American Journal of Law & Medicine (2023), 49: 4, 457–470
doi:10.1017/amj.2024.3

American Society of Law, Medicine & Ethics
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NOTES

The Need for Transparency in Medicaid Managed Care: Section 1115 Waiver Requirements as a Blueprint

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Abstract

Medicaid plays a significant role in the health care space, providing insurance coverage to nearly one quarter of the U.S. population. In recent years, managed care organizations have taken on an increasingly prominent role in the Medicaid space, and in many instances have become the sole insurance option for Medicaid recipients. The scale and method of implementation for managed care programs has varied widely from state to state. This Note discusses the many methods by which a state can enact managed care within its Medicaid program, and summarizes the challenges with assessing the success of such programs. It proposes a uniform approach to managed care reporting requirements designed to increase transparency and accountability across state lines, and in turn ensure quality care for Medicaid managed care beneficiaries.

Keywords: Medicaid Managed Care; Section 1115 waiver; healthcare regulation; reporting requirements

I. Introduction

Medicaid, the government-funded health care program for low-income individuals, has grown to provide health care to roughly one in every four Americans.[1] This equates to significant federal and state government spending, with roughly $728 billion spent on the Medicaid program in Fiscal Year 2021.[2] Historically and generally, states paid for Medicaid services under a fee-for-service structure wherein providers received payment directly from Medicaid programs for each service they performed.[3] This structure inherently places significant administrative and operational responsibilities on state governments. As the number of Medicaid recipients has continued to grow, these burdens have only increased, leading many states to seek alternatives to the fee-for-service model.

One such solution has been the introduction of Managed Care Organizations ("MCOs") into the Medicaid program. Under this model, state Medicaid programs contract with already-existing Health Maintenance Organizations ("HMOs"), Physician Health Plans ("PHPs"), or other institutional health

[1] *January 2023 Medicaid & CHIP Enrollment Data Highlights*, Ctrs. for Medicare & Medicaid Servs. https://www.Medicaid.gov/Medicaid/program-information/Medicaid-ansd-chip-enrollment-data/report-highlights/index.html [https://perma.cc/GM2P-36P4] (last visited May 15, 2023); *see also U.S. Census Quick Facts*, U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/US/PST045222 [https://perma.cc/RDH7-QVME] (last visited October 10, 2022) (estimating the U.S. population at 332,287,557).

[2] *Total Medicaid Spending*, KFF, https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/ [https://perma.cc/9PXV-K8NG] (last visited Jan. 26, 2023).

[3] *Provider Payment and Delivery Systems*, MACPAC, https://www.macpac.gov/Medicaid-101/provider-payment-and-delivery-systems/ [https://perma.cc/PZ2D-H9QC] (last visited Jan. 26, 2023); Glossary Definition of *Fee for service*, Ctrs. for Medicare & Medicaid Servs., https://www.healthcare.gov/glossary/fee-for-service/ [https://perma.cc/W5MK-X57S] (last visited Jan. 26, 2023).

care insurers to serve as Medicaid Managed Care Organizations ("MMCs").[4] These MMC contracts are typically procured via a competitive recruitment process.[5] Traditionally, state Medicaid plans will pay the MMC a fixed amount of money, otherwise known as a capitation rate, for each Medicaid recipient the MMC agrees to insure.[6] In return, the MMC accepts full financial risk and responsibility for that recipient's health insurance.[7]

As MMCs become increasingly popular, they are also becoming the only option for many Medicaid recipients. States may mandate that their Medicaid recipients enroll in an MMC plan as long as they offer a choice between at least two different MMC plan options.[8] Rural Medicaid recipients need not even be offered a choice between two different MMC plans so long as the MMC plan in which they are enrolled gives them an option between at least two different providers.[9] As a result, MMCs are now unavoidable for many Americans and are changing the face of the Medicaid program.

II. Why Implement MMCs Instead of Fee-For-Service Medicaid?

A. The Structure of Medicaid

Each state operates its own Medicaid program, with the programs being jointly funded by the program state and the federal government.[10] For every dollar that a state spends on Medicaid, the federal government matches a certain percentage of that spending under FMAP, the Federal Medical Assistance Percentage.[11] The FMAP for each state is calculated annually based on a formula comparing a state's average personal income to the federal average personal income, with higher percentages of federal matching going to states with lower average incomes.[12]

While the federal government specifies certain basic coverage requirements for all Medicaid programs, the majority of program decision-making and operation is left to the states.[13] As a result, Medicaid programs differ widely, and "variability … is the rule rather than the exception."[14] For example, some states still operate primarily under a fee-for-service model while others have fully transitioned to rely primarily on MMCs. Even among those states which utilize MMCs there is significant variation, beginning with the manner in which the MMC program is implemented.

B. How Do States Implement Managed Care in Their Medicaid Programs?

States can follow one of four methods to authorize the operation of MMCs: (1) executing a contract with MMCs via a competitive procurement process to provide a voluntary Medicaid managed care option under section 1915(a) of the Social Security Act ("SSA")[15]; (2) receiving a waiver under 1915(b) of the SSA allowing states to mandate that Medicaid enrollees receive their care from an MMC for two years

[4]Bowen Garrett et al., *Effects of Medicaid Managed Care Programs on Health Services Access and Use*, 38 Health Servs. Rsch. 575, 576 (2003).

[5]42 U.S.C. § 1396n(a) (2018).

[6]42 C.F.R. § 438.2 (2023).

[7]§§ 438.2, 438.3.

[8]42 U.S.C. § 1396u–2(1) (2020).

[9]§ 1396u-2(3).

[10]Elizabeth Williams et al., *Medicaid Financing: The Basics*, KFF (Apr. 13, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/ [https://perma.cc/8YAS-96GS].

[11]*Id.*

[12]*Id.*

[13]*Id.*

[14]*Medicaid 101*, MACPAC, https://www.macpac.gov/medicaid-101/ [https://perma.cc/UJ7T-ZCHC] (last visited May 15, 2023).

