Chapter 3:

State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

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Recommendations

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

Key Points

- As managed care is the predominant Medicaid delivery system, effective oversight of these programs has increasingly become a priority for stakeholders seeking to ensure that beneficiaries have appropriate access to needed services.
- States use a range of accountability mechanisms to oversee managed care plan performance, including withholds and incentive payments, auto-assignment of enrollees, enrollment freezes, corrective action plans (CAPs), financial penalties such as civil monetary penalties and liquidated damages, and termination of the contract. Most states address identified deficiencies using an incremental, relationship-based approach before escalating to formal sanctions.
- Federal regulation specifies that the Managed Care Program Annual Reports (MCPARs) must include the results of any sanctions, CAPs, or other formal or informal interventions with a contracted plan; however, MACPAC's analysis of MCPARs found that reporting of compliance actions is inconsistent and incomplete. The inconsistency in reporting stems in part from unclear definitions of what should be reported.
- Multiple stakeholders identified challenges in accessing and using available data to assess managed care performance comprehensively. Although CMS requires states to report performance data across a variety of sources, such as the MCPAR, external quality review, and network adequacy and access assurances report, these are not always available in a centralized location or provided in a format that is conducive for analysis that links across plans and states.
- Clarifying reporting requirements for the types of accountability actions that should be reported in the MCPAR and developing a publicly available database that links federally mandated reported data together would provide states, CMS, beneficiaries, and other stakeholders with a more consistent and comprehensive picture of managed care plan performance.

CHAPTER 3: State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

Managed care is now the predominant Medicaid delivery system in most states, growing from less than half (48.3 percent) of Medicaid beneficiaries enrolled in comprehensive, full-risk managed care organizations (MCOs) in fiscal year (FY) 2010 to almost three-quarters (74.1 percent) in FY 2023 (MACPAC 2026a, 2013a). Similarly, managed care capitation payments to all managed care plans have grown from under a quarter (23.5 percent) of Medicaid benefit spending in FY 2010 to over half (57.3 percent) in FY 2023 (MACPAC 2026b, 2013b). With the rise in Medicaid managed care enrollment and spending, effective oversight of these programs has increasingly become a priority for stakeholders seeking to ensure that beneficiaries have appropriate access to needed services. For example, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) has designated oversight of managed care as a priority area, and in 2024, the Government Accountability Office (GAO) called on the Centers for Medicare & Medicaid Services (CMS) to address inconsistencies in MCOs' prior authorization requirements for children's services and limited state oversight of prior authorization actions (GAO 2024a, OIG 2020).

Although CMS and states have made concerted efforts to strengthen oversight of managed care programs, comprehensive information about how state Medicaid agencies use available accountability tools to ensure that managed care plans comply with contract requirements and meet performance expectations has not been made publicly available. Continuing the examination of Medicaid managed care oversight and accountability, MACPAC initiated a study of the tools available to federal and state regulators to oversee states' managed care programs. Specifically, MACPAC staff conducted an environmental scan of federal rules and a review of contracts in states with comprehensive managed care (40 states); held stakeholder interviews with representatives from state Medicaid agencies, managed care plans, and national experts; and analyzed Managed Care Program Annual Reports (MCPARs) available from CMS. MACPAC studied the accountability tools that are available to states and CMS to ensure that managed care plans comply with federal and state requirements and meet performance expectations, which accountability tools are used, and whether states or CMS need additional tools to oversee plan performance.

Our work found that although states had sufficient tools, such as sanctions and incentives to influence plan performance, many stakeholders encounter challenges in using existing data sources to obtain a comprehensive picture of plan performance, both within and across states. Although several measures of managed care plan performance are reported to CMS and made publicly available, these data are reported inconsistently, in part due to unclear definitions. Available data are also fragmented across reports in formats that do not allow for stakeholders to easily combine and analyze. Clarifying certain data definitions and reporting requirements and combining data in a standardized way across federal reports would provide a more consistent, comprehensive picture of managed care performance that would help CMS, states, beneficiaries, and other stakeholders assess past performance and monitor ongoing trends across plans and states. Based on these findings, the Commission makes two recommendations:

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

These recommendations complement and build on our recent work on denials and appeals in Medicaid managed care and the role of external quality review (EQR) in managed care. In our March 2024 report to Congress, MACPAC examined the monitoring and oversight of denials and appeals in Medicaid managed care and the beneficiary experience with the appeals process. The Commission's recommendations included requiring external medical reviews of denials, clinical audits of denials to assess clinical appropriateness, and CMS and states making denials and appeals data publicly available in accessible formats (MACPAC 2024). In our March 2025 report to Congress, the Commission made three recommendations to improve the EQR process, focused on shifting EQR activities from process and compliance to meaningful outcomes and actionable data and improving the usability of EQR findings through greater reporting consistency, summarization, and transparency (MACPAC 2025).

This chapter begins with background on Medicaid managed care and the federal and state oversight requirements governing Medicaid managed care accountability. The chapter then presents key findings about how states are using various accountability tools and the challenges for stakeholders in using these tools effectively. We then present two recommendations, associated rationale, and implications for stakeholders. The chapter concludes with a look ahead at the Commission's continued work in Medicaid managed care accountability.

Background

Managed care is the predominant Medicaid delivery system in most states (MACPAC 2026a, 2026b). States contract with managed care plans, selecting them through a competitive procurement (request for proposal, or RFP) or a non-competitive application process; the contracts through a competitive procurement typically last three to five years (NAMD 2024). The procurement or application documents establish the state's performance expectations, which are then codified in the contract between the state and its selected plans. The managed care procurement process creates the opportunity for state Medicaid agencies to identify priorities for their program, such as improvements to access, quality, and health outcomes for enrollees. Most states require plans to demonstrate how they would improve the managed care program in their bids and often bind them to the commitments they make in RFP responses in the resulting contracts. However, achieving the goals articulated in the procurement process depends on strong federal and state oversight of plans' contractual obligations.

Although CMS and states have made concerted efforts to strengthen oversight of managed care programs, little is known about how state Medicaid agencies use available accountability tools to ensure managed care plans comply with contract requirements and meet performance expectations. States have access to a range of mechanisms to address managed care plan performance, including withhold and incentive arrangements, reducing or suspending new enrollment (including default enrollment), corrective action plans (CAPs), financial penalties such as civil monetary penalties, fines, and liquidated damages, and termination of the contract. Few studies have systematically examined states' use of these mechanisms or their effectiveness. A recent review of nine state contracts found that states commonly use CAPs to address deficiencies in MCO compliance before imposing fines, which may be levied until the MCO comes back into compliance or brings its performance up to par (Young 2022). If an MCO continues to perform poorly, states may take past performance into account when awarding contracts during the next procurement cycle or even terminate an existing contract (FSSA 2025, MACPAC 2022, Baumgarten 2020).

