Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Transparency in Medicaid Managed Care: Findings from a 13- State Scan

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Key Findings

- State Medicaid agency and Managed Care Organization (MCO) websites varied in the amount and type of information that they made publicly available, but most fell far short of including basic information about MCO enrollment and performance for children and pregnant individuals. Out of the 13 states included in the scan:
  - Only three posted child enrollment on an MCO-specific basis.
  - None posted MCO-specific Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening metrics.
  - None posted MCO-specific quality metrics disaggregated by race or ethnicity.
- None of the state Medicaid agency websites posted all of the minimum data elements required by federal regulations.
- The little information available hinted that quality and access to services varied widely between MCOs within states, between states, and across managed care parent firms in calendar year 2018. This variation highlights the need for further transparency as advocates and stakeholders work with state agencies to ensure that children and pregnant individuals enrolled in managed care receive the services to which they are entitled.

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Executive Summary

Medicaid is the nation's largest health insurer for children; more than one in three children in the United States are covered by Medicaid or CHIP.[1] The programs promise children a comprehensive pediatric benefit package at little to no cost and have been shown to improve health and educational outcomes well into adulthood.[2] In 40 states, Medicaid coverage means enrollment in a Medicaid managed care organization (MCO). If the MCO fulfills its obligations to its beneficiaries, Medicaid coverage works; if the MCO does not, Medicaid continues to spend but its full promise is not realized. In this paper we ask the question: Does the public have the information needed to tell whether or not MCOs are fulfilling their responsibilities to children and pregnant individuals* enrolled in Medicaid? We find that, in the states we examined, the answer is "no."

Over a 12-month period, June 2020 through May 2021, we searched the websites of state Medicaid agencies, state insurance departments, and individual MCOs for information on the performance of 56 MCOs in 13 states: Arizona, Georgia, Illinois, Iowa, Kansas, Kentucky, Mississippi, Missouri, Nevada, Pennsylvania, Tennessee, Utah, and West Virginia. We searched for a set of basic, non-proprietary data elements that could help us gauge how individual MCOs are performing. These included the number of children enrolled in an individual MCO, disaggregated by age, race, and ethnicity; whether those children received the Medicaid pediatric benefit, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, to which they were entitled; measures of the quality and accessibility of covered pediatric and maternity services; and the amount of money the state paid each MCO to furnish services to children and pregnant individuals. We also searched for information relating to the structure and organization of MCOs required by federal transparency regulations.[3]

Of the 13 state Medicaid agency websites we scanned, *only three* posted the number of children enrolled in each MCO, and *only two* posted the number of pregnant women* enrolled. *Only one* posted the amount the state paid each MCO to furnish services. No state posted information on receipt of EPSDT services (other than dental care) by children enrolled in each MCO. And none of the 13 states posted enrollment, EPSDT, or child and maternal health quality data disaggregated by race and ethnicity.

The state Medicaid agency websites we searched varied widely in the availability of MCO-specific information and user-friendly organization, but tended towards opacity. Illinois, Iowa, Kentucky, and Pennsylvania's websites were the most transparent; those of Kansas, Missouri, and Utah the least. Even among the more transparent states, however, there was still a considerable lack of data. *None* of the state Medicaid agency websites posted all of the minimum data elements required by federal regulations.

We have three recommendations for improving Medicaid coverage for children and pregnant women by increasing transparency of information about the performance of individual MCOs:

1. **State Medicaid agencies should maintain a child health dashboard that contains MCO-specific performance data and is easily accessible.** At a minimum, this performance data should include EPSDT screenings and treatment, Child Core Set metrics, and all information required to be posted by federal regulations. The dashboard should include a data hub with links to relevant structural information about each MCO.
2. **The Centers for Medicare & Medicaid Services (CMS) should monitor and enforce state Medicaid agency compliance with the minimum transparency requirements in its managed care regulations.**
3. **CMS should add a child health dashboard as a measure to the State Administrative Accountability pillar of its Medicaid & CHIP Scorecard.** The child health dashboard should include MCO-specific performance information on EPSDT screenings and treatment and Child Core Set metrics.

* Editor's Note: To maintain accuracy, CCF uses the term 'pregnant women' when referencing statute, regulations, research, or other data sources that use the term pregnant women to define or count people who are pregnant. Where possible, we use more inclusive terms in recognition that not all individuals who become pregnant and give birth identify as women.

Why Medicaid MCO Performance Matters to Child and Maternal Health

A Medicaid managed care organization (MCO) is an entity that contracts with the state Medicaid agency on a risk basis to manage the provision of comprehensive acute care services to Medicaid beneficiaries. Under the contract between the MCO and the state Medicaid agency, the agency pays the MCO a fixed amount each month on behalf of each beneficiary enrolled with the MCO, regardless of whether the enrollee uses services in that month. In exchange for this monthly capitation payment, the MCO agrees to make services covered under the contract accessible to its enrollees through a network of hospitals, physicians, and other providers with which it has subcontracted.

State Medicaid programs are not required to purchase covered services through MCOs, but most do. As of March 2021, 40 states and the District of Columbia contracted with a total of 287 MCOs on a risk basis.[4] As a result, most of the children and pregnant individuals covered by Medicaid are enrolled in an MCO.[5] Each MCO determines the hospitals, physicians, and other providers with which it will contract; if enrollees want Medicaid to pay for their care, they will generally be limited to using those network providers. MCOs also manage beneficiary utilization of medical services through administrative requirements like prior authorization and review of provider claims for "medical necessity." If an MCO's provider networks are too limited, or if the MCO's utilization controls are too tight, children and pregnant individuals enrolled in the MCO will not receive the services they need and to which they are entitled.[6]

MCOs may be for-profit, nonprofit, or public. Some MCOs are wholly-owned subsidiaries of national, publicly-traded firms for which Medicaid managed care is a profitable line of business.[7] MCOs that belong to these companies have multiple, sometimes competing, incentives: to furnish services to their enrollees per the contract with their state agency client and to maximize profits for their shareholders. Nationally, five companies—Anthem, Centene, CVS (whose health insurance branch is Aetna), Molina, and UnitedHealth Group—own 119 of the 287 MCOs operating in the 40 states and D.C., and each of these parent companies owns subsidiaries in at least 15 states.[8]

Because Medicaid covers over 35 million children and pays for over 40 percent of the nation's births, how well Medicaid works matters enormously to the health and life outcomes of eligible children and pregnant individuals. And because so many state Medicaid agencies contract with MCOs to manage the care of eligible children and pregnant individuals, how well those MCOs perform largely determines how well Medicaid works for these beneficiaries. Finally, because the children and pregnant individuals who are eligible for Medicaid are disproportionately people of color, how well MCOs perform will largely determine how effectively Medicaid addresses racial and ethnic health disparities.

Why Transparency Matters to Medicaid MCO Performance

Medicaid MCOs are complex organizations. In any given state, individual MCOs can be responsible for the coverage of hundreds of thousands of beneficiaries and receive hundreds of millions, if not billions, of state and federal funds to do so. The control over the health care for that many people, and such large sums of federal and state resources, combined with the ability to select providers for their networks, gives them considerable leverage over local health care delivery systems. The hundreds or thousands of jobs they support can make them one of the most economically and politically significant employers in a state. They are typically well-provisioned with actuaries, lawyers, and lobbyists.[9] In contrast, the state Medicaid agencies that are responsible for contracting with and monitoring the performance of the MCOs are often under-resourced relative to the task at hand. With such limited resources, state agencies' focus on the possible savings from managing the care of high-cost populations means that children's primary and preventive care often takes the back seat in both MCO contracting and oversight.[10]

Transparency allows Medicaid stakeholders, including beneficiaries, providers, and competitor MCOs, to understand how individual MCOs are performing.

