Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

A Guide for Child Health Advocates:
Medicaid Managed Care Accountability Through Transparency

In the Guide

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Overview: Medicaid, Managed Care, and Transparency

Medicaid is the nation's largest health insurer for children—over 35 million at last count—and pays for nearly half of the nation's births. It offers a comprehensive pediatric benefit—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services—for children and comprehensive maternity care for pregnant women. In most states, Medicaid agencies contract with managed care organizations (MCOs) to organize networks of providers to deliver covered services to most, if not all, Medicaid-eligible children and pregnant women. As of July 2021, 40 states and the District of Columbia contracted with a total of 287 MCOs to manage services for Medicaid beneficiaries; in almost all of those states, most eligible children are enrolled in MCOs. Total federal and state Medicaid spending on MCOs this year is projected to be in the neighborhood of $300 billion.

How well those 287 MCOs perform determines how good Medicaid coverage is for the children and pregnant women they enroll. And because children and pregnant women eligible for Medicaid are disproportionately people of color, how well MCOs perform will largely determine how effectively the Medicaid program addresses racial and ethnic health disparities. If an MCO is a high-performing organization, Medicaid coverage can improve their health outcomes. If the MCO is a low-performing organization, Medicaid coverage will have little or no value. So how can we know whether an individual MCO is high- or low-performing? How transparent are state Medicaid agencies and MCOs about their performance for children and pregnant women? And if performance information is publicly available, how can advocates use it to identify low-performing MCOs and hold them accountable?

The purpose of this Guide is to help child and maternal health advocates use transparency to hold MCOs accountable for their performance for children and pregnant women. Transparency is not the only tool for holding MCOs accountable—administrative advocacy, legislative oversight, and litigation are also available—but it has the advantage of imposing no new costs on the state treasury and no significant administrative burden on either the MCOs or the state agency. MCOs are already being paid to manage care and report to the state agencies on their performance; state agencies are already reviewing this information to assess the accessibility and quality of care Medicaid beneficiaries are receiving from the MCOs they are paying. Transparency simply requires that this information be made publicly available so that all stakeholders—beneficiaries, providers, state policymakers, investors, and the public at large—can know which MCOs are performing at a high level and which are not.

TOOLS FOR ACCOUNTABILITY

In March 2015, the National Health Law Program (NHeLP) issued the ground-breaking "Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care," a catalogue of the tools available to advocates to improve the performance of Medicaid managed care for all beneficiaries, adults as well as children. These tools include external quality review, grievances and appeals, and analysis of corporate financial filings. Most recently, NHeLP has issued a guide on ways to address health equity in Medicaid managed care for all populations. This Guide for Child Health Advocates is much narrower in scope; it focuses just on how transparency can improve the performance of MCOs for children and pregnant women.

Having MCO-specific performance information in the public domain creates opportunities for advocates to hold MCOs—and the state agencies that contract with them—accountable for substandard performance. Among the most important of these opportunities is the ability of health services researchers, the press, and advocates to analyze information about individual MCOs that under-resourced state Medicaid agencies collect but do not have the time or capacity to examine. Independent analyses could support comparisons of performance by MCOs in the same state as well as those of subsidiaries of the same corporate parent operating in different states.

THREE TRUTHS ABOUT MEDICAID MANAGED CARE

- If you've seen one state's Medicaid program, you've seen one state's Medicaid program.
- If you've seen one state's Medicaid managed care program, you've seen one state's Medicaid managed care program.
- If you've seen one Medicaid MCO, you've seen one Medicaid MCO.

There's another potential benefit as well: call it the "transparency effect." If MCO management knows that performance information will be publicly available, and if they are concerned about their own reputations and those of the organizations they oversee, they are more likely to take actions to improve their MCO's performance than if they are confident that information about substandard performance will remain out of public view. The same dynamic applies to state Medicaid agencies. Contracts with Medicaid MCOs are often the largest contracts that state governments enter into with any vendor; paying out large sums to a contracting MCO that the public knows is failing to meet performance expectations will not reflect well on agency leaders.