Federal Requirements on Oversight

In the past ten years, CMS issued three comprehensive updates to Medicaid managed care rules to modernize federal requirements for how states contract for managed care; balance federal oversight and state flexibility; and improve access to care, quality, and outcomes (CMS 2024a, 2020, 2016). In addition, CMS has supplemented this regulatory framework with a series of five informational bulletins since 2021 to provide tools for states and CMS to improve monitoring and oversight (CMS 2026a, 2024b, 2023, 2022, 2021). A few federal rules govern the Medicaid managed care procurement process, and CMS's involvement once contracts are awarded and approved focuses largely on state reporting requirements and providing technical assistance to states. CMS promulgates regulations to establish requirements that govern how Medicaid managed care programs should operate, but CMS generally does not have a direct role in ensuring that managed care plans are complying with federal and state regulations or other contractual terms because CMS is not a party to the contract.

Managed care procurement

As detailed in MACPAC's 2022 managed care procurement study, the federal government defers to states and their respective procurement laws when selecting Medicaid managed care plans (MACPAC 2022). Federal requirements are minimal; states must establish conflict of interest safeguards on the part of state and local officers, employees, or agents of the state who have responsibilities relating to the managed care contracts (42 CFR 438.58).[1] Federal statute and regulation specify the types of organizations allowed to have comprehensive risk contracts in Medicaid (§ 1903(m)(2) of the Social Security Act (the Act) and 42 CFR 438.2). As part of the contract review process, which occurs no less than annually for comprehensive risk contracts, CMS verifies that selected contractors meet the statutory definitions of an MCO or are one of the other types of limited benefit entities (e.g., prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs)) that may hold a risk contract (42 CFR 438.2 and 438.3).[2] However, in large part, states manage their own managed care procurements, deciding whether to have a competitive or non-competitive selection process, the selection criteria, the evaluation panel, how many plans to contract with, the frequency of contract duration, and the content of the contract beyond the required federal provisions.

State Medicaid agency responsibilities

Section 1932(e) of the Act provides that a state may not enter into contracts with MCOs unless the state has established intermediate sanctions that it may impose on an MCO that fails to comply with specified requirements. Federal regulation originally released in 2002 provides the basis for states to establish sanctions and requires states to establish intermediate sanctions on MCOs for specific instances in which the plan acts or fails to act (Table 3-1) (42 CFR 438.700-708). Medicaid managed care rules in 2016, 2020, and 2024 revised certain standards for access, quality, and costs to which state Medicaid agencies hold plans accountable (42 CFR 438). However, imposing sanctions on MCOs is entirely within the state Medicaid agency's discretion. States also have authority to impose additional sanctions under state law or regulation to address non-compliance, including establishing and imposing sanctions on other types of managed care plans (42 CFR 438.702(b)). Ultimately, states retain responsibility for ensuring that their Medicaid program complies with the state plan and federal requirements and cannot delegate these responsibilities to contractors (42 CFR 431.10).

CMS oversight authorities

Federal regulations provide CMS with direct oversight and enforcement authority in specific instances. CMS must approve states' actuarial rate certifications for capitation payments (42 CFR 438.7) and must review and approve state Medicaid agency contracts with managed care plans to ensure they include all federal requirements (42 CFR 438.3). CMS has the authority to deny federal match on state capitation payments to a plan that does not comply with the applicable requirements of Section 1932 of the Act (§ 1903(m)(2)(A)(xii) of the Act).[3]

TABLE 3-1. Intermediate Sanctions States Can Impose on Medicaid Managed Care Plans

Intermediate sanction types (42 CFR 438.702(a))	Reasons for the sanction (42 CFR 438.700) and maximum civil money penalty amount, if applicable (42 CFR 438.704)
Civil monetary penalties	• Failing to provide medically necessary services that the plan is required to provide to enrollees covered under the contract ($25,000 for each determination). • Imposing on enrollees 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 probable need for substantial future medical services ($100,000 for each determination; $15,000 for each beneficiary not enrolled due to a discriminatory practice, 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 for each determination). • Failing to comply with physician incentive plan requirements (42 CFR 422.208 and 210) ($25,000 for each determination). • Distributing marketing materials that have not been approved by the state or contain false or misleading information ($25,000). • Violating any requirements in Sections 1903(m) (MCO requirements) or 1932 (provisions related to using managed care in a state) of the Social Security Act or any implementing regulations. Federal regulations do not establish authority to impose civil monetary penalties or appoint temporary management for these violations (42 CFR 438.700(d)(3)).
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, including default 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	

Notes: MCO is managed care organization. CMS is the Centers for Medicare & Medicaid Services. States that contract with an MCO must establish intermediate sanctions that it may impose for the reasons specified. States may establish these sanctions on primary care case management entities. States may also impose additional sanctions under state law or regulation, including establishing and imposing sanctions on other types of managed care plans.

Source: 42 CFR 438, Subpart I.

Federal regulations also authorize CMS to impose sanctions on MCOs through payment denials for new enrollees (42 CFR 438.730). CMS, on the recommendation of the state Medicaid agency, may deny federal match to the state on capitation payments made for new enrollees of an MCO when the plan fails to provide medically necessary services, improperly charges enrollees, discriminates based on health status, provides false information to CMS or the state, misleads enrollees or providers, or fails to comply with physician incentive plan requirements (42 CFR 438.730(a) and (e), 42 CFR 438.700(b)). CMS denial of federal payments for new enrollees automatically triggers denial of state payments to the MCO for those same enrollees (42 CFR 438.730(e)(2)). CMS retains independent authority to perform any enforcement functions normally assigned to the state under this process and refers all determinations resulting in payment denials for new enrollees to the OIG, which may impose additional civil money penalties on the MCO (42 CFR 438.730(g)).

In the 2024 managed care rule, CMS increased managed care oversight through additional reporting requirements, particularly around beneficiary access to care (CMS 2024a). The rule requires states to submit and implement a formal remedy plan for any of its managed care plans when monitoring and oversight activities demonstrate a plan needs improvement in meeting required access to care standards, effective in 2028. States must submit a remedy plan to CMS for approval within 90 calendar days of becoming aware of an access issue. The remedy plan must address the issue and improve access within 12 months and must demonstrate those improvements are measurable and sustainable (42 CFR 438.207(f)).