Transparency—i.e., making performance data that is reported by individual MCOs to the state Medicaid agency public—is one solution to this asymmetry. It allows Medicaid stakeholders, including beneficiaries, providers, and competitor MCOs, to understand how individual MCOs are performing in relation to both what their contract with the state requires of them and how their peer MCOs in the state are doing. When performance is high, an MCO can be recognized for that and potentially be rewarded with increased enrollment, improved ability to recruit and retain good providers, and bonus payments. When performance is low, questions can be asked of both the MCO management and the state Medicaid agency. State auditors, legislators, beneficiary advocates, and members of the media all have ways of calling either the MCOs or the agencies, or both, to account.

Transparency is not the only tool for holding MCOs and state Medicaid agencies accountable, but it has the advantage of not imposing additional costs or significant administrative burden on either the MCOs or the state Medicaid agency. *MCOs are already being paid to manage care and report their performance to the state Medicaid agencies; state agencies are already reviewing this information to assess the accessibility and quality of care Medicaid beneficiaries receive from the contracted MCOs. Transparency simply requires that this information be publicly available* so that all stakeholders—beneficiaries, providers, state policymakers, investors, researchers, advocates, and the public at large—can know which MCOs are performing at a high level and which are not.

In addition, we believe there is a potential "transparency effect" that comes from the norm of transparency itself. If MCO management knows that performance information will be made available to public, and if they are interested in protecting their organization's reputation, they are more likely to take action to improve their performance than if they are confident that information about poor performance will remain out of view. The same logic applies to state Medicaid agencies, who do not want to be seen as being poor stewards of public dollars that tolerate substandard performance by individual MCOs under their oversight.

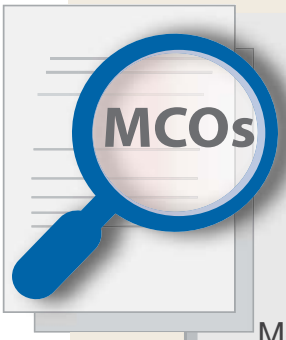
The States and MCOs We Scanned

To obtain information on the performance of individual MCOs for children and pregnant individuals, we searched the websites of state Medicaid agencies, state Insurance Departments, and individual MCOs. We did not submit Public Records Act requests for information to state agencies or make direct requests for data to individual MCOs. (See the Methodology section below). We were unable to find any child or maternal health performance information specific to individual MCOs on the federal Medicaid agency's website, Medicaid.gov. We did not submit a Freedom of Information Act request for this data to CMS.

We focused on 13 states: Arizona, Georgia, Illinois, Iowa, Kansas, Kentucky, Mississippi, Missouri, Nevada, Pennsylvania, Tennessee, Utah, and West Virginia. These states are in different regions of the United States, have both large and small Medicaid populations, and vary in demographic and political makeup (see Table 1). Some—Arizona and Tennessee—have been contracting with MCOs for decades; others—Iowa and Kansas—for just a few years. Despite their diversity, these 13 states are not necessarily representative of all 40 states (and the District of Columbia) that contract with Medicaid MCOs on a risk basis. They were selected because CCF partners with child health advocates in each and because each state contracts with less than ten MCOs.[11]

During the period of our search, these 13 states contracted with a total of 62 MCOs. Six of those MCOs were contracted to furnish services only to youth in foster care and similar highly vulnerable child populations (e.g., justice-involved youth). Our findings on these MCOs are not included in the results presented in this paper; they will be the subject of a separate analysis. The remaining 56 MCOs enrolled both children and adults.

The 56 MCOs represent a mix of for-profit and nonprofit firms and include subsidiaries of all five of the largest national health insurance companies in the Medicaid managed care market (Aetna/CVS, Anthem, Centene, Molina, and UnitedHealth Group). Appendix A lists the MCOs and parent companies by state. They are not necessarily representative of all 287 MCOs with which state Medicaid agencies contracted as of March 2021. We focused our search on results for performance year 2018, the most recent year available at the beginning of our search (see Methodology section for more detail). Because the Medicaid managed care market is not static, some of the MCOs we reviewed have subsequently exited the Medicaid market, changed ownership due to an acquisition, or ceased operations altogether.



Focus on 13 states

in different regions of the country that vary in the size of their Medicaid populations, and in their demographic and political makeup.

Arizona, Georgia, Illinois, Iowa, Kansas, Kentucky, Mississippi, Missouri, Nevada, Pennsylvania, Tennessee, Utah, West Virginia

Table 1. Characteristics of States Selected

State	Total Medicaid and CHIP Enrollment (December 2020)	Total Medicaid and CHIP Child Enrollment (December 2020)	Number of Contracting MCOs in Scan	Share of Low-Income Children		State Rank for Child Health
				who are POC	who are Latino	
Arizona	2,090,266[a]	828,083[a]	7[c]	32.9%	58.8%	28
Georgia	2,093,853	1,463,575	4[c]	63.8%	21.7%	40
Illinois	3,238,003	1,440,817	7[c]	50.8%	34.1%	20
Iowa	750,018	361,097	2	23.6%	18.3%	13
Kansas	429,274	295,769	3	33.8%	30.0%	25
Kentucky	1,529,906	600,553	5[c]	24.5%	8.7%	35
Mississippi	680,078	459,572	3	69.4%	6.4%	50
Missouri	1,022,258	639,211	3	30.3%	10.1%	38
Nevada	749,040	332,540	3	52.9%	54.3%	34
Pennsylvania	3,261,323	1,482,422	9	45.9%	23.2%	17
Tennessee	1,571,521[b]	882,033[b]	3[c]	40.1%	18.1%	39
Utah	390,385	216,642	4	14.9%	36.9%	18
West Virginia	560,146	225,596	3[c]	14.0%	--	43

[a] Arizona does not provide enrollment information to CMS. Georgetown CCF sources enrollment from the state's quarterly report on beneficiary demographics available at https://www.azahcccs.gov/Resources/Reports/population.html; figure represents enrollment as of January 2021.

[b] Historically, Tennessee's enrollment reports to CMS have varied in data quality. As a consequence, Georgetown CCF sources enrollment from the state's administrative records posted on the Agency website, available at https://www.tn.gov/tenncare/information-statistics/enrollment-data.html and at https://www.tn.gov/content/dam/tn/coverkids/documents/Enrollment1220.pdf. Figure represents enrollment as of December 2020. Tennessee child enrollment includes CHIP youth 0-19, unborn children of women over the age of 19, and Medicaid ages 0-18.

[c] Arizona, Georgia, Illinois, Kentucky, Tennessee, and West Virginia all contract with an additional MCO to manage care for specialty populations, such as foster care children. These MCOs are not included in this count.

Note: Estimate suppressed due to high margin of error and low reliability.

Sources:

Enrollment data: Georgetown CCF analysis of "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data," (Center for Medicaid Services, June 2021), available at https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme.

Demographics: Georgetown CCF analysis of U.S. Census Bureau American Community Survey 2019 Public Use Microdata Sample (PUMS). Low-Income defined as living in a household with income below 138 percent of the Census Poverty Threshold.

The American Community Survey defines race and ethnicity as two separate facets of a person's identity. "POC" includes children who are Black, Asian/Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and some other race/two or more races. White and POC individuals may be of any ethnicity. Latino individuals may be of any race.