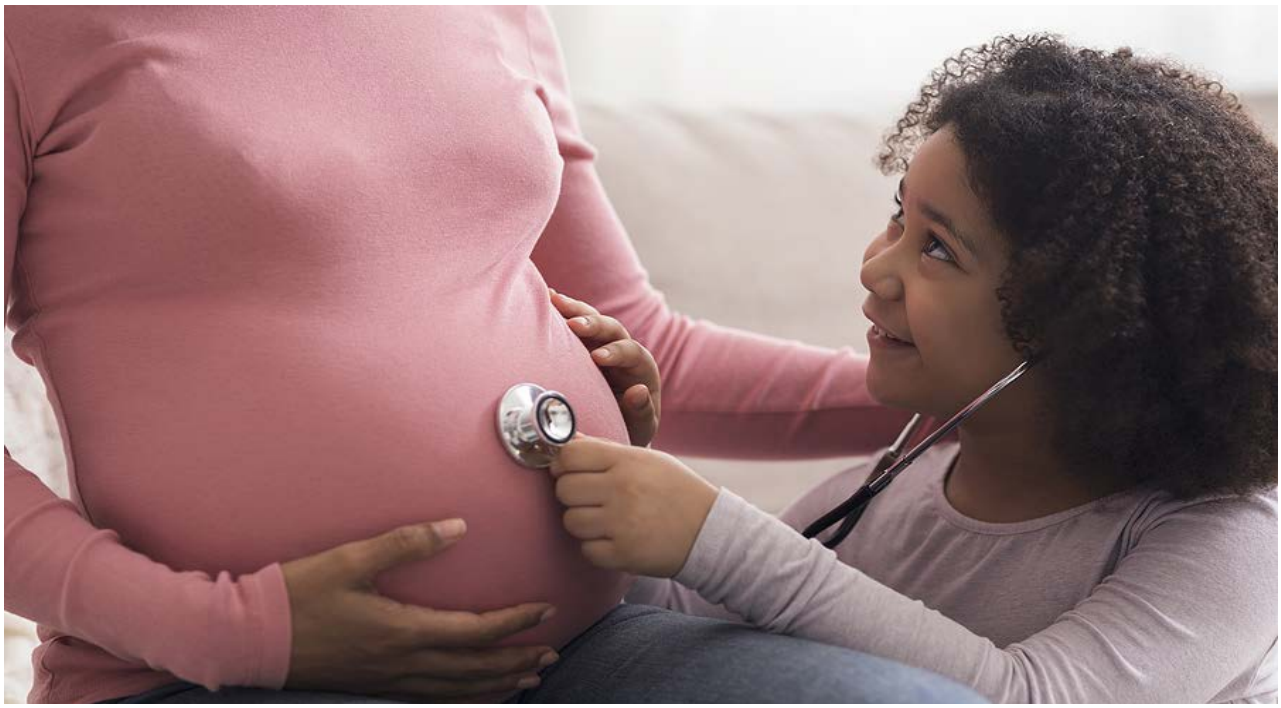
While the case for transparency is strong—public funds are being used by public agencies to purchase needed care for public program beneficiaries—information about the performance of individual MCOs is not always publicly available. Because states have broad flexibility to operate their Medicaid programs within federal guidelines, there is wide variation from state to state in MCO contracting policies and procedures, including transparency. As things now stand, the culture of MCO contracting in many states is one of opacity; what information about individual MCO performance is publicly available can be difficult to access or incomplete (or both). This guide includes action steps for addressing this cultural issue and for holding low-performing MCOs accountable.

What's a Medicaid MCO and why do they matter to children and pregnant women?

A Medicaid managed care organization (MCO) is an entity that contracts with the state Medicaid agency to manage the provision of comprehensive acute care services to Medicaid beneficiaries. The MCO may be for-profit, not-for-profit, or public. Whatever the ownership status, 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, whether or not the enrollee uses services in that month. This is called a capitation or per member per month (PMPM) payment.

In exchange for the 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. Within limits, if the MCO spends more on paying its providers for furnishing covered services to its enrollees, it must absorb the loss; if it spends less, it can keep the difference. Because the MCO can make or lose money under its contract with the state—i.e., it is at financial risk for the provision of covered services to beneficiaries—the contract is often referred to as a risk contract.

In the 40 states (and District of Columbia) that currently contract with MCOs, Medicaid beneficiaries are generally required to enroll in an MCO rather than receive services through the fee-for-service delivery system. Each MCO determines which hospitals, physicians, and other providers it will contract with; 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 the services of those network providers through administrative requirements like prior authorization so that they pay only for services that are "medically necessary." If an MCO's provider networks are too limited, or if the MCO's utilization controls are too tight, enrollees will not receive the services they need and to which they are entitled.