MCPAR

Federal regulations require states to monitor the performance of each Medicaid managed care plan across several aspects, including areas such as appeals and grievances, medical management, availability and accessibility of services, and quality improvement (42 CFR 438.66(b)). The state must use the data collected from its monitoring activities to improve the performance of its Medicaid managed care program (42 CFR 438.66(c)) and submit an annual report to CMS on several aspects of the program (42 CFR 438.66(e)). States submit the information for this annual report to CMS through a standardized reporting template known as the MCPAR. The MCPAR requires states to report detailed information on their Medicaid managed care programs, including accountability actions such as sanctions and CAPs imposed on managed care plans. Current federal regulation specifies that states must report the results of any sanctions or CAPs imposed by the state or other formal or informal intervention with a contracted plan to improve performance on the MCPAR (42 CFR 438.66(e)(2)(viii)). States began submitting MCPARs in 2022, and CMS has begun posting MCPARs from states on Medicaid.gov.

State Use of Accountability Tools

Our review of 23 recent RFPs and 40 contracts executed between state Medicaid agencies and comprehensive MCOs from 2021 to 2024 found that states typically begin their assessment of plan performance during the procurement by including information about past performance as part of their evaluation criteria. Once contracts were executed, financial sanctions and incentives were the most frequently cited accountability tools used by states. States were also universal in applying sanctions after identifying deficiencies in MCO performance, quality of services, and enrollee access to services.

States vary in their use of past performance during the procurement process. Our review found that all 23 state RFPs required bidding MCOs to provide past performance information in their responses. RFPs most frequently requested that bidders disclose instances of non-renewal or early termination of contracts (17 states), corrective actions or CAPs (16 states), and monetary penalties (12 states). Many states limit the look-back time period for which bidders must report past performance issues. Twenty-one states varied in their look-back period requirements, ranging from 2 to 11 years, while the other two states did not specify the look-back period for which the bidder must disclose past performance issues.

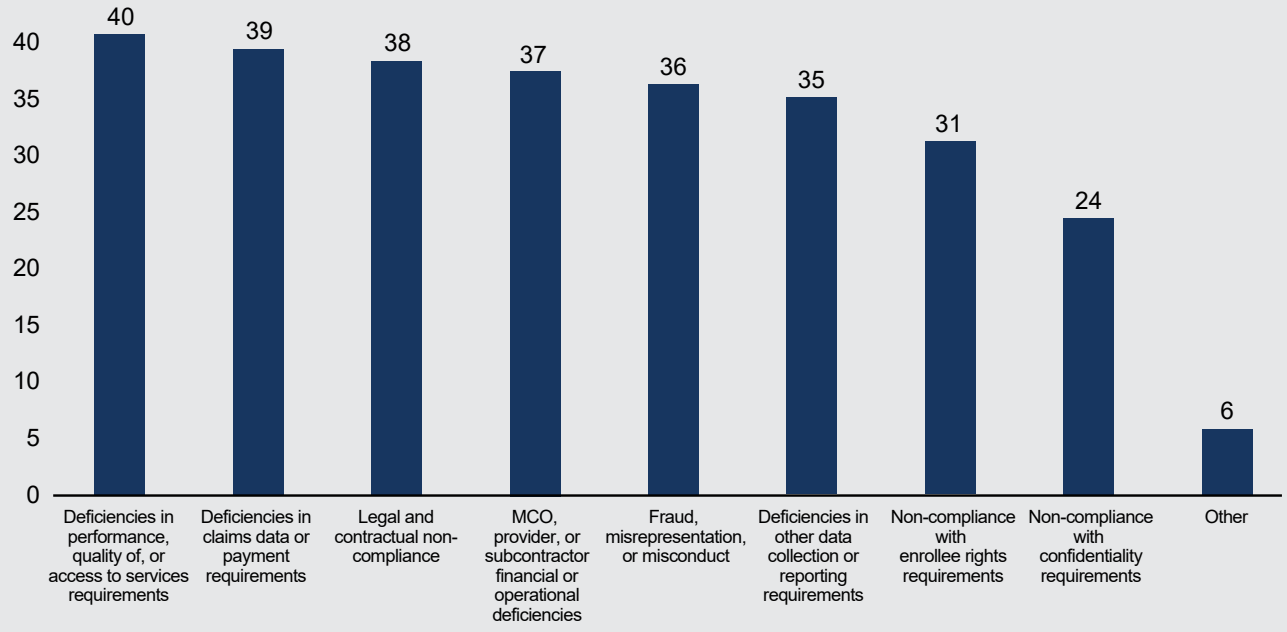
States took a range of approaches in the specific information requested within these broad categories of performance issues and how the information may be ultimately used in awarding a contract. For example, one state primarily used past performance as a tiebreaker between similarly scored proposals, and another included RFP language that would allow the state to refuse to consider any proposal from a bidder who has violated contract provisions. A third state required bidders to explain how they will avoid contract non-compliance in the future even if the bidding MCO did not have deficiencies from the past three years to report.

States include both sanctions and incentives in MCO contracts. As part of our contract review, we classified sanctions into 10 different types: enhanced monitoring and oversight, CAPs, enrollment penalties, capitation payment penalties, other monetary penalties (e.g., fines and liquidated damages), temporary management of a contractor, contract termination, refusal to renew the contract, referral for investigation, and public reporting.

All 40 state contracts reviewed had some type of sanction provisions. The most common sanction types were monetary penalties such as fines and liquidated damages (40 states), CAPs and contract termination (38 states), enrollment penalties (24 states), and capitation payment penalties (21 states). Eighty percent of states (32 of 40) included between five and eight sanction types, with the most being 2 states with eight sanction types.

All 40 states' contracts could impose sanctions in response to identified deficiencies in performance, quality of, or access to services requirements (Figure 3-1). Nearly all states (39 states) had sanction provisions in response to deficiencies in encounter data reporting requirements, claims data, or provider payment requirements. Thirty-eight states specified sanctions for legal and contractual non-compliance.

FIGURE 3-1. Types of Deficiencies that Can Result in Sanctions by Number of States



Note: MCO is managed care organization.

Source: MACPAC and Mathematica, 2024, review of 40 states' publicly available managed care contracts (boilerplate or executed language) executed between 2021 and 2024.

States can push states to meet or exceed specific performance standards through incentive arrangements that can either increase payments or enrollment. We classified incentives that state Medicaid agencies included in their contracts with MCOs into three types: capitation payment bonuses to meet or exceed performance standards or targets, auto-assignment of default enrollees (some states framed auto-assignment as a sanction), and public reporting of MCO performance (some states framed public reporting as a sanction).