Child health rank: "2021 Kids Count Data Book," Annie E. Casey Foundation (June 2021), available at https://www.aecf.org/interactive/databook?d=h&l=54.

The Performance Information We Searched For

There is no generally accepted set of measures for answering the question: How well is a Medicaid MCO performing for children and pregnant individuals? Our search focused on data elements that we believe are the minimum necessary to answer that question. Some of these data elements are required to be posted by federal regulation; others are not. None of the data elements are trade secrets or commercially privileged information.[12] They are listed in Appendix B: Data Elements Sought and fall into four broad categories.

First, we examined a simple question. How many children and pregnant individuals are enrolled in the MCO? What is the age distribution of the children (e.g., <1, 1-5, etc.)? What is the demographic profile of the children and pregnant individuals? How much is the state Medicaid agency paying the MCO to provide covered services to these populations?

Second, we wanted to find out whether children enrolled in the MCO received the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to which they were entitled and for which the state Medicaid agencies contracted. We looked for the same data elements that the state Medicaid agencies report annually to CMS on Form-416 (see text box) on an MCO-specific basis. We also wanted to know whether there were any differences in access to these services based on race or ethnicity.

Collected and Cleaned: EPSDT Services and CMS Form-416

Children enrolled in Medicaid are entitled to the comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit package (§1905(r) of the Social Security Act). In order to monitor access to these preventative services, §1902(a)(43)(D) of the Social Security Act requires that, at a minimum, states report the following on a yearly basis:

- The number of children provided child health screening services
- The number of children referred for corrective treatment as a result of the screenings
- The number of children who received dental services

CMS collects this information from states on CMS-416, the Annual EPSDT Participation Report. In order to complete the form for their states, Medicaid agencies in managed care states have to work with the MCOs to get claims data on the number of children receiving these screenings and services. In other words, MCOs are already required to collect this data in their claims logs. And, state agencies are already cleaning the data by removing duplicative entries, incomplete information, and correcting formatting errors before it is aggregated in the statewide rate. We searched to see if any of the states in our scan made the MCO-specific screening numbers and rates publicly available.[13]

Third, we wanted to know what results each MCO produced for children and pregnant women as measured by the child and maternal health metrics selected by the Centers for Medicare & Medicaid Services (CMS) in its Child Core Set (see text box).[14] Most of these are nationally standardized HEDIS metrics developed by the National Committee for Quality Assurance (NCQA). Again, we looked for whether measure results varied by race and ethnicity.

Finally, we tried to gather information about the structure of each MCO, including its management, its accreditation status, and its subcontractors (if any) for functions such as utilization management. We also looked for the contract between the state Medicaid agency and each MCO. These data elements are among those that federal Medicaid managed care regulations require to be posted on either the state Medicaid agency or the individual MCO's website.

Collected and Cleaned: Child and Maternity Core Set

The Child and Adult Core Set are metrics chosen by a national committee of experts to evaluate access to and quality of care for Medicaid and CHIP beneficiaries. The measures cover a variety of domains including preventative care, oral health, and behavioral health. Measures included in the Child and Adult Core Set that assess maternal and perinatal health compose the sub-group Maternity Core Set. The standard metrics in the Sets allow for comparisons both over time and between states, though there are limitations.

Currently, it is optional for state agencies to report the metrics on an aggregate, statewide basis to CMS, but reporting on all measures will become mandatory starting in fiscal year 2024.[15] As of the 2020 reporting cycle, all states reported on at least two Child Core Set measures and one Maternity Core Set measure.[16] Sixteen states reported 22 or more Child Core Set metrics.[17] As with the EPSDT metrics, this means that managed care states are already collecting the records from their MCOs and are cleaning the data to ensure accuracy and consistency across MCO and FFS records before they combine the datasets to find the statewide rate. Starting in measure year 2022, the National Committee on Quality Assurance will require that the HEDIS metrics for Prenatal and Postpartum Care as well as Child and Adolescent Well Care Visits are disaggregated by race and ethnicity.[18] Some states already disaggregate measures by race and ethnicity on a statewide basis for health equity reports.[19]

Collected, Cleaned, and Validated: External Quality Review Organization Reports

In managed care states, Medicaid agencies are required to contract with an External Quality Review Organization (EQRO) to conduct an annual quality review of each MCO and to report its assessment of the quality, timeliness, and accessibility of care for each MCO in an Annual Technical Report (ATR).[20] The ATR must be posted on the state Medicaid agency's website.[21] States determine which metrics their EQRO contractor should review, which in turn determines which metrics the ATR contains. The EQRO validates the measures by assessing the MCOs' information system and medical record data collection protocol and reviewing its practices for measure calculation with an onsite visit.[22] When states maximize the potential of the EQRO process, ATRs are an excellent and cost-efficient way of collecting, validating, and sharing information on MCO performance.

There are data elements relevant to MCO performance for children and pregnant individuals for which we did not search. These include information on: the adequacy of the MCO's provider network for pediatric and maternity services; denials of services for children and pregnant individuals; the disposition of grievances, appeals, and state fair hearings involving children and pregnant individuals; and sanctions or administrative penalties or corrective action plans imposed on MCOs for violations of contract requirements affecting children and pregnant individuals. We also did not search for information relating to the MCO's financial performance, such as the annual medical loss ratio report to the state Medicaid agency and the annual financial filing with the state insurance department.

The Performance Information We Found

Our search of state Medicaid agency and individual MCO websites did not yield enough data to allow us to answer the basic question: how well is an MCO performing for children and pregnant individuals? Here is what we found (and what we did not).

Enrollment

Of the 13 states we scanned, 11 posted MCO-specific enrollment information; Kansas and Utah did not. *Only three states—Illinois, Iowa, and Pennsylvania—posted child enrollment in each contracted MCO*. After the data collection for this scan was completed, Iowa began to break out child enrollment by age group on its children's health dashboard, becoming the only one of the 13 states to do so.

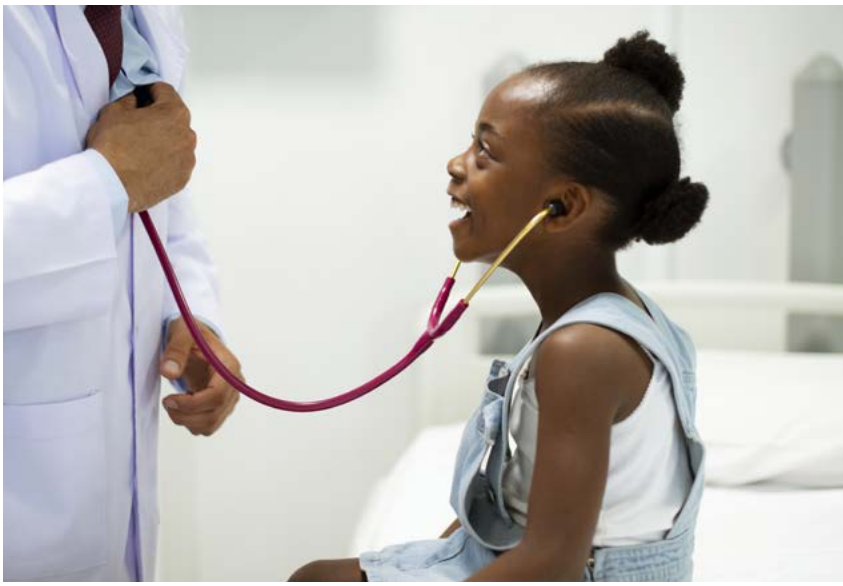
Only two of the 13 states we scanned—Illinois and West Virginia—posted the number of pregnant women enrolled in each MCO. In West Virginia's case, the data appear in one line in a table in an annual agency report to the legislature. No state posted the number of postpartum people enrolled in each MCO.