MEDICAID MANAGED CARE BASICS

Medicaid managed care is complicated. That's in part because Medicaid programs are state-specific and because managed care performance is MCO-specific. Forty states and the District of Columbia contracting with 287 different MCOs produces a lot of variation. Here are some commonalities:

- **State Medicaid programs have choices in how they pay for covered services for eligible children and parents.** They can pay providers directly on a fee-for-service (FFS) basis (i.e., when a provider furnishes a service, the state makes a payment). They can contract with MCOs on a risk basis (i.e., they make fixed monthly capitation payments for each enrollee regardless of whether the enrollee uses services). Or they can mix and match, using FFS for some populations or services, and MCOs for others.
- **State Medicaid programs that choose to contract with MCOs operate within Federal rules.** Those rules are at 42 CFR Part 438. They cover most aspects of the contracting between state Medicaid agencies and MCOs, including qualifications of MCOs and their provider networks and MCO capitation rates. Procurement—i..e., state selection of its contractors—is done under state rules.
- **The Federal rules are designed in part to protect beneficiaries.** Because they are paid on a per member per month (PMPM) basis—i.e. capitation—MCOs have a financial incentive to deny services to enrollees. Their monthly capitation payments do not decline if they withhold payment for needed services and their monthly payments do not increase if they pay out large amounts for services. The less they spend on services for enrollees, the more they keep (within limits). The federal regulations include provisions to ensure that enrollees receive the services they need.
- **The Centers for Medicare & Medicaid Services (CMS) must approve capitation payments to MCOs and contracts between the state Medicaid agency and MCOs.** The federal government will match a state's capitation payments to an MCO (at 50 percent to 90 percent, depending on the state and the population enrolled), but only if CMS determines in advance that the risk contract between the state and the MCO, as well as the capitation rates paid to the MCO, meet federal requirements in 42 CFR Part 438.

The best short overview of Medicaid managed care is from the Kaiser Family Foundation.

The Medicaid and CHIP Payment and Access Commission (MACPAC) has prepared a detailed policy overview of the federal rules for Medicaid managed care which is available here.

If an MCO's provider network does not perform, the MCO does not perform. Here is the link to an Advocacy Action Guide for providers and child health advocates.

What are the basic performance requirements for MCOs for children and pregnant women?

All children enrolled in Medicaid—whether or not they are enrolled in an MCO—have an individual entitlement to have payment made for a comprehensive set of medically necessary services. The acronym for this benefit is EPSDT, which stands for Early and Periodic Screening, Diagnostic, and Treatment services.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) SERVICES

Every child eligible for Medicaid is entitled to a comprehensive pediatric benefit: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. For this purpose, a child is any individual under age 21.

A child's entitlement to EPSDT services exists whether the child is enrolled in an MCO and receives services through the MCO's provider network, or whether the child receives services from providers paid by the state Medicaid program on a fee-for-service (FFS) basis.

Here's the CMS summary of the benefit.

The Building Blocks of EPSDT

Early	Assessing and identifying problems early
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct, or reduce health problems found

States are also required to inform all Medicaid-eligible children under 21 (or their families) of the availability of EPSDT services. States can conduct this outreach themselves or contract with MCOs to do so.

CMS has issued a Guide for States on EPSDT and an Informational Bulletin on the delivery of EPSDT services (and related outreach) through managed care.

The American Academy of Pediatrics (AAP) and CCF conducted webinars in 2019 explaining the EPSDT benefit and how providers, medical-legal partnerships, and legal services organizations can advocate for children enrolled in MCOs to ensure they receive the EPSDT services to which they are entitled.

In 2016, child health advocates in Illinois and Iowa engaged in extensive advocacy around the provision of EPSDT services for children enrolled in MCOs. Case studies of those efforts, including lessons learned, are available here (Illinois) and here (Iowa).

The National Health Law Program has prepared a checklist to help advocates track how EPSDT is working in states that contract with MCOs. NHeLP has also published a Chartbook on statewide EPSDT data through 2019.

Low-income women enrolled in Medicaid on the basis of pregnancy are entitled to have payment made for pregnancy-related services and their newborns are automatically enrolled in Medicaid for their first year of life.

PREGNANCY-RELATED SERVICES

Medicaid covers nearly half of all births in the U.S. The primary pathway to coverage is for women who are pregnant and have income below a specified percentage of the Federal Poverty Level (FPL); the lowest eligibility level allowed is 138 percent FPL ($17,774 for single person, $30,305 for a family of three in 2021), but almost all states have higher thresholds for pregnant women (the median in 2021 is 200 percent FPL). Women who qualify for Medicaid coverage on the basis of pregnancy are entitled to pregnancy-related services and services for other conditions that might complicate the pregnancy.