[15]Social Security Act, 42 U.S.C. § 1396(n)(a) (2023).

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

before requesting renewal for another two or five year period[16]; (3) receiving a waiver under 1115(a) of the SSA to mandate that all Medicaid enrollees receive coverage from an MMC[17]; or (4) by creating a state plan amendment as allowed under section 1932(a) of the SSA that allows states to require Medicaid beneficiaries to enroll in an MMC for an indefinite period of time until and unless the state chooses to alter the amendment.[18,19]

Each of these methods comes with different statutory requirements for enactment and compliance. Moreover, states are held to different reporting standards based on the authority under which their MMC programming is enacted. Although all states have to provide the Centers for Medicare & Medicaid Services (CMS) with programmatic information when seeking approval to contract with MMCs, significantly more detail is demanded from Section 1915(b) states as compared to Section 1932 states.[20] Additionally, while Section 1932 approvals tend to be relatively unrestrictive, Section 1915(b) approvals are typically accompanied by standard terms and conditions.[21] Section 1115 approvals are more restrictive still, requiring detailed and specific contracts between CMS and the state seeking approval.[22] It is generally much easier to implement a Medicaid managed care model under section 1932(a) than the other three provisions, and CMS' ability to place conditions on state plan amendments under that section is limited.[23] By comparison, Medicaid managed care models implemented under section 1115 waivers generally require "[special terms and conditions] that are detailed and state specific, and also establish evaluation requirements."[24]

These are but a few examples of the variation in requirements of states to use an MMC structure instead of a fee-for-service one; although all states operate programs MMC under the same title, the requirements they face and standards to which they are held are very different. Because of the variability between these MMC implementation methods, MMCs can be difficult to analyze and compare. Some programs have more specific and stringent statutory reporting requirements than others, some allow more state autonomy than others, and some require periodic federal approval for continued operation. These inconsistencies can make the overall analysis of MMCs murky and inconclusive. However, many have attempted to assess the impacts that managed care has on the Medicaid space and how MMCs stack up against traditional fee-for-service Medicaid.

MMCs have rapidly increased in use over the last thirty years. While MMCs covered only ten percent of Medicaid enrollees in 1991, that number shot up to fifty-seven percent by 2001.[25] By 2021, that number had risen to seventy percent of total beneficiaries and eighty percent of child beneficiaries.[26] The meteoric rise in popularity of MMCs would suggest that they provide proven benefits that make them better than fee-for-service models. However, a review of what limited data is available on the subject suggests that there is little to no evidence supporting this inference. It may be that the increase in MMCs has more to do with the emergence of statutory changes making their enactment easier to achieve than it does with evidence of program benefits.

[16] § 1396(n)(b).
[17] § 1315.
[18] § 1396(u-2).
[19] Medicaid and Children's Health Institute Program (CHIP) Programs, 81 Fed. Reg. 27498, 27500-01 (May 6, 2016) (to be codified at 42 C.F.R. pts. 431-457) [hereinafter 2016 Rule].
[20] *Key Federal Program Accountability Requirements in Medicaid Managed Care*, MACPAC, https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care/ [https://perma.cc/SM69-YGM8] (last visited Aug. 2, 2023).
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] Garrett, *supra* note 4, at 575.
[26] Andy Schneider & Allie Corcoran, *Medicaid Managed Care in 2021: The Year that Was*, Geo. U. Health Pol'y Inst. (Dec. 21, 2021), https://ccf.georgetown.edu/2021/12/21/Medicaid-managed-care-in-2021-the-year-that-was/ [https://perma.cc/UQ59-9XQN].

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

A. Do MMCs Promote Budgetary Goals Better than Fee-for-Service Medicaid?

MMCs are funded by fixed capitation rate payments, wherein states pay the MMC a certain amount per covered member per month.[27] These payments are usually made up-front to cover a twelve-month period, and federal law dictates that they must be "actuarially sound."[28] The formal definition of actuarial soundness leaves significant room for interpretation. It requires that capitation rates "provide for all reasonable, appropriate, and attainable costs that are required under the terms of [a] contract" and be developed in accordance with "generally accepted actuarial principles and practices."[29] However, the federal law fails to dictate that the capitation rate be developed according to any particular standard of care.[30] Some of the language in the 2020 Final Rule does suggest that capitation rate development may have had a muddied history in some states. As the drafters note, "[the] proposal was intended to eliminate any ambiguity in the regulation and clearly specify our intent that [capitation rate] variation … must be tied to actual cost differences and not to any differences that increase Federal costs and vary with the rate of [federal financial participation]."[31]

In recent years, CMS has attempted to crack down on state flexibility in determining capitation rate payments. Some states were permitted to work with rate ranges as wide as thirty percent when negotiating capitation rates with MMCs.[32] Such a wide rate range gave states broad power to determine how much MMCs should be paid per enrollee, potentially underequipping MMCs to provide competent care in some scenarios, and giving MMCs power to bargain for more than they needed in others. In short, this breadth suggests that states may have been abusing the lack of specific rate restriction in the federal regulations, and negotiating capitation rates that were not actuarially sound. Furthermore, CMS significantly restricted states' authority to retroactively make rate changes, admitting a concern that, "these changes are used to provide additional reimbursements to the managed care plans or to some providers without adding corresponding new obligations under the contract."[33] Overall, wide rate range variability and retroactive adjustments have made it difficult to cleanly assess how much money is going to MMCs. Some studies also suggest that the money, even if based on actuarially sound calculations, is not being spent where or how intended. A study in South Carolina found that when the state agreed to pay increased supplemental payments for high-risk and chronically ill patients, both the number of diagnoses and the number of non-urgent emergency room visits increased.[34] Researchers inferred that, despite the MMCs receiving more money for covering these patients, the money was not actually put towards patient treatment.[35]

Assessments of economic effectiveness are further muddied by the fact that many states "carve out" portions of care from MMCs and provide them under a fee-for-service structure instead. One prominent example of this practice is pharmacy benefits, where many states pay MMCs a capitation rate to provide the majority of patient care, and then separately cover those patients' medication costs under a fee-for-service model.[36] When states "carve in" pharmacy benefits, and make medication coverage part of the responsibility of the MMCs under the capitation rate payments, there is little clarity on spending and

[27]Elizabeth Hinton & Jada Raphael, *10 Things to Know about Medicaid Managed Care*, KFF (Mar. 1, 2023), https://www.kff.org/Medicaid/issue-brief/10-things-to-know-about-Medicaid-managed-care/ [https://perma.cc/3XVC-W4PK].