None of the states posted race and ethnicity or other demographic information on either children or pregnant individuals enrolled in individual MCOs.

None of the states posted the total amount they were paying each MCO for furnishing services to children or pregnant individuals. (We were searching not for capitation rates but for total amounts paid over a contract year). Arizona's state Medicaid agency posted the amount it paid each MCO on its website but did not break out the amount paid for children or pregnant individuals.[23]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children

None of the 13 states we scanned posted information about the provision of EPSDT services by individual MCOs, except with respect to dental care. Six states (Arizona, Georgia, Kentucky, Illinois, Pennsylvania, and West Virginia) posted a dental care metric, and two of them (Kentucky and West Virginia) explicitly identified the metric as a form of EPSDT reporting. *After the data collection for this scan was completed, Iowa added a children's health dashboard to its quarterly report on Medicaid MCO performance*. *The dashboard includes EPSDT metrics for lead, hearing, and vision screenings*.[24] All 13 states report information on the use of EPSDT services annually to CMS on Form-416; the sources of their data are the MCOs with which they contract to furnish these services.[25]



Child and Maternal Health Quality Metrics

Child Health

We searched for MCO-specific performance on ten measures drawn from the Child Core Set. As shown in Table 2, no single measure was available for all 56 MCOs in our scan. The most frequently reported metric was well-child visits in the 3rd, 4th, 5th, and 6th years; the least frequently reported metric was depression screenings and follow-up among children aged 12 to 17. There was wide variation in the number of measures posted by the 13 states. Pennsylvania reported almost all of the Child Core Set metrics for which we searched; Kansas and Missouri reported the fewest (see Appendix C).

For the measures for which we found results, there was wide variation from MCO to MCO across all states, within a state, and among subsidiaries of national companies.

Table 2. Child Core Set Metrics: Children's Health

Child Core Set Measure	Number of MCOs Reporting the Measure
Well-child visits in 3rd, 4th, 5th, and 6th years	51
Well-child visits in first 15 months	47
Weight assessment for children and adolescents	41
Childhood Immunization Status, Combination 3	40
Adolescent Immunization Status, Combination 1	40
Adolescent well care visits	37
Children and adolescent access to primary care	36
Chlamydia screening in women ages 16-20	22
Developmental screening in first 3 years	19
Depression screening and follow-up ages 12-17	9

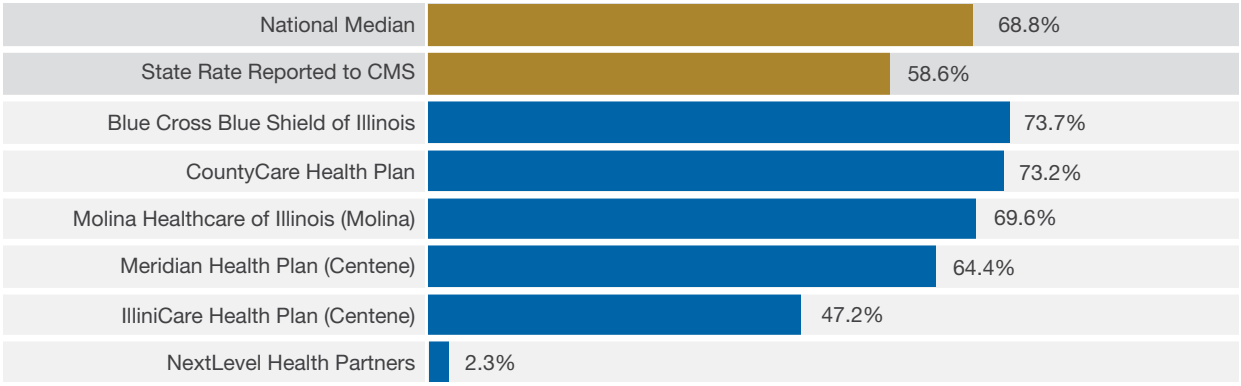
Note: Table excludes MCO/FCs in Arizona, Georgia, Illinois, Kentucky, Tennessee, and West Virginia.

Comparing measures across all states, performance on Childhood Immunization Status (Combination 3) showed the greatest variation, with a 77.0 percentage point difference between the highest and lowest reported rates (see Appendix C). Children and Adolescent Access to Primary Care: 12-24 Months had the smallest variation with a range of only 10.4 percentage points.

Comparing the performance of MCOs within states reveals that not all beneficiaries have equal access to care. For example, in Illinois, the statewide rate reported to CMS for the share of children up-to-date on their Combination 3 vaccines by age two was 58.6 percent, approximately ten percentage points below the national median. However, three MCOs achieved rates higher than the national median and two MCOs were substantially lower. One MCO even reported that only 2.3 percent of enrolled two-year olds were up-to-date on their Combination 3 vaccines (see Figure 1).[26]

Figure 1. Childhood Immunization Status: Combination 3

Performance for Illinois MCOs



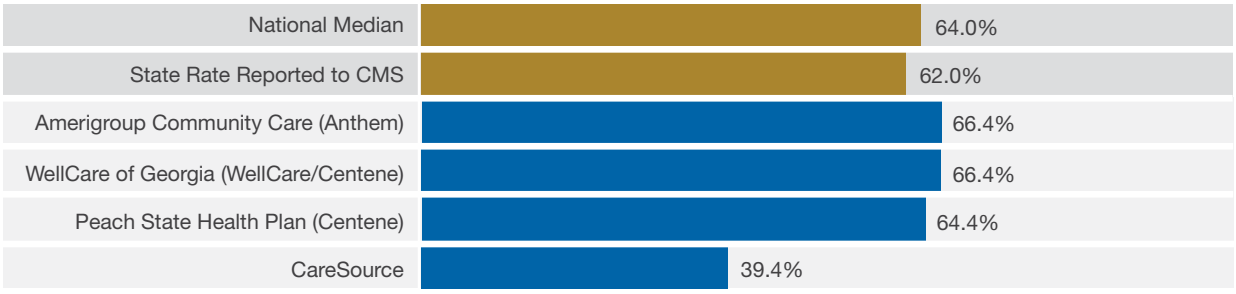
Note: Reflects performance in calendar year 2018.

Source: Georgetown Center for Children and Families analysis of 2019 Child Core Set Report and Illinois 2020 External Quality Review Annual Technical Report.

Similarly, in Georgia, three out of the four MCOs' performance on the measure for ensuring enrolled infants receive six or more well-child visits were near the national median level, while the fourth MCO was more than twenty percentage points lower (see Figure 2).

Figure 2. Well-Child Visits in the First 15 Months of Life

Performance for Georgia MCOs



Note: Reflects performance in calendar year 2018.

Source: Georgetown Center for Children and Families analysis of 2019 Child Core Set Report and Georgia 2020 External Quality Review Annual Technical Report.

Finally, performance also varied among subsidiaries of the same parent company that operate in different states (see Appendix E). For example, only 29.1 percent of young children enrolled in one of Centene's Arizona subsidiaries received appropriate developmental screenings while almost double this share (59.4 percent) of children enrolled in its Georgia subsidiary were screened.