Pregnancy-related services are services "necessary for the health of the pregnant women and fetus, or that have become necessary as a result of the woman having been pregnant," including prenatal care, delivery, postpartum care, and family planning services. Services for other conditions that might complicate the pregnancy include those for "diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus." Coverage extends through the end of the month in which the 60-day period following the end of the pregnancy falls, although states have the option of extending this postpartum coverage for 12 months.

Unlike EPSDT services for children, pregnancy-related services do not include an outreach requirement and states are not required to report on the extent to which pregnant women are receiving the services to which they are entitled. As with EPSDT services, there are no requirements specific to pregnancy-related services in the federal managed care regulations.

There is more than one eligibility pathway to coverage for pregnant women. A good summary of Medicaid and CHIP coverage for pregnant women is available here.

In states that contract with MCOs, the MCO is generally responsible for ensuring that its enrollees receive the EPSDT or pregnancy-related services to which they are entitled. Some state Medicaid agencies "carve out" certain services from their contracts with MCOs and purchase those services directly on a fee-for-service basis. In either case, the scope of the service for which the MCO is responsible, and for which it is receiving monthly capitation payments, should be set forth in the risk contract.

Because CMS must approve each risk contract between a state and an MCO, all of them have certain common elements specified in federal regulation. State Medicaid agencies are required by federal regulations to post their risk contracts so that the public can see exactly what the state is purchasing. (See Appendix 1). But beyond those minimum requirements, states have considerable flexibility, and most have exercised it. The variation among state risk contracts is on full display in the Commonwealth Fund's Medicaid Managed Care Database; see for example the range of provisions on pediatric clinical preventive services.

MCO risk contracts can run for hundreds of pages. For purposes of transparency, the most important provisions for child and maternal health advocates will be found in the sections on benefits and reporting. The benefits section should set forth the MCO's obligations to furnish EPSDT and pregnancy-related services and identify any "carved out" services for which the MCO is not responsible (but for which the state Medicaid agency is). The reporting section should set forth what performance information the MCO is required to submit to the state Medicaid agency and to the External Quality Review Organization (EQRO) with which the agency contracts. The greater the specificity in the language of the contract, the more likely there will be concrete standards against which to measure MCO performance.

Under its contract with the state Medicaid agency, an EQRO conducts a review of each MCO's performance each year for all enrollees, not just for children and pregnant women. To ensure that the review is objective, federal regulations require that the EQRO be independent of both the MCOs with which the state Medicaid agency contracts and the agency itself. The EQRO must prepare an Annual Technical Report on its findings; that report must be posted on the state Medicaid agency's website. In some states, this is the only publicly available source of performance information about individual MCOs.

THE EXTERNAL QUALITY REVIEW PROCESS AND ANNUAL TECHNICAL REPORTS

Federal regulations require that state agencies contract with at least one external entity (the EQRO) to assess MCO performance and quality. While the regulations set minimum standards for the type of monitoring activities that the independent entity must conduct, state agencies can also mandate additional oversight activities in the contract. Each year, the EQRO prepares a technical report detailing MCOs' activities and performance on quality metrics in the previous year. The state must then post the report on its website by April 30th of the following year. When done well, EQRO annual reports can be a wealth of publicly-reported information about how individual MCOs are doing for children.

The EQRO must:

- ☑ Validate each MCO's performance improvement projects (PIPs) (annually)
- ☑ Validate performance measures that are directed by the state as part of its managed care quality strategy (annually)
- ☑ Validate compliance with the MCO standards set out in CFR 42 §438, subpart D (i.e., availability of services, coordination and continuity of care, coverage and authorization of services, grievance and appeal systems, and subcontracting practices) as well as disenrollment practices, enrollee rights, emergency services, and internal quality improvement programs (every three years)

In addition, at the request of the state, the EQRO may:

