and incentives to oversee MCO performance
- Most states take an incremental approach and use regular check-ins to identify and address performance issues before issuing formal sanctions
- Stakeholders generally agreed that incentives and sanctions that have a substantial impact on plan revenue are more effective (e.g., changes to auto assignment)
- Many stakeholders thought that public reporting of MCO performance, such as information on the frequency and type of sanctions, could be a useful tool for oversight and future procurement decisions
- Stakeholders suggested there may be opportunities for CMS toolkits or other guidance that could help states design more effective procurement processes or sanction policies
- Federal officials and national experts commented that CMS does not have same authority to oversee and address issues in managed care that they do in the FFS program, and they were interested in equalizing the tools across delivery systems

Next steps

- Commissioner feedback on findings and areas for potential policy options
  - Our research indicated that states have sufficient accountability tools, but CMS does not have analogous oversight authorities in fee for service and managed care (e.g., partial deferrals of capitation payments, issuing CAPs). To what extent should CMS have consistent oversight authorities across delivery systems?
  - Availability and transparency of data on plan performance (e.g., sanctions, quality measures) has been a key theme across our managed care work. Is the information collected through federal reporting (e.g., MCPARs) sufficient and available to stakeholders to understand plan performance?
  - Decisions on MCO procurement or imposing sanctions/incentives lie primarily with the state, but some stakeholders noted an opportunity for additional federal guidance. Would federal guidance on procurement processes or sanction policies be useful to states or MCOs?
- Staff can present potential policy options at future meeting

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DECEMBER MEETING

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