Maternal Health

We searched for individual MCO results on seven maternal health measures drawn from the Maternity Core Set. Overall, state posting of maternal health measures can best be described as sparse (see Appendix D). As shown in Table 3, of those measures, only two—postpartum visit on or between 21 and 56 days after delivery, and timeliness of prenatal care—were reported frequently (42 and 41 MCOs, respectively). One state—Arizona—did not post *any* maternal health metrics for any of its seven MCOs. Kansas reported only one (timeliness of prenatal care). Pennsylvania, on the other hand, posted six of the seven measures for all of its MCOs.

Table 3. Child Core Set Metrics: Maternal Health

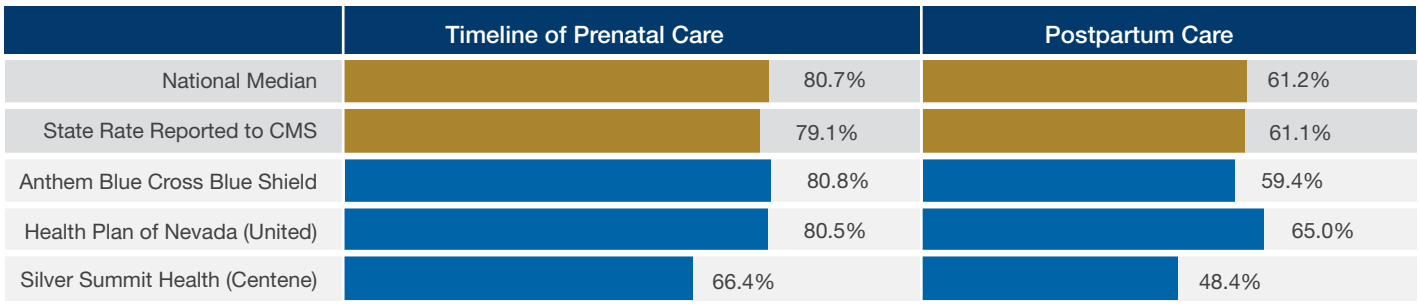
Child Core Set Measure	Number of MCOs Reporting the Measure
Postpartum care	42
Timeliness of prenatal care	41
Live births weighing less than 2,500 grams	13
Cesarean birth	9
Contraceptive care for postpartum women ages 15 to 20	9
Contraceptive care for all women ages 15 to 20	9
Audiological diagnosis no later than 3 months	0

Note: Table excludes MCO/FCs in Arizona, Georgia, Illinois, Kentucky, Tennessee, and West Virginia.

As with performance on the child health metrics, performance on the maternal health metrics varied widely among MCOs across all states, within a state, and among subsidiaries of national companies. Across the selected states, MCOs showed the most variation on the timeliness of prenatal care measure, ranging from 61.8 percent for NextLevel in Illinois to 99.03 percent for Molina in Mississippi (see Appendix D).[27]

Within a state, among the three MCOs in Nevada, one lagged far behind the other two on measures for timeliness of prenatal care and postpartum care (see Figure 3).

Figure 3. Maternal Health Metrics
Performance for Nevada MCOs

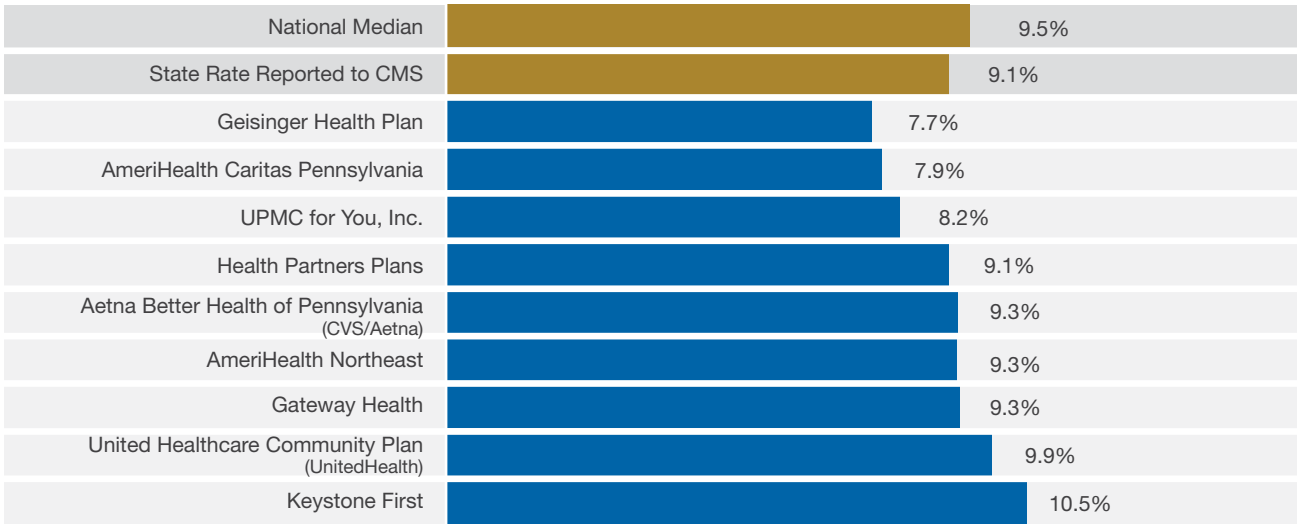


Note: Reflects performance in calendar year 2018.
Source: Georgetown Center for Children and Families analysis of 2019 Child Core Set Report and Nevada 2020 External Quality Review Annual Technical Report.

Similarly, as shown in Figure 4, several MCOs in Pennsylvania performed close to the national median for low-birthweight births while at least one was much higher (lower rates are better for this measure).

Figure 4. Live Births Weighing Less than 2,500 Grams

Performance for Pennsylvania MCOs



Notes: Low rates are better for the measure. Reflects performance in calendar year 2018.

Source: Georgetown Center for Children and Families analysis of 2019 Child Core Set Report and Pennsylvania 2020 External Quality Review Annual Technical Report.

MCO performance on maternal health metrics also varies within parent companies (see Appendix F). The widest range in performance—37 percentage points—occurred among Molina subsidiaries on the "timeliness of prenatal care" measure. The lowest performer was the subsidiary in Utah, where only 62.3 percent of beneficiaries had a prenatal care visit in their first trimester or within 42 days of their enrollment in the MCO. In comparison, according to their own report (as opposed to an EQRO-validated score), 99 percent of beneficiaries in Molina's subsidiary in Mississippi had a visit in that same time period.

Racial and Ethnic Disparities

For each category of performance data above—enrollment, EPSDT services, and child and maternal health—we searched for data disaggregated by race and ethnicity. Of the 13 states we scanned, only Pennsylvania reported MCO-specific enrollment by race and ethnicity; even then, the state did not post MCO-specific child enrollment by race and ethnicity. No state posted EPSDT by race and ethnicity. And while all states posted at least some MCO-specific child and maternal health metrics from the Child and/or Maternity Core Set, no state posted these measures stratified by race or ethnicity (see Table 4). A CMS assessment of 2018 state administrative records ranked those of Mississippi and Tennessee as "unusable" and those of Arizona, Kansas, Iowa, Missouri, Utah, and West Virginia as "high concern" for the purposes of analyzing beneficiary race and ethnicity. However, several states were only deemed "medium" or "low" concern, yet still failed to make their data available for public inspection.