[28]*Id.*

[29]42 C.F.R. § 438.4(a)-(b)(1) (2023).

[30]Jeff C. Goldsmith et al., *Medicaid Managed Care: Lots of Unanswered Questions (Part 2)*, Health Affs. (May 4, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20180430.510086/full/ [https://perma.cc/VJ5E-K6HQ].

[31]Medicaid Program, 85 Fed. Reg. 72754, 72767 (Nov. 13, 2020) (to be codified at 42 C.F.R. pts. 438, 457) [hereinafter 2020 Rule].

[32]*Id.* at 72760.

[33]*Id.* at 72765.

[34]Daniela F. Montoya et al., *Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update*, 41 Ann. Rev. of Pub. Health 537, 543 (2020).

[35]*See id.*

[36]Christopher Smith et al., *States Are Questioning Medicaid MCO Rx Benefits*, Chain Drug Rev. (July 27, 2020) https://www.chaindrugreview.com/states-are-questioning-medicaid-mco-rx-benefits/.

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

pharmacy costs.[37] This is largely due to the fact that MMCs often use Pharmacy Benefit Managers ("PBMs") to negotiate medication costs with pharmacies.[38] States have little control or knowledge about how much PBMs profit on negotiations.[39] In 2018, the state of Ohio discovered that its PBMs were pocketing thirty-one percent of what they charged the MMCs, and made $662.7 million on generics in a single year.[40] Furthermore, after making the decision to "carve out" pharmacy benefits and cover them under fee-for-service rather than through MMCs, the state of West Virginia reported a savings of $54.4 million in the first year following its decision.[41]

Although MMCs are required by law to provide drug coverage consistent with that provided by fee-for-service Medicaid, MMCs typically impose stricter clinical requirements for medication coverage and utilize narrower preferred drug lists.[42] When four state Medicaid programs carved Hepatitis C medication coverage out of MMCs and instead began providing it under the fee-for-service structure, they found an increased use of the drug and anticipated improvements in health and quality of life as a result.[43]

To date, there is no peer-reviewed evidence supporting the belief that MMCs lead to cost-saving as compared to fee-for-service Medicaid.[44] Until Medicaid programs are required to collect and produce this kind of data, it will be impossible to conclusively assess whether MMCs improve spending transparency.

B. Do MMCs Provide Better Care than Fee-for-Service Medicaid?

Studies on clinical and health outcomes for MMC enrollees are limited, and the data they report is mixed. Even if there is a dearth of evidence to support the claim that MMCs make Medicaid spending more transparent, MMCs could still demonstrate added value by improving clinical outcomes for enrollees. Both supporters and opponents of MMCs make cogent arguments about the relationship between capitation rates and health care spending. Supporters of the program argue that the capitation rate pay structure incentivizes MMCs to provide better preventive care to avoid footing the bill for high-cost interventions later down the road.[45] Conversely, opponents argue that capitation rates incentivize MMCs to under-serve enrollees and deny costly care in order to maximize profits.[46] Unfortunately, an utter lack of data makes these arguments primarily theoretical.

A 2009 study reported that, as compared to their fee-for-service counterparts, adults enrolled in MMCs were 24.9% more likely to wait in excess of thirty minutes to see a primary care provider, 32% more likely to report problems with accessing specialists, and 10.2% less likely to report having received a flu shot within the last year.[47] Still, the researcher concluded that there were no dramatic changes in health care access between fee-for-service and MMC enrollees.[48] A 2003 study found that children enrolled in MMCs experienced better clinical outcomes, but adult women were more likely to report unmet need and decreased utilization.[49] A 2002 study found that outcomes for MMC enrollees were

[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] Samantha G. Auty et al., *Association of Medicaid Managed Care Drug Carve Outs with Hepatitis C Virus Prescription Use*, 2 JAMA Health F. 1, 2 (2021).
[43] *Id.*
[44] Goldsmith et al., *supra* note 30.
[45] Marguerite E. Burns, *Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities*, 44 Health Servs. Rsch. 1521, 1523 (2009).
[46] *Id.*
[47] *Id.* at 1530-32.
[48] *Id.* at 1533.
[49] Garrett et al., *supra* note 4, at 590-91.

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

equal or better to those for fee-for-service enrollees.[50] Moreover, it postulated that because MMC enrollees reported similar numbers of hospital admissions but less overall time spent in the hospital, MMCs perhaps spent more money on preventive care.[51]

Perhaps the biggest differences exist in patient populations with particularized needs. A 2022 study found that fee-for-service Medicaid was more generous with patients suffering from Opioid Use Disorder than MMCs were.[52] Similarly, a study from the early 1990s found that the health of elderly patients declined more rapidly on MMC plans than on fee-for-service plans.[53] Regardless, it is impossible to draw a reliable conclusion about MMC program efficacy based on two studies limited in size and conducted thirty years apart.

The reliability of data in this space is especially troubling considering the variable nature of MMCs. Although MMCs vary in their methods of operation even at a state level, studies suggest that because states report on all of their MMCs in combination, rather than on each contracted MMC individually, "aggregation masks significant variation in performance."[54] Beneficiaries enrolled in one MMC program will not have equal access to care when compared to beneficiaries enrolled in another.[55] Realistically, the data on MMC clinical efficacy is too poorly delineated and too dated to make any comprehensive conclusions about the relationship between clinical outcomes and Medicaid pay structure.