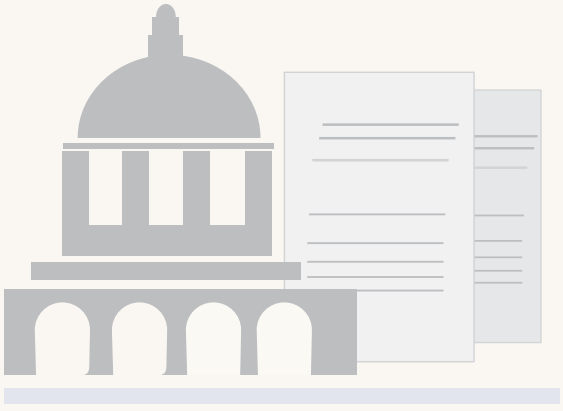
- ☑ Validate MCO encounter data
- ☑ Administer or validate consumer and provider quality of care surveys
- ☑ Calculate and report performance measures above and beyond those required as part of the state's managed care quality strategy
- ☑ Launch performance improvement projects
- ☑ Conduct special studies on clinical or nonclinical services and quality of care

Questions to ask about your state's EQRO Annual Technical Report

- ? What quality measures does the report present on an MCO-specific basis, and do they address care for children and pregnant women?
- ? Does the report clearly benchmark MCO performance against national, regional, or statewide results?
- ? Does the EQRO that my state contracts with also serve as the EQRO in other states? (For a list of which states EQROs contract with, see Table 1 of CMS's EQRO Technical Reports Chart Pack.)
- ? If so, do the reports in other states contain more or less information? (For example, see Text Box on Transparency in EPSDT Performance on page 10.)
- ? How many of the optional activities listed above does the EQRO undertake?

Additional resources

For an in-depth overview of the External Quality Review process and links to every state's annual technical reports, see the National Health Law Program's ongoing series of briefs.



Typically, the performance information that is contained in an Annual Technical Report includes measures from the CMS Child Core Set. Examples include childhood immunization and postpartum care. An MCO's performance on any individual measure in any particular year doesn't necessarily tell you how well (or poorly) the MCO is performing for children or pregnant women. But the results do allow for comparison with the performance of other MCOs and, in the case of a low-performing MCO, for questions about the actions the MCO and/or the state Medicaid agency will take to improve performance going forward.

USING CORE SET METRICS TO JUDGE MCO PERFORMANCE

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.

Table 1. Example Metrics

Child Core Set	Maternity Core Set
Childhood Immunization Status	Live Births Weighing Less than 2,500 Grams
Developmental Screening in the First Three Years of Life	Timeliness of Prenatal Care
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Postpartum Care

States use the Child and Adult Core Sets as evaluative metrics in their external quality review process and publish the results on a MCO-specific basis in their annual technical reports. Louisiana even has an interactive dashboard that tracks MCO performance on key metrics. With these measures, you can see which MCOs are performing well for kids in your state and which MCOs are falling short.

Things to remember when reading Core Set metrics:

- ☑ While higher rates indicate better performance on most metrics, there are several where lower rates are better, such as Live Births Weighing Less than 2,500 Grams.
- ☑ There is a significant reporting lag, meaning that the data you are seeing reflects MCO performance two or three calendar years ago.

Red flags to watch for when evaluating Core Set metrics for MCOs:

- ☒ The annual technical report includes no or very few metrics on a MCO-specific basis.
- ☒ An MCO has a rate that is significantly lower than the other MCOs in the state.
- ☒ An MCO shows a decline on a given measure in consecutive years.
- ☒ The state reports an overall state rate for a given measure to CMS, but does not include MCO-specific data in its annual technical report.

What information is publicly available about the performance of individual MCOs for children and pregnant women?

State Medicaid agencies vary greatly in how much information they make available to the public on their websites and how easily the public can navigate those sites. Iowa's Medicaid website has a child health dashboard that contains data on the number of children enrolled in each MCO, broken down by age, as well as the number of well-child exams and lead, hearing, and vision screenings provided by each MCO, also broken down by age. The state updates the information on a quarterly basis. At the other end of the transparency spectrum is Kansas, which as of April 2021, had posted none of the MCO-specific performance information available on the Iowa child health dashboard—not even the number of children enrolled in each MCO.

State Medicaid agencies that decide to contract with MCOs have to follow detailed requirements in federal regulations if they want to receive federal Medicaid matching funds for their managed care spending. Among these requirements are specifications relating to transparency. There are certain types of information that state Medicaid agencies must post on their websites or ensure are posted on the websites of the MCOs with which they contract. These include: the risk contracts between the state agency and the MCO, the annual report on MCO performance prepared by the state's External Quality Review Organization (EQRO), and the names of the CEO, CFO, and other management of the MCO who are responsible for its performance. See Appendix 1 for a list of the federal transparency requirements relating to MCOs.