Table 4. State Transparency in MCO Race and Ethnicity Reporting

State	CMS Rating of State Race and Ethnicity Data Quality	Presents Managed Care Plan Enrollment by Race and Ethnicity	Presents Managed Care Plan Child Enrollment by Race and Ethnicity	Presents Quality Metrics Disaggregated by Race and Ethnicity
Arizona	High Concern	No	No	No
Georgia	Medium Concern	No	No	No
Illinois	Low Concern	No	No	No
Iowa	High Concern	No	No	No
Kansas	High Concern	No	No	No
Kentucky	Medium Concern	No	No	No
Mississippi	Unusable	No	No	No
Missouri	High Concern	No	No	No
Nevada	Low Concern	No	No	No
Pennsylvania	Low Concern	Yes	No	No
Tennessee	Unusable	No	No	No
Utah	High Concern	No	No	No
West Virginia	High Concern	No	No	No

Source: Georgetown Center for Children and Families analysis of state administrative websites. CMS rating from CMS DQ Atlas, an analysis of calendar year 2018 state administrative data submitted to the T-MSIS system. More information can be found at https://medicaid.gov/dq-atlas/landing/topics/single/map?topic=3m16&tafVersionId=16.

Federal Transparency Requirements

Federal regulations require state Medicaid agencies that contract with Medicaid MCOs to post certain information on their websites (or ensure that the information is posted on the websites of the MCOs).[28] In theory, this publicly accessible information gives advocates and stakeholders an understanding of an MCO's contractual obligations to beneficiaries and the MCO's standing in the eyes of third-party reviewers, auditors, and accreditation bodies. We searched for a subset of that information that was most relevant to the performance of MCOs for children and pregnant individuals: the risk contract between the state and each MCO; the management and other individuals with ownership or control interests in each MCO; subcontractors (if any) used by each MCO to carry out utilization management and other critical functions; the accreditation status of each MCO; and EQRO Annual Technical Reports.

Our findings are summarized in Table 5. Of the 13 states we scanned, eight did not post the risk contracts between each MCO and the state Medicaid agency. Some of these eight states posted template contracts, rather than the final, executed contracts. In Kansas, the contracts available had to be cross-referenced with the initial request for proposal (RFP) issued by the state and were consequently difficult and time-consuming to interpret. Mississippi made an executed contract available, but it expired in June 2020.

Most states did not make information about MCO (or subcontractor) management easily accessible on the state Medicaid agency's website. The exception is Pennsylvania, which posted a directory listing both the MCO management and the state official in charge of overseeing the contract.

Nine of the state Medicaid agencies posted the accreditation status of each MCO on their website as required. Kansas, Nevada, and Tennessee provided a link to the website of the National Committee on Quality Assurance (NCQA).

All 13 states posted the EQRO Annual Technical Report.

Table 5. Performance Data Elements: MCO-Specific Information Available on State Agency Websites

Data Element	AZ	GA	IA	IL	KS	KY	MO	MS	NV	PA	TN	UT	WV	Total
Service Area	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	12
Risk Contract			✓			✓		✓*			✓	✓		5
Management						✓				✓				2
MCO-Specific Medicaid Enrollment	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	11
MCO-Specific Medicaid Enrollment (Child)			✓[a]	✓						✓				3
MCO-Specific Medicaid Revenues (Total)	✓													1
MCO-Specific Medicaid Revenues (Child)														0
NCQA Accreditation	✓**	✓		✓	✓[b]		✓		✓[b]	✓	✓[b]		✓	9
HEDIS Child Metrics	✓	✓[c]	✓	✓	✓[d]	✓	✓[e]	✓[f]	✓	✓	✓	✓[g]	✓	13
HEDIS Maternal Health Metrics		✓	✓	✓	✓[h]	✓		✓[g]	✓	✓	✓	✓[h]	✓[i]	11
EPSDT Metrics	✓[i]	✓[i]	✓[a]	✓[i]		✓				✓[i]			✓	7
Total	6	6	7	7	3	7	4	5	5	8	6	4	6	

Table Notes:

Elements in blue are required by federal regulation.

* No current risk contracts were available; the most current were for July 2017-June 2020.

** As of July 2021, only one MCO in AZ has achieved accreditation.

[a] Began reporting after scan.

[b] KS, NV, and TN only provide a link to NCQA's website on their state website. In our initial sweep, NV and TN did not include any reference to NCQA Accreditation on their Medicaid agency websites; they have since added these links.

[c] Thirteen HEDIS metrics were available in GA's EQRO report; almost all HEDIS metrics were available in separate reports entitled Validation of Performance Measures for each MCO. One of the Validation for Performance Measure reports was not posted until months after the other plans' respective reports upon inquiry from the press.

[d] All three MCOs reported only three HEDIS Child Health metrics. MCO-specific results were found in an annual report to CMS on the state website, as opposed to the state EQRO report.

[e] All three plans in Missouri reported only two HEDIS Child Health Metrics for Calendar Year 2018.

[f] Only two MCOs out of the three in Mississippi reported HEDIS metrics for Calendar Year 2018; Molina was not included in the state's EQRO report.

[g] Some measures for Molina were found only on Molina's website in Mississippi and Utah; these few measures were not included in the EQRO report for the other MCOs in Utah.

[h] Only one maternal health metric reported. In Kansas, this metric was included in a report to CMS buried on the website, not in the annual EQRO report.

[i] Reported the HEDIS Annual Dental Visit (ADV) measure as a proxy for EPSDT in state EQRO report for Calendar Year 2018. Georgia presented the HEDIS Annual Dental Visit (ADV) measure and the Percentage of Eligibles Who Received Preventative Dental Services (PDENT-CH) measure in a report entitled Validation of Performance Measures, rather than in the state's EQRO report.

Discussion and Recommendations

Risk-based managed care is the dominant delivery system for children and pregnant individuals enrolled in Medicaid. Currently, forty states and the District of Columbia contract with a total of 287 MCOs on a risk basis to manage services for Medicaid beneficiaries. How those MCOs perform determines the quality and accessibility of the care that beneficiaries receive. What can publicly available information tell us about the performance of Medicaid MCOs for children and pregnant individuals? Based on our analysis of the websites of 13 states and the 56 MCOs with which they contracted, the public has very little information available to answer this important question.

In fact, our analysis found that opacity is often the norm. We frequently confronted a maze of different websites, hidden webpages, outdated documents, and large gaps in information. We infrequently found the MCO-specific performance information we were seeking.

We were able to find the number of children enrolled in each MCO on only three of the state websites we scanned. Only two states posted the number of pregnant women enrolled in each MCO on their websites. None of the MCOs posted this information on their websites. Without this enrollment data, demographic data like age, gender, and race and ethnicity are, by definition, also unavailable. This information is foundational to any assessment of the performance of individual MCOs.

EPSDT services are the core of Medicaid coverage for children. Children enrolled in an MCO depend on the MCO to manage the delivery of EPSDT services for them. None of the 13 state Medicaid agencies posted information on receipt of EPSDT services (other than dental care) by children enrolled in each MCO. MCO performance for children simply cannot be assessed without information on the delivery of EPSDT services.

We were unable to find how much any of the 13 state Medicaid agencies were paying each MCO to furnish children's services (including EPSDT) or pregnancy-related services. Only one agency posted the amount it paid each MCO to provide services to all of its enrollees on its website, but even that agency did not post payments made on behalf of children and pregnant individuals. As in the case of enrollment data, the size of the state and federal investment in an MCO is foundational to an evaluation of its performance.