C. MMC Transparency (or Lack Thereof) in Reporting and Acquisitions

Many of the biggest issues with MMCs boil down to a lack of transparency. For a program that utilizes so much federal funding, states and MMCs receive surprisingly little oversight when it comes to the utilization of federal resources. In reviewing studies in this space, the emerging reality is that it is nearly impossible to draw reliable conclusions about whether MMCs are effective clinically and economically, or whether they improve budget predictability, simply because we don't have the data to answer those questions. Despite this ongoing shroud of mystery that cloaks Medicaid managed care programming, federal and state governments continue to fund Medicaid with little noise or complaint.

In late 2021, the Georgetown University Health Policy Institute conducted a thirteen-state study to assess how much transparency existed in the MMC space.[56] The study's key conclusion was that both transparency about program information and the quality of MMC care varied widely from state to state.[57] However, the study also noted that most of the study's thirteen states failed to provide key basic information about their programs. None of them provided MCO-specific information about Early and Periodic Screening and Diagnostic and Treatment metrics, nor did they provide metrics disaggregated by race and ethnicity, and only three states provided child enrollment data on an MCO-specific basis.[58] In sum, the paper concluded that the American public does not have "the information needed to tell whether or not MCOs are fulfilling their responsibilities to children and pregnant individuals enrolled in Medicaid."[59]

Information transparency can provide significant benefits, but the absence of transparency can also be deeply harmful. The most obvious harm is that Medicaid programs might end up paying MMCs too

[50]Lynda C. Burton et al., *Health Outcomes and Medicaid Costs for Frail Older Individuals: A Case Study of a MCO Versus Fee-for-Service Care*, 50 J. Am. Geriatric Soc'y 382, 382 (2002).

[51]*Id.* at 387.

[52]Amanda J. Abraham et al., *Coverage and Prior Authorization Policies for Medications for Opioid Use Disorder in Medicaid Managed Care*, 3 JAMA Health F. 1, 1 (2022).

[53]Burton et al., *supra* note 50, at 382.

[54]Allie Corcoran et al., Geo. U. Health Pol'y Inst., Transparency in Medicaid Managed Care: Findings from a 13-State Scan 17 (2021).

[55]*Id.*

[56]*Id.*

[57]*Id.* at 1.

[58]*Id.*

[59]*Id.* at 2.

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

much while receiving too little in turn, with taxpayer money not being spent in a way that maximizes its value and benefit to Medicaid enrollees.[60] However, some data suggests that the lack of transparency and oversight for MMCs also allows them to engage in unethical and discriminatory practices, including providing disproportionately low coverage to people of color. A 2001 study found that Black Medicaid beneficiaries required to enroll in MMCs showed lower overall service-use than white beneficiaries in comparable situations.[61] Furthermore, a Texas study found that MMCs made "strategic efforts" to avoid enrolling pregnant African American women because of their increased likelihood for pregnancy-related complications.[62] The study also found that MMCs which operated in areas with large African American populations were less likely to advertise the benefits they provided for pregnant women, and suggested that this was potentially a strategic decision made to minimize the enrollment of pregnant African American women.[63] Not only are such practices deeply unethical, but they are also violations of the law behind Medicaid: MMCs are not entitled to government payment if they discriminate on the basis of an enrollee's health status.[64] Unfortunately, the significant opacity of available data on MMC operation means that, at least in some instances, MMCs can engage in unethical and illegal practices while still receiving capitation payments without penalty.

D. What's in It for the MMCs?

The profitability of MMCs varies greatly state by state.[65] In 2019, one of West Virginia's four MMCs withdrew from the Medicaid market after determining that being part of the program was not cost-effective.[66] Conversely, California's Medicaid program fell under criticism in 2017, when it came to light that its MCOs made a $5.4 billion profit in only two years.[67] Of course, it is hard to imagine that managed care providers would continue to grow their presence in the Medicaid market if it was not proving profitable. One analysis found that in 2021 alone, three MCOs that were assessed grew their respective revenues between thirteen and forty-three percent.[68]

In practice, it can be very difficult to assess exactly how profitable any given MMC is. This is partially because many MMCs are subsidiaries of large national corporations, some of which do not break out their Medicaid-specific profits and losses when doing financial reporting.[69] Only three of the five biggest national-scale MMCs provide Medicaid revenue data, and only one of them discloses what percentage of its overall business comes from Medicaid.[70] The result of this is that states rarely know exactly how MMCs are spending Medicaid funds.[71]

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[60] *See* Andy Schneider et al., Geo. U. Health Pol'y Inst. Transparency in Medicaid Managed Care for Children and Youth in Foster Care 2 (2021).

[61] Ming Tai-Seale et al., *Racial Disparities in Service Use among Medicaid Beneficiaries after Mandatory Enrollment in Managed Care: A Difference-in-Differences Approach*, 38 Inquiry 49, 56 (2001).

[62] Montoya et al., *supra* note 34, at 544.

[63] *Id.* at 545.

[64] Social Security Act §1915(b), 42 U.S.C. 1396n(b).

[65] *See* Jeff C. Goldsmith et al., *Medicaid Managed Care: Lots of Unanswered Questions (Part 1)*, Health Affs. (May 3, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20180430.387981/full/ [https://perma.cc/AW9E-FVPR].

[66] Liz Beaulieu, *Not All MCOs Are Hot on Medicaid: Smaller and Nonprofit Organizations Exit, Consolidating Market*, Hme News, (May 2019) https://www.hmenews.com/article/not-all-mcos-are-hot-medicaid [https://perma.cc/Y86J-NW4A].

[67] Chad Terhune & Anna Gorman, *Insurers Make Billions off Medicaid in California During Obamacare Expansion*, L.A. Times (Nov. 5, 2017, 6:00 AM), https://www.latimes.com/business/la-fi-medicaid-insurance-profits-20171101-story.html [https://perma.cc/9EUR-RDWE].