It is one thing for federal regulations to require transparency; it is quite another for state agencies to comply. We searched the websites of the state Medicaid agencies and insurance departments of 13 states (Arizona, Georgia, Illinois, Iowa, Kansas, Kentucky, Mississippi, Missouri, Nevada, Pennsylvania, Tennessee, Utah, and West Virginia) as well as the websites of 56 MCOs for information about the performance of the individual MCOs for children and pregnant women. Our findings confirm two truths. First, if you've seen one state's Medicaid website, you've seen one state's Medicaid website. Second, websites like that of Iowa's Medicaid agency are the exception that proves the rule: there is not nearly enough transparency about the performance of individual MCOs for children and pregnant women.

IOWA'S CHILD HEALTH DASHBOARD

The Iowa Medicaid agency contracts with two MCOs: Amerigroup Iowa (Anthem) and Total Care Iowa (Centene). Over 386,000 children are currently enrolled in one or the other of these MCOs. In March 2021, the Iowa Medicaid agency added a child health dashboard to its quarterly MCO performance reports.

The dashboard (pp. 19-20) presents the following information for each MCO:

- The total number of children enrolled in each MCO (broken down by age group);
- The total number of children receiving well-child visits;
- The total number of children receiving lead, vision, and hearing screenings; and
- The total number of immunizations.

Currently, the dashboard does not disaggregate data by race and ethnicity. Child health advocates at Common Good Iowa are continuing to work with the state Medicaid agency to improve the dashboard to increase transparency.

CCF FINDINGS FROM A 13-STATE, 56-MCO SCAN

CCF researchers searched the websites of state Medicaid agencies and the MCOs they contracted with in 13 states: Arizona, Georgia, Illinois, Iowa, Kansas, Kentucky, Mississippi, Missouri, Nevada, Pennsylvania, Tennessee, Utah, and West Virginia. Here are the top-line findings:

- Only three states—Illinois, Iowa, and Pennsylvania—posted the number of children enrolled in each MCO. Of the three, Iowa was the only state that broke down child enrollment by age group.
- Only two states—Illinois and West Virginia—posted the number of pregnant women enrolled in each MCO.
- None of the states provided a breakdown of enrollment of either children or pregnant women by race or ethnicity.
- Only one state—Iowa—posted information about the delivery of EPSDT services by individual MCO (three states posted one dental service metric).
- Each of the 13 states posted at least some MCO-specific HEDIS measures for children. However, two states—Arizona and Missouri—posted no MCO-specific maternal health metrics whatsoever.
- In no state were either EPSDT or HEDIS performance measures disaggregated by race or ethnicity.

The full report and other information about MCOs are available at ccf.georgetown.edu/topic/managed-care.

Four of the states we reviewed—Arizona, Illinois, Kentucky, and Pennsylvania—provided "report cards" for individual MCOs. The contents of these "report cards" vary, but most include measures of patient satisfaction, getting needed care, getting care quickly, how well doctors communicate, how well care is coordinated, etc. MCO ratings were often presented in the number of stars, ranging from 1 to 5. These can be useful for giving beneficiaries information to help them select an MCO upon initial enrollment and during open enrollment periods. But they don't provide the information needed to assess an individual MCO's performance for children and pregnant women.

For example, none of the "report cards" we reviewed explained whether children enrolled in an MCO were receiving the EPSDT services for which they are covered. Contrast that with the Annual Technical Report prepared for the D.C. Medicaid agency, which presents EPSDT performance data for each of the three MCOs with which the agency contracts. And because the agency has been tracking the EPSDT performance of its MCO contractors for several years, it is able to—and does—compare each MCO's performance on screening, participation, and dental services ratios over time.

TRANSPARENCY IN EPSDT PERFORMANCE

In 2020, the D.C. Medicaid agency contracted with three MCOs to provide EPSDT and other Medicaid services to over 73,000 children. To assess performance, the agency directed its EQRO to audit the accuracy and reliability of the EPSDT measures that each MCO reported to the agency (this is referred to as "validation" of the data). For the measures for which data were considered "reportable," the agency directed the EQRO to present the results specific to each MCO in its Annual Technical Report, which the agency then posted.

For example, 52,700 of the children enrolled in AmeriHealth Caritas District of Columbia should have received at least one initial or periodic screen, but only 31,200 actually received the screen to which they were entitled. This yields a participation ratio of 59 percent. The participation ratio for one of the other MCOs, CareFirst Community Health District of Columbia, was lower (54 percent); that for the other MCO, Heath Services for Children with Special Needs, was higher (65 percent). (Table 17 of the Annual Technical Report).