All but one of the 40 states included incentives in their contracts to encourage MCOs to achieve or exceed performance standards. Ninety percent (36 of 40) of MCO contracts allowed for capitation payment bonuses when plans meet or exceed certain performance standards or targets, followed by 17 states providing incentives for higher enrollment through the auto-assignment of enrollees.[4] Three states' contract language allowed the state to publicly report individual MCO performance on quality measures and other performance indicators.

States typically address compliance issues informally before escalating to formal sanctions. All state Medicaid agencies interviewed in our study engaged in regular meetings with MCOs to proactively identify and address performance issues. Many states and MCOs reported that informal engagement and iterative informal oversight are the primary tools they use to manage plan performance and resolve issues. These states and MCOs noted that maintaining ongoing communication and relationships is important for addressing and resolving issues before they escalate to formal accountability actions, such as sanctions. All interviewed states discussed maintaining regular touchpoints between MCOs and state staff as an effective approach to developing partnerships and lines of communication to detect and fix problems.

For failure to meet minimum quality standards and first-time offenses, all states interviewed generally addressed issues using informal channels, followed by an escalation or tiered approach to give MCOs an opportunity to correct these types of problems. One state first requires an MCO to submit an MCO Improvement Plan for minor compliance violations, failures, or deficiencies. If the plan does not resolve the issue in a timely manner, the state may escalate to a CAP, followed by the issuance of a fine.

States vary the use of accountability tools based on severity and duration. To determine which accountability tool is most appropriate, some states rank contract violations and performance issues by severity and how quickly the plan resolves the problem. For violations or performance issues that have immediate consequences for enrollees or have not been resolved in a timely manner, all six states interviewed set thresholds that automatically impose a serious penalty, such as a fine or enrollment suspension that involves financial consequences, without giving the MCO an opportunity to remedy the problem through warnings or a CAP.

For problems that do not affect enrollee care directly but that are essential to program operations (e.g., encounter data), some states impose automatic, albeit relatively small, fines. Two states levy fines automatically for incomplete or tardy submission of encounter data, which are required to set capitation rates, monitor utilization and access, and validate plan-reported quality metrics.

The states interviewed as part of this study varied in the criteria they used to determine when to adopt an informal approach or impose formal sanctions. The interviewed states varied in how and when they imposed formal sanctions, and some lacked documented criteria that trigger an escalation, which raises the risk of inconsistency in the application of sanctions to all plans in a state or over time. To have a more consistent process, one state assigns points to non-compliance issues based on the severity and likelihood of recurrence. The accumulation of a certain number of points can trigger formal, escalating sanctions for an MCO. Another state expressed interest in establishing a written, formal escalation policy to ensure the process is clear to all MCOs.

Incentives are often more effective than penalties in motivating improved MCO performance. Incentives, such as bonus payments or a greater proportion of auto-assignment, play an important role in assuring that MCOs meet minimum quality standards and motivating them to improve quality and outcomes. All six study states indicated these

tools are usually effective in modifying or shaping MCO behavior in response to financial motives. If MCOs do not meet the quality goals, they forgo revenue. Interviewed states noted that incentives are more effective if a substantial amount of revenue is associated. According to some national experts, financial penalties may not be a strong motivator for improvement because MCOs often assume a certain level of sanctions as part of their operating expenses. In addition, the dollar value of monetary penalties is often relatively small compared to the almost $500 billion made through Medicaid capitation payments (Table 3-1, MACPAC 2026b).

State officials and MCO representatives discussed the effectiveness of using auto-assignment to motivate MCO performance on quality or performance metrics because enrollment drives a plan's revenue. This can be done as an incentive; by assigning a greater share of new members who do not choose a plan to a high-performing MCO; or, as a penalty, by suspending new auto-assignments. One state indicated that they prefer to suspend auto-assignment instead of suspending all new enrollment into a plan because they did not want penalties that constrict patient choice. Even though auto-assignment can have a significant effect on plan enrollment and revenue, one MCO noted that using auto-assignment as an incentive may not shift behavior substantially if the performance of the MCOs did not vary widely.

Financial sanctions can be challenging to administer. Some interviewees noted that sanctions can be hard to impose because MCOs frequently appeal such enforcement actions, which lengthens the time it takes to resolve the problem. Officials from one state noted that the state was shifting toward incentives because of the delays in resolution resulting from MCO appeals of sanctions.[5] A recent study echoed these challenges; researchers found that approximately 25 percent of sanctions reported in the 2023 MCPARs indicated no remediation action (Ramakrishnan and Tran 2026).

Additionally, the extent to which state Medicaid agencies use available accountability tools can reflect the priorities of the state's executive or legislative branch. A few state officials mentioned that MCOs lobbied the state legislature or governor's office to obtain relief from sanctions. State Medicaid agencies indicated that they are more successful in using accountability tools when legislative and executive support can hold plans accountable for compliance with contract requirements and performance standards.

Public reporting of plan performance is widely recognized as an effective accountability tool. All state officials, national experts, and federal officials recognized public reporting as a tool to promote transparency and accountability, though states vary in the information released and reporting methods. Two study states published quality performance measure results but did not publicly post corrective actions imposed on MCOs. Four of the study states posted CAPs and monetary penalties on state websites throughout the term of the contract.

One state official noted that public disclosure often motivates the plans to resolve issues, so public reporting is seen as one of their most effective accountability tools. Federal and national experts agreed that public reporting of MCO performance, including sanctions, generally is an important tool for driving improvements in MCO performance and better outcomes for enrollees but emphasized that it needs to be in an accessible, understandable format to be effective. One national expert noted that public reporting is critical for informing policymakers, providers, enrollees, and the general public about MCO performance. Enrollees could use the performance and sanctions data to reconsider their MCO choice if a plan was repeatedly sanctioned or had CAPs imposed.

MCO representatives acknowledged that public reporting can be an important accountability tool and were not opposed to disclosure of plan performance, including sanctions. However, they expressed the need to place information in the appropriate context. For example, one plan representative expressed concern about posting information on sanctions that are still undergoing the appeals process.

Challenges in Oversight and Accountability

The environmental scan, stakeholder interviews, and MCPAR analysis identified several challenges and opportunities related to managed care accountability and oversight. States generally have sufficient tools to oversee plan performance and typically use an incremental, relationship-based approach before escalating to formal sanctions. However, the findings surfaced concerns about the consistency and completeness of MCPAR data; CMS's ability to directly address deficiencies within state managed care programs; and the availability and usability of managed care performance data to support state actions, such as procurement and oversight decisions.