[68] Andy Schneider & Ally Corcoran, *Medicaid Managed Care Financial Results for 2021: A Big Year for the Big Five*, Geo. U. Health Pol'y Inst. (Feb. 11, 2022), https://ccf.georgetown.edu/2022/02/11/Medicaid-managed-care-financial-results-for-2021-a-big-year-for-the-big-five/ [https://perma.cc/JQ83-NFKB].

[69] Goldsmith, *supra* note 65.

[70] Schneider & Corcoran, *supra* note 68.

[71] Goldsmith, *supra* note 65.

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

III. MMC Reporting Requirements – The 2016 Final Rule

In 2016, CMS published a final rule that detailed new reporting expectations of state Medicaid programs and MMCs.[72] The voluminous rule (termed "mega reg" by some) spanned 405 pages, and introduced a number of mechanisms intended to increase transparency and decrease fraud in Medicaid programs.[73] Acknowledging that MMCs utilize significant state and federal taxpayer dollars, CMS vowed to "adopt procedures and standards to ensure accountability and strengthen program integrity safeguards to ensure the appropriate stewardship of those funds."[74] Specifically, CMS identified goals of (1) modernizing the managed care regulatory structure; (2) promoting the effective use of data collection and analytics; and (3) strengthening actuarial soundness and improving accountability.[75] In order to achieve these goals, CMS introduced Medical Loss Ratios for MMCs, addressed the issue of pass-through-payments, and took limited action on regulating network adequacy standards and quality improvement strategies for MMC programs.[76]

Perhaps one of the most significant changes made in the 2016 Final Rule was the implementation of a Medical Loss Ratio (MLR), which had not previously existed for MMCs.[77] Originally enacted for health insurance carriers in 2011 under the Affordable Care Act,[78] MLRs prescribe what percent of income a health care provider must be spending directly on patient care in any given time period.[79] The 2016 Final Rule established a minimum MLR of eighty-five percent, meaning that, at maximum, MMCs are permitted to spend fifteen percent of their capitation rate income on overhead expenses like administrative costs and company profits.[80] The rule also authorized states to demand remittances if MMCs spent more than fifteen percent (or whatever smaller percentage the state chose as its MLR) on overhead costs.[81] Notably, CMS allowed states to determine whether to grant an exemption to the MLR requirement for new MMCs during their first year of operation, indicating a preference to leave decision-making to state-level program leaders when possible.[82]

In calculating MLR data, most states rely on financial data that has been reported by MCOs to state insurance regulators.[83] Some states go further, requiring MCOs to submit enrollee encounter data (information pertaining to items and services received by Medicaid enrollees) and then comparing that data against the financial reports to assess their accuracy.[84] CMS noted that federal matching funds to state Medicaid programs were predicated on the states reporting enrollee encounter data, and that Medicaid programs would not receive matching funds for any enrollees whose encounter data they failed to report in an "accurate, complete, and timely" fashion.[85]

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[72]2016 Rule, *supra* note 15, at 27498.

[73]Kelly Hightower Hibbert et al., *2020 Medicaid Managed Care Rule Summary*, Crowell (Feb. 16, 2021), https://www.cmhealthlaw.com/2021/02/2020-medicaid-managed-care-rule-summary/ [https://perma.cc/MF3P-TU9S].

[74]2016 Rule, *supra* note 19, at 27501.

[75]*Id.*

[76]*Id.* at 27521, 27530, 27567.

[77]Julia Paradise & MaryBeth Musumeci, *CMS' Final Rule on Medicaid Managed Care; A Summary of Major Provisions,* KFF (Jun. 9, 2016), https://www.kff.org/Medicaid/issue-brief/cmss-final-rule-on-Medicaid-managed-care-a-summary-of-major-provisions/ [https://perma.cc/3S52-SAQP]; 42 C.F.R. § 438.74(a) (2023).

[78]Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010); Jennifer Haberkorn, *Medical Loss Ratios (Updated)*, Health Affs. (Nov. 17, 2010), https://www.healthaffairs.org/do/10.1377/hpb20101124.949788/ [https://perma.cc/46TZ-W4X7].

[79]Glossary definition of *Medical Loss Ratio (MLR)*, Healthcare.gov, https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/ [https://perma.cc/D6J5-MVED] (last visited May 15, 2023); *Medical Loss Ratio*, Healthinsurance.org https://www.healthinsurance.org/glossary/medical-loss-ratio/ [https://perma.cc/Q7JX-2A39] (last visited May 15, 2023).

[80]2016 Rule, *supra* note 19, at 27524.

[81]*Id.*

[82]*Id.* at 27533.

[83]Allan Baumgarten, LLC, Analyzing Medicaid Managed Care Organizations: State Practices for Contracting With Managed Care Organizations and Oversight of Contractors 16 (2020).

[84]*Id.*

[85]2016 Rule, *supra* note 19, at 27737.

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The 2016 Final Rule also announced the termination of permissible pass-through payments.[86] Pass-through payments are one "distinguishing characteristic" of MMC pay structures, and allow states to contractually require their contracted MMCs to "pay providers an amount that is disconnected from the amount, quality, or outcomes of services delivered to enrollees under the contract during the rating period of that contract."[87] Effectively, pass-through payments allow MCOs to receive Medicaid funding while bypassing rules and requirements they are supposed to comply with in order to qualify for that funding.

