

December 2025 MACPAC Meeting: Accountability and Oversight in Medicaid Managed Care

On December 11, 2025, the Medicaid and Children’s Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) held a public meeting, which included a session titled, *State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations: Interview Findings*. This summary highlights key takeaways from that session.

The full meeting agenda and session presentations are available [here](#).

MACPAC EXAMINES STATE AND FEDERAL OVERSIGHT TOOLS FOR MEDICAID MANAGED CARE

During the session, MACPAC provided an update on its ongoing examination of accountability mechanisms in Medicaid managed care, with a focus on the tools available to states and the federal government to oversee managed care organizations (MCOs). Managed care plays a dominant role in Medicaid delivery: 41 states and the District of Columbia contract with MCOs, and approximately 73 percent of Medicaid beneficiaries are enrolled in managed care, accounting for 56 percent of total Medicaid spending.

Oversight responsibility largely rests with states, with the Centers for Medicare & Medicaid Services (CMS) maintaining more limited federal authority. Federal oversight currently includes identifying conflicts of interest, verifying contractors, approving state-MCO contracts, and reviewing actuarial rate certifications. When MCOs violate federal requirements, CMS may withhold federal matching funds or refer the case to the Office of the Inspector General (OIG) for further investigation, potentially resulting in monetary penalties. Certain violations — such as failure to provide medically necessary services, misrepresentation of information, or overcharging — may also trigger required MCO state-level sanctions before the state can renew an offender’s contract.



Findings from Stakeholder Interviews and Data Analysis

As part of its research, MACPAC conducted wide-ranging stakeholder interviews in 2024 and 2025 focused on contract requirements, accountability tools, and CMS's oversight role. Interviewees noted that many states consider MCO's past performance during the bid evaluation process. In some cases, this leads to enhanced monitoring provisions. One state, for example, reported instituting monthly reporting and tracking requirements in response to historical service denial issues. However, not all states have this flexibility, as some states limit or prohibit such practices.

MACPAC staff found that states employ a wide variety of accountability tools for existing MCO contracts. In response to potential violations, states typically begin with informal processes and escalate to formal sanctions. All six states interviewed reported having thresholds under which certain violations automatically trigger penalties. States also use incentives to influence MCO behavior, though stakeholders noted that these can be complicated by legal challenges from MCOs or appeals to state legislators.

Transparency practices vary across states. Four of six states interviewed publish MCO Corrective Action Plans (CAPs), while two others only publish quality measure performance data. At the federal level, CMS's primary punitive action is the deferral of federal matching funds, which applies only to the full capitation payment amount. Stakeholders expressed concern that this "all-or-nothing" approach limits CMS's ability to respond proportionately. Several suggested more flexible tools, such as the authority to impose CAPs on states or defer a portion of matching funds. Others recommended the creation of a nationwide database of MCO contract violations and sanctions.

MACPAC also analyzed Managed Care Program Annual Reports (MCPARs), which states are required to post publicly. From September 2023 to August 2024, staff identified 359 CAPs across states. Only 12 of these CAPs (3.3 percent) were associated with financial penalties, most of which were under \$5,000. More than half of reported sanctions (54.8 percent) were remediated within 90 days, while only 3 percent took longer than 360 days to resolve. Overall, stakeholders generally believed states had sufficient oversight tools but emphasized the need for improved public reporting.

Commission Discussion

Commissioners broadly supported the findings but raised concerns about gaps in MCPAR reporting and whether the data adequately capture the full scope of state enforcement activity. They noted that inconsistencies in completeness and definitions limit the usefulness of MCPARs for procurement decisions, cross-state comparisons, and public accountability. Several commissioners emphasized the need for clearer

definitions, technical assistance, and improved usability before imposing additional reporting requirements.

Commissioners also discussed whether CMS should have intermediate enforcement authority in managed care similar to that available in fee-for-service Medicare, while cautioning against undermining state flexibility or imposing uniform approaches across diverse Medicaid programs. Others highlighted the importance of incorporating beneficiary and provider perspectives, increasing transparency around performance data, and placing sanctions in the context of broader oversight strategies.

The Commission broadly indicated interest in further analysis of potential MCPAR improvements, development of CMS guidance or toolkits for states, and evaluation of whether existing federal oversight authorities are sufficient to ensure accountability across Medicaid delivery systems.

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