CMS has broad authority to oversee state managed care programs but limited tools to address specific deficiencies

Although 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 deficiencies because states are the primary managers of plan performance due to their direct contractual relationship with the plans. CMS uses several tools to ensure state and managed care plan accountability following review and approval of state MCO contracts. CMS staff conduct ongoing, regular communication and monitoring calls with states. If CMS learns of plan compliance or performance problems through meetings or provider or beneficiary complaints, CMS staff can issue compliance letters informing the state of the issue, provide technical assistance to the state regarding possible remedies, and/or modify Section 1115 or 1915(b) waiver terms and conditions, if applicable, that clarify compliance and monitoring expectations.

CMS can defer or withhold federal matching funds only for the entire amount of the capitation payment made to MCOs. In practice, CMS rarely uses this authority because deferring or withholding funding for the entire capitation payment can disrupt the financing of all beneficiary care provided through the managed care plan and not just the particular issue that needs to be addressed. CMS may have authority to impose sanctions directly on managed care plans in certain situations (42 CFR 438.730(g)). However, CMS officials indicated that to do so, they must have documented evidence that the managed care plan committed a deficiency and that the deficiency harmed the beneficiary. These officials did not recall using this authority over the past several years. Although federal officials generally agreed that states are primarily responsible for ensuring that plans meet performance expectations, they also acknowledged they lack some of the administrative tools that are otherwise available to oversee a fee-for-service (FFS) program. These officials suggested that in some cases, it would be useful if CMS had the same statutory authority as they have in FFS, such as the authority to impose formal CAPs on states or defer or withhold a share of the federal match for capitation payments in proportion to the severity of non-compliance or performance issue.

State Medicaid officials and MCOs agreed that contract monitoring and enforcement should be managed by states and that additional CMS involvement in contract compliance is unnecessary. As CMS sets the minimum standards through federal regulation and guidance, state Medicaid agencies believe the standards afford them the flexibility they need to decide how and in what circumstances to use various accountability tools.

The Commission considered an amendment to Section 1903(m) of the Act to authorize CMS to withhold, defer, or disallow federal match for all or part of a managed care capitation payment, proportional to the severity of non-compliance with existing federal requirements. This approach would have been analogous to CMS's existing authority to defer or disallow federal match in proportion to non-compliance in FFS programs. Although some Commissioners noted that a proportional deferral authority in managed care could be more credible and targeted, the Commission ultimately decided not to proceed with a recommendation. Some Commissioners raised concerns about federal intervention in the state-contracted relationship with MCOs, the breadth of the proposed authority without sufficient guardrails or specification of remedial steps, and the potential for arbitrary or disproportionate disruption to beneficiary care. Commissioners also noted the practical challenge of quantifying what portion of a global capitation payment should be attributable to a specific deficiency.

Inconsistent and incomplete MCPAR reporting limits data usability

To supplement our environmental scan and stakeholder interviews, we reviewed and analyzed the MCPARs submitted for comprehensive MCO programs for performance year 2023, which includes contracts that were in effect on June 30, 2024, representing 34 states. The MCPARs include information on sanctions and CAPs states imposed on their managed care plans during the reporting period. Our analysis focused on the types of sanctions, amount of financial penalties, reported reasons for the intervention, and time to remediation.

MCPAR reporting appears to undercount the actual use of accountability actions. States began submitting MCPARs in 2022, which include information on sanctions, CAPs, and other accountability tools states imposed on their managed care plans. However, a 2024 GAO review of state MCPARs for performance year 2022 found reporting was inconsistent and incomplete (GAO 2024b). Based on our analysis of the number and type of sanctions reported in MCPARs for the states examined in this study, it is likely that states are not reporting all compliance actions in MCPARs. We compared findings in the MCPARs to publicly available state-level information on plan sanctions or other compliance actions and found inconsistencies in the reporting.

In our interviews, state officials indicated that they often pursue informal accountability actions before escalating to formal sanctions. All state Medicaid agencies interviewed engaged in regular meetings with MCOs to proactively identify and address performance issues, and all states interviewed generally addressed issues using informal channels before issuing formal sanctions, using an escalation approach to oversight. Our analysis of performance year 2023 MCPARs echoed these findings; states were more likely to take intermediary steps such as CAPs versus monetary penalties (25 states issued 359 CAPs; 11 states issued 106 civil monetary penalties) (Table 3-2).

We found evidence that the MCPAR sanctions data do not necessarily align with other reports. For example, one state did not report any liquidated damages in their MCPAR sanctions, but according to the state's website, their managed care compliance actions totaled $33.8 million in liquidated damages for state fiscal year 2024 (July 1, 2023–June 30,2024) and one sanction of $2,500 (AHCA 2025). The MCPAR data reflect the $2,500 sanction but fail to capture the liquidated damages. The National Health Law Program has also studied variation in compliance actions reported on MCPARs and found evidence that states are not reporting liquidated damages consistently (Young 2025).

TABLE 3-2. Financial Sanctions by Sanction Type

Sanction type	Number of sanctions	Number of states with sanction type	Number of sanctions with financial penalty	Average sanction amount
Civil monetary penalty	106	11	106	$402,833
Corrective action plan	359	25	12	590,047
Corrective action plan and liquidated damages	19	2	18	124,552
Liquidated damages	187	10	184	37,962
Compliance letter	66	8	0	0

Notes: Managed Care Program Annual Report (MCPAR) submissions categorized as both corrective action plan and civil monetary penalty were excluded due to the small sample size (two submissions). One MCPAR submission did not have data available on the sanction type. The average sanction amount includes only sanctions with an associated financial penalty; sanctions reported as "N/A" or "$0" for financial amount were excluded from the average.

Source: MACPAC, 2025, analysis of state-submitted MCPARs in performance year 2023 (34 states).

CMS has provided written guidance and frequently asked questions to help states submit complete and accurate data across the MCPAR's program areas, including the scope of sanctions states must provide (CMS 2024a, 2024b). Although CMS can ask states to submit corrected data, it has few tools to ensure states submit accurate data. In its 2026 informational bulletin, CMS discussed implementation of a Medicaid Managed Care Oversight Review (MCOR) in 2025 as part of an effort to develop monitoring and oversight tools. As part of the first set of MCORs that started in December 2025, CMS is conducting review activities to analyze how states are using sanctions in managed care plans (CMS 2026a).