Next, the 2016 Final Rule addressed the issue of network adequacy standards by requiring each state to assess whether they were supplying an adequate network of providers based on time and distance standards.[88] However, CMS did not go so far as to establish these time and distance standards. Instead, CMS left it up to the states to determine what amount of travel time and distance between enrollees and providers would be sufficient to constitute network adequacy.[89]

Finally, while CMS had initially intended to implement rules requiring every state Medicaid program to initiate its own quality improvement strategy, significant pushback led CMS to settle on requiring that states have a "managed care quality strategy."[90] Prior to the 2016 Final Rule, states were required to develop and publish a Medicaid managed care quality rating system ("MMC QRS") but only to make the technical reports available upon request.[91] In the body of the rule, CMS made clear it had considered the possibility of enacting federal quality rating standards that every state operating any portion of its Medicaid program under a managed care model would have to follow.[92] CMS outlined what this federal MMC QRS would have entailed, including a focus on "clinical quality management; member experience; and plan efficiency, affordability, and management."[93] However, CMS eventually settled on a policy by which states could opt to utilize the MMC QRS developed by CMS or implement their own version of MMC QRS so long as it yielded "substantially comparable" information to the federally developed CRS.[94]

Overall, the 2016 Final Rule took moderate steps towards transparency and accountability. However, it reflected hesitation on the part of CMS to enact regulations which might be viewed as overly burdensome or stringent. Despite acknowledging issues with oversight, the Rule failed to implement firm national measures that would hold all state MMCs to a consistent standard. While the rule mandated network adequacy and quality strategy standards, it gave the states flexibility to define those terms. Even with this softer regulatory approach, the next administration weakened the 2016 Final Rule.

IV. The 2020 Final Rule and Beyond

CMS Administrator Seema Verma, appointed early in the Trump Administration, announced a close review of the 2016 Final Rule.[95] One day before the 2016 Final Rule was to be implemented, CMS released a bulletin pausing compliance while CMS determined any new adjustments.[96] These moves were a reflection of the Trump Administration's efforts to undermine Medicaid and address complaints that the

[86] *Id.* at 27860-61.
[87] 2020 Rule, *supra* note 31 at 72783.
[88] 2016 Rule, *supra* note 19, at 27653.
[89] *Id.* at 27658.
[90] *Medicaid Managed Care Final Rule: Implications for Missouri*, Mo. Found. for Health, https://mffh.org/wp-content/uploads/2016/08/Medicaid-Managed-Care-Final-Rule.pdf [https://perma.cc/R6R8-JZ5J] (last visited May 15, 2023).
[91] 2016 Rule, *supra* note 19, at 27626.
[92] *Id.* at 27679.
[93] *Id.* at 27686.
[94] *Id.* at 27687; 42 C.F.R. § 438.334(a) (2020).
[95] Elizabeth Hinton & MaryBeth Musumeci, *CMS's 2020 Final Medicaid Managed Care Rule: A Summary of Major Changes,* KFF (June 30, 2017) https://www.kff.org/medicaid/issue-brief/cmss-2020-final-medicaid-managed-care-rule-a-summary-of-major-changes [https://perma.cc/ES6N-6522].
[96] *Id.*

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

2016 Final Rule imposed excessive administrative burden on states and MMCs.[97] The bulletin was nonspecific about both which states were being affected and what kinds of changes CMS intended to make moving forward.[98] Several years later, CMS published the 2020 Final Rule, which significantly loosened many of the restrictions established by the 2016 Final Rule.[99]

The 2020 Final Rule amended the 2016 Final Rule in several ways: First, in an effort to accommodate states' desires to continue making pass-through-payments in order to retain certain providers and transition more fee-for-service recipients into MMC programs, CMS announced that pass-through payments would now be permitted in the first three years of life of a contract being transitioned from fee-for-service to managed care payment.[100]

Next, CMS removed the network adequacy requirements which focused on time and distance requirements between enrollees and their available providers, and instead allowed each state's Medicaid program to define network adequacy in its own terms.[101] While the 2020 Final Rule encouraged states to integrate multiple definitions of adequacy in order to ensure access, it left all of the key decision-making to the states.[102] Not only did CMS grant states the power to determine what level of access to specialists is sufficient for Medicaid recipients, it also allowed states to define what a specialist was in their own terms, asserting that states are best equipped to make those decisions.[103] Some states choose to define network adequacy standards via statutes and regulations, but the majority define it within the body of their contracts with MMCs.[104]

Finally, the 2020 Final Rule loosened the requirements of a state-developed QRS. Acknowledging that different states may have different administrative capabilities, the rule did away with the requirement that a state-developed QRS yield "substantially comparable" information to the federally-developed one, instead requiring that the information be substantially similar only "to the extent feasible."[105] This decision has not gone without criticism.[106] In the 2020 Final Rule, CMS acknowledged that many "commenters expressed concerns that this proposal would create too much flexibility, limiting comparability and allowing states to implement inadequate rating systems with measures that are not useful for Medicaid populations, especially vulnerable populations within their state."[107]

Overall, the 2020 Rule reflected a trend toward state autonomy at the potential cost of consistency and program efficiency. Allowing states to characterize network adequacy and quality rating standards for themselves leaves room for inconsistency in definitions, both between state Medicaid programs and between MMCs in the same state. This inconsistency means that beneficiaries may face a lack of access to specialist care in states that choose to enact looser definitions of network adequacy.

Roughly two years after releasing the 2020 Final Rule, CMS uploaded standardized reporting templates to its website, with the stated intention of "help[ing] states improve their monitoring of Medicaid and CHIP managed care programs."[108] Reporting with the new templates was set to begin in

[97]Alexander Somodevilla, *CMS Releases the New Medicaid Managed Care Final Rule*, Foley Hoag LLP (Nov. 13, 2020), https://www.medicaidandthelaw.com/2020/11/13/cms-releases-the-new-medicaid-managed-care-final-rule/ [https://perma.cc/EL8S-YYQR].

[98]*See id.*

[99]2020 Rule, *supra* note 31, at 72754.

[100]*Id.* at 72784.

[101]*Id.* at 72802.

[102]*Id.*

[103]*Id.* at 72806.

[104]*Id.* at 72781.

[105]Elizabeth Hinton et al., *State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid,* KFF (Jan. 12, 2022), https://www.kff.org/Medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-Medicaid/ [https://perma.cc/FC57-CGU9].