This transparency means that all stakeholders—the agency, each MCO, network providers, and child health advocates—can see the data and, because the data has been validated, have reasonable confidence that it is accurate. And since the agency's EQRO has conducted audits of EPSDT performance measures for each MCO contractor for each of the past five years, the public can judge the performance of an individual MCO in any given year, track its performance over time, and compare its performance with that of its competitors. Where the participation ratios are low, or where they are declining over time, questions can be asked of both the MCO and the Medicaid agency.

What actions can advocates take to improve transparency of MCO performance?

Here are some action steps for child health advocates:

1. **Take inventory**. Start with a search of your state Medicaid agency's website and those of the MCOs with which it contracts to see what's posted and what's not. (You may also find useful information on the state insurance department website). You'll find a template for a spreadsheet to record data on individual MCOs at ccf.georgetown.edu/topic/managed-care.

TIPS FOR SEARCHING STATE MEDICAID AGENCY WEBSITES

CCF researchers searched Medicaid agency websites in 13 states (AZ, GA, IL, IA, KS, KY, MS, MO, NV, PA, TN, UT, WV) for information about the performance of individual MCOs for child and maternal health. Each website differed in transparency and user-friendliness. On some, basic information was available and relatively easy to find, while on others information was sparse and hard to locate—even the information required to be posted by federal regulations (Appendix 1). Based on the lessons learned from those searches, here are some tips for finding specific types of information.

- **Risk contract between the MCO and the state Medicaid agency:** This is sometimes located in a specific section for solicitations, contracts, or procurements on the Medicaid agency's website. If not, try the state's Department of Administration website. Look for the section for procurements or contracts and search by the name of the MCO; you may be able to find the RFP, proposals, and the award for the MCO's contract.
- **Medicaid Enrollment by MCO:** This should be available under reports or statistics on the state Medicaid agency website, although not all states currently post this information. (As of March 2021, eight states did not). In some cases, the information may appear in agency reports to the state legislature. The enrollment data may be broken down by eligibility group (e.g, TANF, SSI, Foster Care, etc.).
- **MCO Revenue from Medicaid:** If the Medicaid agency website does not provide this information, search for individual MCO financial statements filed with the state insurance department. If the statement is posted, look for "capitated revenues" to find the total revenue that the MCO generated for that contract period.
- **NCQA Accreditation:** Some states provide accreditation information under sections for reports or quality measurement, while others may list accreditation results on the landing page for MCOs. Some don't post it at all; in that event, check NCQA's website.
- **HEDIS Measures for Child and Maternal Health:** These measures are found in the Annual Technical Review (ATR) conducted by the state's External Quality Review Organization (EQRO). The ATR can usually be found under the Medicaid website's section for resources, reports, or quality measurement. (Note that the year during which performance is being measured is usually the year before the year the ATR is prepared and may be two years before the ATR is posted).
- **MCO Management Accountable for Performance:** The Medicaid agency website sometimes links directly to the website of each contracting MCO. If neither website identifies each MCO's management—CEO, CFO, and COO—and Board members, check the annual financial reports on the state's insurance department website.

2. **Talk to your state Medicaid agency**. Once you've searched the agency's website, discuss your findings with agency staff. If they have not posted what the federal regulations require, point that out. If they have posted what the federal regulations require but not much else, try to get them to up their game. Show them what other states have done (Appendix 2 identifies some best state website practices we found). As the Iowa Medicaid agency's child health dashboard demonstrates, a state that wants to do the right thing does not need the federal government to require it to do so. The same can be said for the District of Columbia Medicaid agency's posting of EPSDT performance measures. (Federal regulations do not require that states stand up child health dashboards or that they post EPSDT data for each MCO, although they should). One forum for a conversation with your state Medicaid agency is its Medical Care Advisory Committee.

3. **File a Public Records Act request and post the performance data disclosed as a result of the PRA on your organization's website**. If your state Medicaid agency does not want to set up a child health dashboard or otherwise post data about the performance of individual MCOs, and if it won't disclose the information even when you ask politely, file a Public Records Act (PRA) request for the information and post it on your organization's website. The Reporter's Committee for Freedom of the Press has a database of all state open records laws PRAs. Children Now, a nonprofit research and advocacy organization, used California's PRA process to collect child health performance metrics for each of the MCOs in the state and posted the metrics on its website.