State variance in MCPAR reporting reflects unclear definitions of what should be reported. Federal regulation specifies that the MCPAR include the results of any sanctions or CAPs imposed by the state or other formal or informal intervention with a contracted managed care plan to improve performance (42 CFR 438.66(e)(2)(viii)). Although CMS requires states to report formal and informal interventions, the current MCPAR instructions do not provide sufficient clarity on what constitutes "informal interventions" or how to appropriately report various accountability actions. For example, it is unclear whether states should report activities such as verbal warnings during routine monitoring calls, requests for additional data or information about compliance issues before formal intervention, or informal performance improvement discussions. CMS has released technical assistance materials but did not include additional definitions of "informal" or how to report various types of accountability actions like liquidated damages. In MCPAR guidance on frequently asked questions from August 2025, CMS stated that the "scope of sanctions" collected in MCPARs "includes, but is not limited to, financial penalties, CAPs, suspension of enrollment, written warnings, and other formal or informal intervention with a contracted plan to improve performance" (CMS 2025). This broad language leaves room for interpretation regarding which specific oversight actions states should report and how to categorize them.

MCPARs are in the early years of implementation, so states may be getting used to the reporting process and definitions. In our interviews, some state officials and national experts suggested CMS has an opportunity to require that this information be more complete and transparent across states. For instance, some state officials suggested that CMS develop a contract violations template that could be used to assess and track the past performance of plans; such a template could build on the sanctions section of the MCPAR. MACPAC previously made recommendations to improve the usability of denials and appeals data included in the MCPARs, recognizing the ongoing need for clarity in MCPAR reporting standards across multiple program areas (MACPAC 2024).[6]

Managed care performance data are siloed across multiple reporting systems and are difficult to access and compare

Multiple stakeholders identified challenges in accessing and using available data to assess managed care performance comprehensively. Although CMS requires states to report performance data across a variety of sources, such as the MCPAR, EQR, and network adequacy and access assurances report (NAAAR), these are not always available in a centralized location or provided in a format that is conducive for analysis that links across plans and states. These data are not publicly available in a comprehensive or user-friendly format that states can easily leverage to assess plan performance or that beneficiaries can use to inform their choice of plan.

Several interviewees suggested that CMS could help states by developing a national database of managed care contract violations and sanctions to support transparency and state efforts to contract with high-performing plans. Additionally, interviewed states indicated that a national, publicly available dataset on managed care performance would assist them with refining their routine monitoring and oversight activities. Although the interviewed states all review past performance in their evaluation of bids to understand potential performance problems, they vary widely in the look-back periods for which bidders must disclose issues and the types of disclosures they require. In addition, the information on past performance submitted by plans is specific to each state procurement and cannot be used by other states. CMS and states are already collecting data on managed care performance and sanctions,

but it has historically not been publicly available in a comprehensive or user-friendly format.[7]

National experts noted that the MCPAR is a good first step in collecting plan-level sanctions data but that CMS could do more to help state Medicaid agencies better understand managed care plan performance in other states, such as repeat problems across multiple states. They suggested that a database or a dashboard that keeps the data dynamic, up to date, accurate, and comprehensive would allow states to understand sanctions across the country.

Commission Recommendations

The Commission makes the following recommendations to improve the usability of managed care performance data and provide states with additional guidance and tools to more effectively assess and oversee plan performance.

Recommendation 3.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

Rationale

Current federal regulation specifies that the MCPAR must include the results of any sanctions or CAPs imposed by the state or other formal or informal intervention with a contracted managed care plan to improve performance (42 CFR 438.66(e)(2)(viii)). However, as identified in our analysis, states are likely reporting inconsistent or incomplete data, and it is not clear that states share the same definitions of sanctions and informal interventions.

The inconsistency in reporting stems in part from unclear definitions of what should be reported. As discussed above, one state's reporting of liquidated damages exemplifies this problem; the state reported $33.8 million in liquidated damages on its own compliance dashboard but none on its MCPAR (AHCA 2025). This discrepancy in reporting likely reflects a difference in how the state and CMS view liquidated damages. In its report, the state defines liquidated damages separately from sanctions and indicates that liquidated damages are not considered a penalty.

Similarly, states appear to vary in their reporting of informal interventions. As noted in our stakeholder interviews, states commonly use informal accountability actions before escalating to formal sanctions. The MCPAR includes an intervention type for all compliance-related notices or letters (e.g., warnings, non-compliance). Because most states use an escalation process, states typically issue either informal or formal warnings before imposing CAPs or financial penalties. However, fewer states (8 states) reported issuing compliance letters than either CAPs (25 states) or civil monetary penalties (11 states) in the performance year 2023 MCPARs (Table 3-2). Likewise, a 2024 GAO review of state MCPARs for contracting year 2022 found reporting was inconsistent and incomplete (GAO 2024b). CMS subsequently provided written guidance to help states submit complete and accurate data, but additional clarification is needed to ensure consistent reporting across states.

Given that CMS and states recently started reporting data through MCPARs, this is an opportune time for CMS to provide additional guidance and standardization. MACPAC previously made recommendations in its March 2024 report to Congress to improve the usability and transparency of denials and appeals data included in the MCPARs, recognizing that clear data definitions and reporting instructions are essential for making MCPAR data useful for oversight and monitoring purposes.

This recommendation would provide guidance on the types of accountability actions that should be reported on the MCPARs. Specifically, CMS should clarify reporting requirements for liquidated damages, informal interventions that states may use before escalating to formal sanctions, and other accountability actions that respond to plan non-compliance. CMS should determine a clear threshold for reporting informal interventions and provide examples to distinguish routine oversight activities from reportable compliance events. The goal of this recommendation is not to

document every communication between the state and managed care plan or to dampen states' ability to communicate informally with their plans, but to capture notable communications and interventions in response to a lapse in plan performance. For example, CMS could exclude routine monitoring calls from reporting.

Improved MCPAR data quality and completeness would enhance CMS's ability to oversee state managed care programs and identify patterns of compliance issues across states and plans. More consistent and complete data would allow for better understanding of how states use accountability tools and assessment of the effectiveness of different accountability approaches.

This recommendation is not intended to create new data collection requirements or impose new reporting burdens beyond what is already required in regulation. Rather, it seeks to clarify what should be reported under existing requirements and standardize how states report this information to ensure consistency and completeness. CMS would need to identify where additional clarification and standardization are needed, which could involve consulting with states about the range of compliance actions they take and reviewing the variation in current reporting to understand which definitions or instructions would be most helpful. CMS should seek a balance in obtaining a clear picture of states' accountability actions and minimizing state burden in reporting. CMS should solicit feedback from states on how to strike a balance between capturing accurate data and ensuring only meaningful compliance actions are reported. This recommendation would apply to all managed care plans that submit MCPARs, including MCOs, PIHPs, PAHPs, and primary care case management (PCCM) entities.

Implications

Federal spending. The Congressional Budget Office (CBO) does not estimate any change in federal direct spending. The recommendation may result in increased administrative effort such as developing and disseminating updated instructions, data definitions, and reporting templates through technical assistance materials, MCPAR instruction updates, or subregulatory guidance.