The one area of relative transparency relates to the Child Core Set. We were able to find many—but not all—of the child health measures and some of the maternal health measures for each MCO. This information was in the Annual Technical Review prepared by each state's EQRO and posted on each state Medicaid agency website. In a few cases, results were posted on individual MCO websites. Although the measures available were far from complete, a quick comparison between the MCO-specific metrics and statewide rates makes clear that aggregation masks significant variation in performance: children and pregnant individuals enrolled in different MCOs do not have equal access to care. If advocates and other stakeholders are going to address which children are underserved and in what ways, they need access to these MCO-specific rates on a timely and consistent basis.

Finally, none of the 13 state Medicaid agency websites we scanned posted enrollment, EPSDT, or child and maternal health quality data disaggregated by race and ethnicity. This is particularly concerning. Collecting and reporting MCO-level enrollment and performance disaggregated by race and ethnicity data is vital to ensuring that Medicaid equitably delivers care to all of its enrollees. An MCO may report high overall scores on quality metrics, but without data that is disaggregated by race and ethnicity, these scores can hide disparities in the receipt of services and inequitable patterns of care. To be sure, there are gaps in Medicaid administrative data on race and ethnicity that can make disaggregation difficult. Nonetheless, some states have developed techniques for reducing these gaps, leading to more complete and accurate data.[29] The next step is to post this data on an MCO-specific basis.

The state Medicaid agency websites we searched varied widely in the availability of MCO-specific information and user-friendly organization. *By our reckoning, Illinois, Iowa, Kentucky, and Pennsylvania's websites were the most transparent; those of Kansas, Missouri, and Utah the least*. Even among the more transparent states, however, there is still a considerable lack of publicly available performance data, especially with respect to maternal health metrics. None of the state Medicaid agency websites posted all of the minimum data elements required to be posted by federal regulations.

With these findings in mind, we make three recommendations to improve transparency about the performance of individual MCOs for children and pregnant individuals.

1. **State Medicaid agencies should maintain a child health dashboard that contains MCO-specific performance data and is easily accessible.** At a minimum, this performance data should include EPSDT screenings and treatment, Child Core Set metrics, and all information already required to be posted by federal regulations. The dashboard should include a data hub with links to relevant structural information about each MCO with which the state contracts.

2. **CMS should monitor and enforce state Medicaid agency compliance with the minimum transparency requirements in its regulations.** This would help reset state and MCO expectations about transparency.

3. **CMS should add a child health dashboard as a measure to the State Administrative Accountability pillar of its Medicaid & CHIP Scorecard.** The child health dashboard should include performance information on EPSDT screenings and treatment and Child Core Set metrics specific to each MCO in each state.

These recommendations are designed to promote accountability for the performance of individual MCOs for children and pregnant individuals—accountability not just on the part of the MCOs, but also on the part of the state Medicaid agencies that contract with them and the federal agency that finances two thirds of the public investment. Without transparency, there is no accountability. And without accountability, children and pregnant individuals enrolled in MCOs are at risk of poor access and quality. Having Medicaid coverage is essential for many families to ensure they do not go uninsured, but this is not enough. Medicaid managed care is the predominant delivery system for low-income children and pregnant women and disproportionately serves families of color. Federal and state policymakers alike must do a better job of ensuring that Medicaid provides high quality care to all children and promotes health equity.

Appendix tables referred to in this report can be found at https://ccf.georgetown.edu/2021/09/09/transparency-in-medicaid-managed-care-findings-from-a-13-state-scan-appendix/.

Methodology

Data Sources

We searched state Medicaid agency websites, state insurance department websites, and individual MCO websites for data about the performance of MCOs for children and pregnant individuals. In some cases, state agency websites referred us to external websites, such as that of the National Committee for Quality Assurance (NCQA).

We cross-checked our findings relating to MCO contractors, parent companies, and overall MCO quality rankings with the information presented on the Kaiser Family Foundation's Medicaid Managed Care Market Tracker.

The quality measures presented in this paper reflect MCO performance during calendar year (CY) 2018 (Healthcare Effectiveness Data and Information Set 2019). These rates were the most recent data available at the beginning of our scan in June 2020. In order to permit comparison of MCO performance, we present (CY) 2018 performance data for all 56 MCOs, even though (CY) 2019 (HEDIS) may have become available for some MCOs in some states during the course of our scan.

Data Collection

The 13 states included in this scan are states where CCF provides ongoing technical assistance to child health advocates as part of our Finish Line project. Each of the 13 states had fewer than ten MCOs in operation as of June 2020. As noted below, neither the states nor the MCOs we scanned are necessarily representative of all states that contract with MCOs or all MCOs contracting with those states. We limited our scan in order to be able to provide information on MCO performance and state agency transparency to state child health advocates in a reasonable period of time.

The list of data elements for which we searched can be found in Appendix B. In our view, these elements are the minimum necessary for advocates and the public to make an informed assessment of the performance of an individual MCO for children and pregnant individuals. There are other data elements that could also inform an assessment of MCO performance for which we did not search. These include MCO-specific information on: the resolution of grievances, appeals, and state fair hearings relating to denials of care; sanctions and administrative penalties imposed; and financial performance (e.g., Medical Loss Ratios). Federal regulations require states to report this information annually to CMS; the first reports are not due until December 2022.

We limited our search to publicly accessible websites. We did not file Public Records Act requests with state Medicaid agencies or insurance departments for the performance data we were seeking. We also did not file Freedom of Information Act requests for this information with CMS.

We organized the data that we were able to find into MCO-specific profiles using Google Sheets. This facilitated collaboration with other researchers and comparison of results across MCOs.

Limitations

This scan was limited to 56 MCOs operating in 13 states. It focused on a minimum set of performance data and, with respect to Child Core Set measures, captured only information for CY 2018. The findings therefore do not necessarily apply with respect to the remaining 231 MCOs that operate in the other 27 Medicaid managed care states or the District of Columbia.

The 13 states we scanned do not represent a random sample; we selected them from a narrow pool (24 states included in the Finish Line project) and excluded from that pool those with more than ten MCOs in operation as of June 2020. It is possible that a scan of the MCOs operating in the remaining 27 Medicaid managed care states and the District of Columbia would have found greater or less transparency around performance for children and pregnant individuals.

The same applies to the performance data for which we searched. We limited the data elements to those we considered most relevant to the performance of individual MCOs for children and pregnant women. It is possible that, had we searched for all potential performance data, we would have uncovered more information to assess the performance of individual MCOs, thereby affecting our judgments regarding transparency in the 13 states that we did scan.

In addition to disaggregation by race and ethnicity, states may sometimes disaggregate enrollment by sex (male or female). Only one state broke out MCO enrollment by sex (Pennsylvania); no other states made MCO enrollment by sex publicly available. We did not address the issue of disaggregating data by sex, gender identity, or sexual orientation in our scan.

Finally, we looked for Child Core Set data only for one year (CY 2018). We are therefore not able to present trends in MCO performance on child and maternal health measures from year to year. In addition, even for the one year for which we found measure data, caution should be exercised in comparing MCO performance across states. The demographic profile and health status of the children and pregnant women enrolled in MCOs, as well as the provider networks that MCOs are able to assemble to furnish services to those populations, may vary significantly from state to state, affecting measure results.

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Endnotes

[1] "Health Insurance Coverage of Children 0-18," Kaiser Family Foundation, available at https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] Park, E., Alker, J., and Corcoran, A., "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm" (Washington DC: The Commonwealth Fund, December 2020), available at https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm.