CHILDREN NOW WEBSITE

Unlike Iowa, California does not have child health dashboard that posts performance data for individual MCOs. Instead, California's Medicaid child health dashboard presents statewide data, which is helpful for context but not for identifying which of the MCOs with which it contracts are performing well for kids and which are not. Children Now, a research and advocacy organization based in Oakland, California, decided to set up, in effect, its own MCO-specific child health dashboard. Advocates there submitted multiple PRA requests to obtain information on how each of the 25 MCOs performed in 2018 on four measures of child quality (childhood immunizations, well-child visits, adolescent immunizations and asthma medication). They issued a report identifying the high-performing and low-performing MCOs and posted the data for each MCO on their website. The organization also posted an analysis of individual MCO performance in 2019 on children's preventive services that will inform advocacy on the state's upcoming procurement.

APPENDIX 1. MCO-Specific Federal Requirements for Transparency, 42 CFR Part 438

This table lists the transparency provisions in the federal Medicaid managed care regulations at 42 CFR Part 438. CMS has issued guidance further explaining some of these regulatory provisions (e.g., medical loss ratio, rate review, contract review) but not the transparency requirements. The absence of federal emphasis on transparency may help to explain the lack of transparency on many state Medicaid agency websites relating to MCO performance for children or other beneficiary populations.

Requirement	Citation
The State must operate a Website that provides, directly or by link to individual MCO website, the following specified content:	438.10(c)(3)
1. Enrollee Handbook	438.10(g)
2. Provider Directory	438.10(h)
3. Drug Formulary	438.10(i)
In addition, the State must post the following program integrity content:	
4. MCO risk contract with State	438.602(g)(1)
5. Documentation for adequacy of MCO provider network submitted to the state per 438.207(b)	438.602(g)(2)
6. Name and title of individuals with ownership or control interest in the MCO (includes officers and directors per 455.101)	438.602(g)(3)
7. Name and title of individuals with ownership or control interest in each subcontractor (includes officers and directors per 455.101)	438.602(g)(3)
8. Results of independent audit of encounter and financial data (required at least once every 3 years per 438.602(e))	438.602(g)(4)
In addition, the State must post the following quality content:	
9. Accreditation status	438.332(c)(1)
10. External Quality Review Organization (EQRO) Annual Technical Report (by April 30 of each year)	438.364(c)(2)(i)
11. Managed Care State Quality Strategy (not MCO-specific)	438.340(d)

NOTE: Provisions 1 through 9 became effective during risk contracts starting on or after July 1, 2017; provisions 10 and 11 during risk contracts on or after July 1, 2018.

APPENDIX 2. State Medicaid Agency Website Best Practices

If you've seen one state's Medicaid website, you've seen one state's Medicaid website. Some are easy to navigate, while others bury relevant information in webpage after webpage. Poor website design hinders the transparency of a state's Medicaid program generally, and transparency with respect to individual MCOs in particular. Based on a review of 13 state Medicaid agency websites for MCO-specific performance data relating to children, CCF researchers found that the following practices increase transparency:

A landing page for one-stop shopping about Medicaid managed care in your state

- The landing page should be a centrally located webpage on the state Medicaid agency website. The landing page should present the basic information about your state's managed care program: which MCOs operate in the state, in which regions or counties they operate, and contact information for the MCOs. The Pennsylvania Medicaid agency's website has a page that provides a color-coded map showing the MCOs operating in each region of the state along with direct links to each MCO's website.
- In addition to this basic information, the landing page should include direct link to all of the other information about Medicaid managed care in the state. West Virginia's Medicaid agency website is a good example. Its managed care page links directly to monthly enrollment data for each MCO, to the Annual Technical Reports from the state's EQRO, and to the annual audited financial statement submitted by each MCO to the Insurance Department. The page also links to a report to the legislature that includes information specific to each MCO on: enrollment by eligibility group, including pregnant women (but not children); total claims denied and pended; number and percentage of grievances and appeals resolved in favor of enrollees; and medical loss ratio and administrative expenses.

A child health dashboard

- A managed care landing page should link to a child health dashboard that consolidates all MCO-specific information relating to children in one location. An example is Iowa, where the state Medicaid agency has built out its quarterly managed care performance report to include child-specific information for each MCO: enrollment by age group (<1, 1-4, 5-11, 12-21); well-child exams by age group; lead, hearing, and vision screenings by age group; and immunizations. Advocates in Iowa are working with the agency to augment this information. One limitation of the Iowa agency's dashboard is that it is not interactive and web-based. For an example of this technology, which allows updates more frequently than quarterly, see the Nevada agency's website.

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