States. States already collect information on their accountability actions and are required to submit this information on MCPARs. The primary change would be more specific guidance on what and how to report, rather than requiring states to collect new information. However, some states may need to adjust their internal tracking systems or processes to ensure they are capturing and reporting all required information consistently. States could benefit from more complete and accessible data on compliance actions to help assess plan performance as part of the procurement process and benchmark their use of accountability tools against other states. Improved MCPAR data quality and completeness would enhance the usability of these data for assessing and monitoring plan performance by state Medicaid agencies. More consistent and complete data would allow for better understanding of how states use accountability tools, identification of patterns across states, and assessment of the effectiveness of different accountability approaches.

Enrollees. Improved MCPAR data quality would enhance transparency regarding how states hold plans accountable for performance. More complete and publicly accessible information on sanctions and other accountability actions could help beneficiaries make more informed choices during plan selection and could create additional incentives for managed care plans to improve the quality of and access to care being provided.

Plans. Managed care plans should not see a substantial increase in administrative burden because they are not directly submitting MCPAR data. However, plans may face indirect effects if states request additional documentation to support more complete MCPAR reporting. Standardized reporting could benefit plans by creating consistent expectations across states regarding what constitutes reportable accountability actions and by making reported plan performance comparable through reduced variation.

Providers. Although this recommendation would not directly change providers' operations, providers could benefit from complete and publicly accessible information on plan performance. Providers must make decisions about contracting with plans, and access to standardized performance data could inform those contracting decisions.

Recommendation 3.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

Rationale

Several stakeholders mentioned challenges in accessing and using managed care performance data across states for comparison or benchmarking. Although CMS requires states to report performance data across a variety of sources (e.g., NAAAR, MCPAR, EQR, and the Quality Rating System (QRS)), these are not always available in a centralized location or provided in a format conducive to analysis.[8] Although states can assess the performance of their plans, they also seek information on plan performance in other states. For example, states often ask for information on past performance during procurement; however, it can be challenging to compare in-state and out-of-state performance when each state and plan highlights different metrics.

Several interviewees suggested that CMS could help states by developing better tools to access and compare managed care performance data program-wide. National experts noted that although the MCPAR is a good first step in collecting plan-level data, understanding plan performance across states remains difficult. They suggested that CMS could help state Medicaid agencies better understand plan performance in other states, such as repeat problems across years or multiple states. They suggested that a publicly available, comprehensive, up-to-date database would provide states a standardized way to access data on plans' prior performance, such as sanctions. States could benchmark their programs' outcomes and compliance data compared to other states. This type of comparison could help states identify gaps in their oversight practices or identify emerging trends in other states that should be monitored. Although the data included from the MCPAR or EQRs would be lagged due to the nature of retrospective reporting, states and other stakeholders could benefit from viewing historical data trends and plan-level reports. Additionally, CMS guidance and toolkits on how to use the database effectively could help some states better structure their own internal data and reports for real-time monitoring of their plans.

CMS developed a Medicaid Data Collection Tool (MDCT) to collect data required to monitor, manage, and review the managed care programs for each state, which includes a Managed Care Reporting (MCR) web portal that states use to submit MCPARs, NAAARs, and medical loss ratio reports (CMS 2025, 2023). This portal provides a structured system that allows CMS to generate and analyze state-specific and nationwide data across all managed care programs and requirements, and it can be used to identify areas for improvement and target technical assistance to states (CMS 2026a). Although this database is not available to the public, CMS could build on this structure to develop a comprehensive public-facing database or dashboard that states and enrollees can use to understand managed care performance. Box 3-1 describes managed care data sources that potentially could be linked in a public-facing resource.

This recommendation builds on the Commission's prior work on managed care oversight. In our March 2025 report to Congress, the Commission made recommendations on EQRs, including the need to reduce areas of duplication with other federal quality and oversight reporting requirements; create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies; and identify key takeaways on plan performance. This option would build on those prior recommendations by combining the information across the different federal reports on managed care quality and oversight. Additionally, it would allow stakeholders to view EQR activities, sanctions, or other oversight actions to track the outcomes of compliance actions over time. Plan representatives have noted that any public reporting should be put into appropriate context. Combining information across data sources could provide that additional context to specific metrics, which may reflect differences in state procedures and benchmarks instead of overall plan performance. For example, states may have different standards and benchmarks

to determine when to assess sanctions. Combining information on sanctions from the MCPAR with EQR findings on the development and validation of performance measures and QRS metrics on access and quality outcomes would provide additional context and a more holistic view of plan performance than just a count of sanctions itself.

CMS could also benefit from a more holistic view of state and plan compliance with federal requirements through better integration of existing data sources. The development of a public-facing database could strengthen CMS's role in assessing the performance of states' managed care programs and improve the overall quality of managed care oversight at the federal level. Furthermore, stakeholders such as consumer advocates and researchers could use comprehensive performance data to identify systemic issues affecting beneficiaries.

BOX 3-1. Sources of Managed Care Performance Data

States and managed care plans are required to report managed care performance data across several different reports and systems.

- **Managed Care Program Annual Report (MCPAR):** The MCPAR is a standardized reporting template that all states with managed care programs must submit annually to the Centers for Medicare & Medicaid Services (CMS) (42 CFR 438.66(e)). MCPARs capture a wide range of information at the plan level, including information on financial performance, encounter data submission, grievance and appeals, quality measures, and sanctions. States submit this report through the Medicaid Data Collection Tool for Managed Care Reporting (MDCT MCR) web portal.
- **Network Adequacy and Access Assurances Report (NAAAR):** The NAAAR requires states to submit an assurance of compliance to CMS that each contracted managed care plan meets the state's requirement for availability of service and to include documentation of a network adequacy analysis (42 CFR 438.207(d)). In 2025, CMS began gathering these data in the MDCT MCR (CMS 2026).
- **Medical Loss Ratio Report (MLR):** Each managed care plan under contract submits an annual MLR report to the state, including the percent of revenues that plans spend on services, activities that improve health care quality, and fraud prevention activities (42 CFR 438.8). States use these data to submit an MLR summary report annually to CMS (42 CFR 438.74(a)). States submit this summary report through the MDCT MCR web portal.
- **External quality review (EQR):** A state must contract with an EQR organization to review and validate the performance of their contracted managed care plans on an annual basis (42 CFR 438 Subpart E). The EQR must include four mandatory activities: performance measurement validation, performance improvement project validation, compliance review, and network adequacy validation, and states may add optional review activities as well (42 CFR 438.358). States must publish EQR findings in an annual technical report that includes an assessment of each plan's strengths and weaknesses regarding quality, timeliness, and access to services and recommendations for improvement (42 CFR 438.364).
- **Medicaid and CHIP Quality Rating System (MAC QRS):** States that operate a managed care program must implement a MAC QRS by December 31, 2028. The MAC QRS will be a state-run public website that provides information on quality measures and ratings for managed care plans (42 CFR Part 438 Subpart G).