[3] See "Appendix 1: MCO-Specific Federal Requirements for Transparency, 42 C.F.R. Part 438," in Schneider, A. "A Guide for Child Health Advocates: Medicaid Managed Care Accountability Through Transparency" (Washington DC: Georgetown University Center for Children and Families, July 2021), available at https://ccf.georgetown.edu/2021/07/16/a-guide-for-child-health-advocates-medicaid-managed-care-accountability-through-transparency/.

[4] Georgetown CCF analysis of "Medicaid MCO Enrollment by Plan and Parent Firm, March 2021," Kaiser Family Foundation (March 2021), available at https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-march-2021. Total count includes some MCOs that cover children in foster care on a statewide basis, which we refer to as MCO/FCs. Georgetown CCF will explore MCO/FCs in more detail in a future brief. Georgetown CCF's total count differs slightly from the Kaiser Family Foundation's (KFF) table as MCOs that have enrollment for special populations may be aggregated under one name in the KFF table. Georgetown's count also includes MCOs in North Carolina, which began enrollment in March 2021 and are fully operational as of July 2021.

[5] The most recent national data, from fiscal year 2018, shows that 81.3 percent of children enrolled in Medicaid are enrolled in comprehensive managed care plans. This share has likely grown as North Carolina completed its transition to risk-based managed care in July 2021. MACStats, "Exhibit 30: Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2018," Medicaid and CHIP Payment and Access Commission (December 2020), available at https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2018.pdf. See also, Hinton, E., et al., "10 Things to Know About Medicaid Managed Care" (Washington DC: Kaiser Family Foundation, October 2020), available at https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

[6] "Managed Care's Effect on Outcomes," Medicaid and CHIP Payment and Access Commission, available at https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/.

[7] Schneider, A. and Corcoran, A., "Medicaid Managed Care: 2020 Results for the 'Big Five'" Georgetown University Center for Children and Families, SayAhh! Health Policy Blog, February 23, 2021, available at https://ccf.georgetown.edu/2021/02/23/medicaid-managed-care-2020-results-for-the-big-five/.

[8] "Medicaid MCO Enrollment by Plan and Parent Firm, March 2021," op cit.

[9] To wit, one MCO in Pennsylvania has a form on its website inviting candidates running for public office to request a donation from its affiliated political action committee.

[10] Guyer, J., Boozang, P., and Toups, M., "Moving to the Vanguard on Pediatric Care: Recommendations for the MassHealth 1115 Waiver Renewal" (Washington DC: Manatt Health, November 2020), available at https://www.manatt.com/insights/white-papers/2020/moving-to-the-vanguard-on-pediatric-care-recommend.

[11] The child health partners with whom Georgetown CCF partners in each state are as follows: Children's Action Alliance (Arizona); Voices for Georgia's Children (Georgia); EverThrive Illinois and Sargent Shriver National Center on Poverty Law (Illinois); Child and Family Policy Center (Iowa); Kansas Action for Children (Kansas); Kentucky Voices for Health (Kentucky); Mississippi Center for Justice (Mississippi); Kids Win Missouri, Missouri Budget Project, and Missouri Coalition of Children's Agencies (Missouri); Children's Advocacy Alliance (Nevada); Pennsylvania Partnerships for Children (Pennsylvania); Tennessee Justice Center (Tennessee); Voices for Utah's Children (Utah); and West Virginians for Affordable Health Care (West Virginia).

[12] Most managed care contracts provide for the protection of trade secrets, as aligned with exemption four of the Freedom of Information Act Statute (P.L. 114-185) and there is a growing body of case law about what information can be considered proprietary. MCOs may claim that public access to information on rate setting, formularies, and fee structures would put them at a competitive disadvantage. However, it is not plausible to claim that basic enrollment numbers, enrollee demographics, EPSDT performance data and HEDIS metrics should be exempt from public oversight. See, Turner, W., Machledt, D., and Somers, S., "A Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care" (Washington DC: National Health Law Program, March 2015), available at https://healthlaw.org/wp-content/uploads/2015/03/2015_03_17_NHeLP_ManagedCareAccountabilityGuide-1.pdf.

[13] "MCO External Quality Review Annual Technical Reports," District of Columbia Department of Health Care Finance, available at https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.

[14] In this instance, we use the term women because the original data source—the state websites—do so.

[15] "State Readiness to Report Mandatory Core Set Measures," Medicaid and CHIP Payment and Access Commission, March 2020, available at https://www.macpac.gov/publication/state-readiness-to-report-mandatory-core-set-measures/; and, §1139A of the Social Security Act.

[16] Center for Medicaid and CHIP Services, "Quality of Care for Children in Medicaid and CHIP: Findings from the 2019 Child Core Set" (Baltimore, MD: Centers for Medicaid and Medicare Services, October 2020), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-chart-pack.pdf; and Center for Medicaid and CHIP Services, "Quality of Maternal and Perinatal Health Care in Medicaid and CHIP: Findings from the 2019 Maternity Core Set" (Baltimore, MD: Centers for Medicaid and Medicare Services, December 2020), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2020-maternity-chart-pack.pdf.

[17] Center for Medicaid and CHIP Services, "Quality of Care for Children in Medicaid and CHIP," op cit.

[18] O'Kane, M. et al., "The Future of HEDIS: Health Equity," National Committee on Quality Assurance (webinar, June 22, 2021), available at https://www.ncqa.org/wp-content/uploads/2021/06/2021-0622-Future-of-HEDIS.pdf.

[19] "Health Equity Reports," Michigan Department of Health & Human Services, available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--,00.html.

[20] Machledt, D., "Medicaid External Quality Review: An Updated Overview" (Washington, DC: National Health Law Program, November 2020), available at https://healthlaw.org/resource/medicaid-external-quality-review-an-updated-overview/.

[21] 42 *C.F.R.* §438.364 (2020).

[22] Center for Medicaid and CHIP Services, "CMS External Quality Review (EQRO) Protocols" (Baltimore, MD: Centers for Medicaid and Medicare Services, October 2019), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[23] Iowa, Pennsylvania, and Tennessee posted the amount paid to each MCO on their states' Department of Insurance website, as opposed to their state Medicaid Agency website.

[24] Trefz, M. "Iowa's New Child Health Dashboard Provides Insight into How Medicaid Managed Care is Working for Kids," Georgetown University Center for Children and Families, SayAhh! Health Policy Blog, February 23, 2021, available at https://ccf.georgetown.edu/2021/06/07/iowas-new-child-health-dashboard-provides-insight-into-how-medicaid-managed-care-is-working-for-kids/.

[25] See Washington DC's EQRO report for an example of EPSDT reporting on an MCO-specific basis. "MCO External Quality Review Annual Technical Reports," District of Columbia Department of Health Care Finance, available at https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.

[26] Combination 3 includes DTAP, IPV, MMR, HIB, Hepatitis B, VZV and PCV vaccinations. "Childhood Immunization Status (CIS)," National Committee on Quality Assurance, available at https://www.ncqa.org/hedis/measures/childhood-immunization-status/.

[27] Note that this measure was posted on the Mississippi Molina subsidiary website, not included in an externally-validated EQRO ATR.

[28] See "Appendix 1: MCO-Specific Federal Requirements for Transparency, 42 C.F.R. Part 438," in Schneider, A. "A Guide for Child Health Advocates: Medicaid Managed Care Accountability Through Transparency," op cit.

[29] "Collection of Race, Ethnicity, Language (REL) Data in Medicaid Applications: A 50-state Review of the Current Landscape," State Health Values and Strategies, February 2021, available at https://www.shvs.org/resource/collection-of-race-ethnicity-language-rel-data-in-medicaid-applications-a-50-state-review-of-the-current-landscape/.