[106]*See, e.g.,* 2020 Rule, *supra* note 27, at 72813.

[107]*Id.*

[108]Ctrs. for Medicaid & Chip Servs., Informational Bulletin on Medicaid and CHIP Managed Care Monitoring and Oversight Tools (2022).

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

late 2022, and CMS planned to publish the resulting data on its website to ensure public accessibility.[109] Whether states will comply with these expectations, and whether CMS will deliver on its public accessibility promise, remains to be seen. Additionally, although CMS regulations clearly require MMCs to be monitored, no guidance has been issued as to how CMS will monitor state compliance with that requirement nor how, if at all, it will utilize that data.[110]

Evidence of compliance with new reporting requirements is mixed. A 2021 study found that eight of thirteen states did not publicly post the risk contracts between themselves and specific MMCs, some posted drafts rather than final contracts, and one posted an expired contract.[111] All of the states posted their Annual Technical Report, but only nine posted the accreditation status of each MMC with which they contracted as is required.[112] Furthermore, only one state provided information about how much money it paid each of its MMCs to provide care to its enrollees, and none of the states provided information reflecting how much states paid MMCs specifically for the care of children and pregnant people.[113] There is an asymmetry between the information about Medicaid managed care that CMS purports to require from states, and the information that states actually provide.

The guidance on MMC evaluation and reporting requirements is a hodgepodge of recommendations lacking internal consistency, and it falls short on requiring the data states really need to ensure adequacy of programming. Luckily, CMS already has a framework after which all MMC reporting requirements could be successfully modeled: the requirements for Section 1115 waiver programs.

V. Section 1115 Waiver Requirements

A. Understanding Section 1115 Waivers as a Model

Section 1115 waivers allow the Secretary of HHS to waive certain Medicaid requirements so that states may perform "experimental, pilot, or demonstration project[s]."[114] The ACA required states to adhere to strict reporting protocols for waivers.[115] Every state must hire independent evaluators to assess the demonstration program's progress, as well as enrollment and spending, and to provide quarterly and annual reports based on that data.[116] CMS regulations specify expectations for both development of evaluation design as well as reporting mechanisms.[117] CMS will evaluate state waiver renewal requests in part on these evaluations.

CMS provides guidance to states on establishing a program evaluation design, stressing a "principal focus" of "obtaining and analyzing data on the process … outcomes … and impacts of the demonstration" so as to better "inform policy decisions."[118] Among the statutory requirements for states applying for section 1115 waivers is a public notice and comment period before submitting waiver

[109]Andy Schneider, *Transparency in Medicaid Managed Care: Are the Times A-Changin'?*, Geo. U. Pub. Health Institute (Jul 26., 2022), https://ccf.georgetown.edu/2022/07/26/transparency-in-Medicaid-managed-care-are-the-times-a-changin/ [https://perma.cc/5ABP-Y4GF].

[110]MACPAC, *supra* note 20.

[111]Corcoran et al., *supra* note 54, at 15.

[112]*Id.*

[113]*Id.* at 17.

[114]42 U.S.C. § 1315(a)(1) (2012).

[115]*Id.* at (e).

[116]*Section 1115 Research and Demonstration Waivers*, MACPAC, https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/ [https://perma.cc/556R-J28J] (last visited Jan. 20, 2023); *1115 Demonstration State Monitoring & Evaluation Resources: General Monitoring and Evaluation*, Ctrs. for Medicare & Medicaid Servs., https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html [https://perma.cc/AY6Y-9KLR] (last visited Oct. 10. 2023).

[117]*Section 1115 research and demonstration waivers*, MACPAC (last visited Jan. 20, 2023), https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/ [https://perma.cc/556R-J28J] (last visited Jan. 20, 2023); Ctrs. for Medicare & Medicaid Servs., Section 1115 Demonstrations: Developing the Evaluation Design (2020).

[118]Ctrs. for Medicare & Medicaid Servs., Section 1115 Demonstrations: Developing the Evaluation Design (2020).

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

applications; a federal notice and comment period before HHS approves a waiver; a public forum for feedback six months post-implementation; cooperation with an independent evaluator selected by CMS after waivers are approved; the use of quantitative research methods; and annual reporting on metrics including financial performance, care outcomes, and beneficiary satisfaction, which must be both reported to CMS and posted publicly on the state's website.[119] Moreover, CMS retains the right to terminate the section 1115 grant at any time for noncompliance with statutory requirements.[120] One of the primary goals for these requirements is ensuring that state evaluations adequately identify whether or not the demonstration achieves the goals set forth in its section 1115 waiver application.[121] This in turn impacts whether HHS will approve state applications to renew waivers:

> [State Medicaid programs seeking to extend their existing section 1115 waivers are required to present] the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program[;] … [s]ummaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration[;] … [f]inancial data demonstrating the state's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration[;] … [a]n evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions[; and] … [d]ocumentation of the State's compliance with the public notice process, … with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration application.[122]

Effectively, to continue receiving federal funding while operating under a section 1115 waiver, states must provide financial data and proof of efficacy as well as evaluations and evidence of compliance with all state laws, including those requiring data reporting and transparency with the public.

As discussed prior, section 1115 waivers are the method some states have used to implement MMC programming, and states that opt for this method are subject to a "significantly greater level of detail" than their counterparts which introduce managed care programming through alternative means (e.g., via a section 1932 state plan amendment).[123] They are also subject to additional expectations, such as the provision of "extensive information regarding [their] evaluation process[es]" as well as "submi[ssion] of [their] monitoring efforts to CMS" and "submi[ssion] of periodic monitoring reports and waiver evaluations."[124] MACPAC, a federal agency that makes policy and data recommendations to CMS, has suggested that the evaluation requirements and higher level of detail required of states that implement Medicaid managed care subject to a section 1115 waiver "reflect[s] that waivers under Section 1115 are for demonstration purposes."[125]

B. Section 1115 Waiver Reporting Practices & California Procurement Process as a Guidebook

Other than the regulatory path to enactment a state chooses to follow, it is not entirely clear what makes MMCs "for demonstration purposes" in some states but not in others. Considering that there is little to

[119]42 C.F.R. § 431.408-431.428 (2023).