As part of their understanding of managed care performance data, some national experts suggested that CMS develop guidance about the necessary state capacity to support managed care procurement, such as staff experience and qualifications, design of evaluation criteria, and contract provisions that ensure states have sufficient accountability tools. They noted that CMS could help develop state capacity in procurement, perhaps through a state learning collaborative. Specifically, they suggested guidance on selecting standardized indicators of past performance to include in the RFP to compare bidders. States frequently use past performance as a component of their procurement decisions, and this recommendation would provide a standardized way to collect this information across all plans that would be readily available if a state wishes to use it. Currently, it can be challenging to compare plans if each plan highlights different metrics. Additionally, states could use the database to identify patterns of compliance problems across years or in multiple states that could be reflected through reduced scoring during procurement or the addition of enhanced monitoring provisions to the standard contract. CMS routinely provides technical assistance to states and has indicated that states may request direct technical support on managed care program planning and procurement; however, information has not been disseminated broadly like other monitoring and oversight toolkits the agency has published on its website (CMS 2026b, 2026c).

Implications

Federal spending. The CBO does not estimate any change in federal direct spending. To implement this recommendation, CMS would develop a public database that combines existing data sources, possibly using an available chassis such as the MDCT MCR as well as supporting guidance materials and facilitating state learning collaboratives. CMS would need to identify the database requirements and publish the data in a format that enables analysis. These investments could lead to more effective oversight and better use of existing data resources across the agency as well as for states.

States. This recommendation would provide states with complete and standardized plan performance data that could improve their ability to procure high-performing plans and implement effective accountability provisions in contracts. The recommendation would not increase the administrative burden on states because CMS would be responsible for linking and updating the data. States would collect and report the same data that are currently required. However, some states may need to adjust their internal tracking systems or processes to ensure they are capturing and reporting all required information consistent with federal reporting expectations.

Enrollees. Performance data that are publicly available and readily accessible can improve the ability of beneficiaries to assess plan performance and make informed decisions during plan selection. Beneficiaries could make more informed plan choices. Improved plan performance resulting from more effective state oversight could lead to better access to care and quality of services for beneficiaries.

Plans. Plans should not see an increase in administrative burden because the recommendation would use data that plans are already reporting. More standardized assessment approaches across states could reduce administrative burden for plans operating in multiple states, and these national carriers could benefit from improved comparability of their performance in different states. Combining information across data sources could provide additional context to specific metrics and provide a more complete picture of overall plan performance.

Providers. Although this recommendation would not directly change providers' reporting operations, providers could benefit from complete and publicly accessible information on plan performance. Providers must make decisions about contracting with plans, and access to standardized performance data could inform those contracting decisions.

Next Steps

The recommendations in this chapter build on MACPAC's ongoing work examining effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. These recommendations address near-term opportunities to improve the completeness and usability of existing federally mandated data and to equip states with the guidance and tools to translate that data into stronger oversight and procurement decisions.

Looking ahead, the QRS represents an important development in the landscape of managed care accountability. CMS finalized a framework for the Medicaid QRS in the 2024 managed care rule, and states must implement the QRS, which includes 16 mandatory metrics, by December 31, 2028 (42 CFR 438, Subpart G). When implemented, the QRS will add a standardized, publicly reported layer of plan performance information that should be incorporated into the public data resource recommended in this chapter. The Commission will continue to monitor the implementation of QRS and other requirements from the 2024 managed care rule as they take effect.

The Commission will continue to monitor the maturation of MCPAR reporting. MCPARs are still in the early years of implementation. CMS has already taken steps to improve data quality through technical assistance and guidance and CMS is planning to implement validation checks on certain data at the point of MCPAR submission in MDCT (CMS 2026a). The Commission will examine whether additional steps are needed to ensure MCPARs become a reliable, comprehensive source of accountability data across states and plans.

Endnotes

[1] These safeguards must be at least as effective as those specified in Section 27 of the Office of Federal Procurement Policy Act, which limits communications and activities of personnel involved in the development and submission of proposals to federal agencies.

[2] Section 1903(m)(1)(A) of the Act defines an MCO: The term "medicaid managed care organization" means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and (ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency." In the implementing regulations at 42 CFR 438.2, an MCO are defined as an entity that has, or is seeking to qualify for, a comprehensive risk contract.

[3] CMS, on the recommendation of the state Medicaid agency, may also deny federal match to the state on capitation payments made for new enrollees of an MCO when a state's MCO acts or fails to act in six circumstances (§ 1903(m)(5)(A) of the Act, 42 CFR 438.730): fails substantially to provide medically necessary services to an enrollee; improperly charges enrollees for services; discriminates against enrollees based on their health status or need for services; provides false or misleading information to CMS or the state; provides false or misleading information to enrollees, potential enrollees, or providers; and fails to comply with physician incentive plan requirements.

[4] States may consider several criteria to conduct default enrollment (also called auto-assignment), including quality assurance and improvement performance and procurement evaluation elements (42 CFR 438.54(d)(8)(ii)).

[5] Due process for appealing enforcement actions can vary across states. Regulations only require that the state must give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that the state elects to provide, with the exception that states must provide a hearing before terminating an MCO contract and cannot delay imposition of temporary management to provide a hearing (42 CFR 438.710, 438.708, 438.706(c)).

[6] In the March 2024 report to Congress, the Commission made seven recommendations on denials and appeals in managed care, including requirements for states to conduct routine clinical audits of denials and to collect and report data on denials, beneficiary use of continuation of benefits, and appeals outcomes. As part of these new requirements, the Commission recommended CMS update the MCPAR template to include data on the results of the clinical audit and denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. Additionally, CMS should publicly post all MCPARs to the CMS website in a standard format that enables analysis, and CMS should require that states include denials and appeals data on their QRS websites (MACPAC 2024).

[7] On April 30, 2026, CMS published the first public use file (PUF) of MCPAR data for performance year 2024. These data were not available during the course of MACPAC's study, but the PUF does provide the MCPAR data in a publicly available format that enables analysis.

[8] States must implement the QRS by December 31, 2028 (42 CFR 438.404(a)(2)).

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, McCarthy, Nardone, Snyder
No	0	

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

3.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, McCarthy, Nardone, Snyder
No	0	