[120]§ 431.420(d).

[121]Ctrs. for Medicare & Medicaid Servs., Section 1115 Demonstrations: Developing the Evaluation Design (2020).

[122]42 C.F.R. § 431.412(c)(2).

[123]MACPAC, *supra* note 20.

[124]*Id.*

[125]*Id.*

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

no large-scale or peer-reviewed data suggesting that MMCs save money, improve clinical outcomes for enrollees, or improve state budget predictability when compared to the standard Medicaid provision method of fee-for-service care, classifying MMCs as "experimental" seems entirely appropriate. Indeed, commentators have called states' enrollment of child beneficiaries in MMCs serving only children "a natural experiment."[126] With the lack of data currently available, enrolling children in MMCs is ultimately an experiment in how their health outcomes will compare with those of children enrolled in traditional Medicaid. An experiment in children's health care quality is an inherently dangerous one. Considering the federal government's well-established understanding of the unique concerns of personal dignity, autonomy, and need for consent when dealing in human subjects research, this commentary is particularly relevant.[127]

Increasing information transparency is an effective and relatively inexpensive way to ensure and improve MMC program quality.[128] Transparency provides Medicaid stakeholders with the information they need to reward high-performing MMCs and to hold low-performing MMCs accountable; it also creates an incentive for MMCs to provide the best care possible in order to protect their public reputations while simultaneously incentivizing state Medicaid offices to increase their managed care oversight in order to prevent being viewed as inefficient stewards of taxpayer dollars.[129]

Certainly, regardless of the designation or label that MMCs receive, increased evaluation and analytical measures are necessary. The evaluation and reporting process in place for section 1115 waivers creates an excellent guidebook, could be easily translated into new regulations for Medicaid managed care programs in all states, and would improve program transparency greatly. Additionally, requiring regular review periods and predicating the continued operation of MMC programs on compliance with evaluation and reporting protocols and proof of clinical or economic benefit would ensure that government funds and enrollee interests are maximally protected. Moreover, requiring states to provide data disaggregated by race and ethnicity would increase transparency and help to ensure equitable access to care for all Medicaid recipients.[130]

Finally, increasing transparency around MMC reporting would give state Medicaid programs the information they need to learn from each other's mistakes and success. California's approach to MMC procurement in 2022 is a perfect example of this.[131] During its procurement process, California required that all applying MCOs submit comprehensive information about their operations and histories.[132] The required information included any and all enforcement actions taken against the company in the past five years (or, in the case of a subsidiary, taken against either the subsidiary or its parent company), the number and outcome of enrollee grievances, and annual quality performance measures.[133] Furthermore, all of this data was publicly reported with the stated intention of providing clarity and feedback to organizations which were not chosen, and creating new expectations about transparency while establishing a perspective that MMCs are fundamentally public entities with duties of transparency, not private entities entitled to secrecy.[134]

[126]Andy Schneider & Allie Corcoran, *Medicaid Managed Care for Foster Care Children and Youth: A Natural Experiment with Little Transparency*, Geo. U. Health Pol'y Inst. (Oct. 12, 2021), https://ccf.georgetown.edu/2021/10/12/Medicaid-managed-care-for-foster-care-children-and-youth-a-natural-experiment-with-little-transparency/ [https://perma.cc/8XKS-42KN].

[127]*The "Common Rule"*, Nat'l Inst. Just. (Nov. 19, 2007), https://nij.ojp.gov/funding/common-rule [https://perma.cc/L9S5-F8BK].

[128]Corcoran et al., *supra* note 54, at 4.

[129]*Id.*

[130]*Id.* at 17.

[131]Andy Schneider, *California's Medicaid Managed Care Procurement: A Transparency Event*, Geo. U. Health Pol'y Inst. (Oct. 18, 2022), https://ccf.georgetown.edu/2022/10/18/californias-Medicaid-managed-care-procurement-a-transparency-event/ [https://perma.cc/8DDP-DKCH].

[132]*Id.*

[133]*Id.*

[134]*See id.*

https://doi.org/10.1017/amj.2024.3 Published online by Cambridge University Press

Already, one private MCO which was not selected has appealed the decision, stating that the procurement process was "highly flawed" and that a competing provider that beat it out for a Medicaid contract provided "false" information in its proposal.[135] Ironically, these allegations of falsification coming to light indicate California's process is successful. Whether the allegations have merit or not, their investigation will increase transparency and allow California to be sure that it is selecting better MMC providers for its Medicaid enrollees.

VI. Conclusion: More Transparency Is Needed and Section 1115 Waivers Are a Blueprint

MMCs could be improved by a number of interventions. However, increasing transparency requirements and streamlining those requirements to be identical from state to state is a key starting point. Honest and comprehensive reporting holds stakeholders accountable, provides the data needed for reliable studies, allows programs to learn from each other, and gives states the information they need to make informed decisions about the improvement of beneficiary care.[136] Section 1115 waiver requirements are a readily available blueprint to which some state MMC programs are already subject. Applying those expectations to every state would increase MMC transparency (and accordingly, program quality) nationwide.

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[135]Bernard J. Wolfson, *Health Plan Shake-Up Could Disrupt Coverage for Low-Income Californians*, KFF Health News (Sep. 27, 2022) https://khn.org/news/article/health-plan-shake-up-could-disrupt-coverage-for-low-income-californians/ [https://perma.cc/XR2Q-A3J2].

[136]Corcoran et al., *supra* note 54, at 4.

Cite this article: Doherty, N. (2023), 'The Need for Transparency in Medicaid Managed Care: Section 1115 Waiver Requirements as a Blueprint', *American Journal of Law & Medicine*, **49**, pp. 457–470. https://doi.org/10.1017/amj.2024.3