Managed Care as Medicaid's Administrative Architecture: Does It Still Provide Value to States?

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CONTENTS

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ABSTRACT

After three decades of expansion, managed care organizations (MCOs) — health insurance plans that contract with state governments — now finance and deliver care for more than 70% of Medicaid enrollees. Yet MCOs have largely assumed this role by default rather than design. As states brace for federal funding cuts and potentially large disenrollments in Medicaid, this report assesses the extent to which Medicaid managed care delivers value across its core functions: reducing financial risk for states; utilization management; network formation; care management; quality improvement; and paying for claims. We conclude that many of the functions MCOs perform, including care management, quality oversight, and utilization control, could be carried out more transparently and at potentially lower administrative cost through centralized, standardized processes. We examine alternative administrative approaches states could pursue to strengthen accountability, efficiency, and outcomes in the Medicaid program — and offer key questions for states to consider as they assess the value that MCOs bring to their programs.

POLICY POINTS

- As Medicaid managed care has expanded, it has evolved from a payment mechanism to the dominant approach for administering all of Medicaid's core functions.
- As states brace for federal Medicaid funding cuts and lower enrollment, they may benefit from reassessing which of Medicaid's administrative functions are best performed by managed care, and which functions might be better performed through a centralized process.

INTRODUCTION

Medicaid and the Children's Health Insurance Program (CHIP) are the largest sources of insurance coverage in the United States, covering almost 75 million people,[1] including approximately 1 in 5 people living in the US, 2 out of 5 children, 3 out of 5 nonelderly adults in poverty, 2 out of 5 nonelderly adults with disabilities, and a disproportionate share of Black, Hispanic, and American Indian or Alaska Native children and adults.[2,a] Medicaid's core goal is to provide essential health coverage and services to low-income Americans, including children, pregnant individuals, older adults, and people with disabilities. In fiscal year 2023, Medicaid spending totaled nearly $900 billion — about $620 billion in federal funds and $280 billion in state funds[3] — accounting for roughly one-fifth of all US health care expenditures.[2]

Alongside this growth, the administration of the Medicaid program has also transformed over the decades. Enacted in 1965, the Medicaid program was initially administered by state agencies under the fee-for-service (FFS) model. In the 1990s, as part of a broader movement to introduce market-based principles into health policy, states began outsourcing the administration of Medicaid to private "risk-bearing" entities, known as managed care organizations (MCOs). In 1995, just 15% of Medicaid recipients were enrolled in comprehensive risk-based managed care; by 2009, that share had grown to 47%.[4] By 2024, 70% of all Medicaid enrollees were in managed care, with 41 states and the District of Columbia using some form of MCO contracting.[5]

As managed care has expanded, it has evolved from a payment mechanism to the dominant administrative layer through which states administer Medicaid. This trajectory raises a fundamental question: is managed care is the most effective administrative vehicle for achieving states' goals, or could alternative approaches better align accountability, state capacity, and value? This question is particularly salient as states face new federal policy changes that will reduce enrollment and funding. This brief evaluates MCO value propositions across core administrative functions and outlines policy-relevant considerations for states contemplating the most effective program structure to achieve their Medicaid program goals.

OVERVIEW OF MEDICAID MANAGED CARE

MCOs operate within a complex web of accountabilities that reflects their hybrid role as publicly financed but privately administered entities. (We note that the term *managed care* is itself somewhat ambiguous; for the purposes of this brief, we define *managed care* as the use of private health insurance plans that contract with state governments to deliver health care, while acknowledging that several states rely on less-traditional models that still retain much of the MCO framework.) Their most direct accountability lies with state Medicaid agencies, which negotiate contracts with MCOs that stipulate a fixed per-member, per-month capitation rate for delivering covered services. These detailed contracts define requirements for network adequacy, quality reporting, and financial oversight, making MCOs accountable to both the state and taxpayers. MCOs also answer to their members, who enroll at no direct cost

[a] CHIP, which covers children in families with incomes above Medicaid eligibility thresholds, is administered alongside Medicaid in most states and is typically subject to the same managed care arrangements that are the focus of this brief.

and may choose among plans when more than one is available. For these members, MCOs serve as the organizing hub for access to care and benefit management.

Beyond the state and Medicaid enrollees, a third set of relationships involves providers, who deliver services and are reimbursed by MCOs. Typically, provider supply is constrained, and payment rates are below commercial levels. Maintaining adequate networks, therefore, requires MCOs to balance cost containment with competitive payment rates and strong provider relationships. Ownership structure adds a fourth dimension of accountability. A growing number of MCOs are owned by large, publicly traded for-profit parent firms; in 2020, five national parent firms — UnitedHealthcare, Centene, Elevance, Molina, and Aetna/CVS — accounted for 60% of managed care enrollment.[6] These ownership attributes are likely to influence organizational mission, reinvestment, and responsiveness to state and local priorities.

States also differ widely in how they use managed care across Medicaid populations and benefits. Some rely primarily on MCOs for low-income families, children, and expansion adults, while others extend MCO coverage to individuals who are aged, blind, or disabled; certain undocumented groups; or dually eligible beneficiaries. Federal matching rates and fiscal considerations shape these choices, as do decisions about whether to include behavioral health, prescription drugs, or long-term services and supports within managed care contracts. States also use MCO contracts as a vehicle for broader policy goals, including payment reform and programs to address health-related social needs.

HOW ARE MEDICAID MANAGED CARE PLANS PERFORMING ON THEIR CORE FUNCTIONS?

MCOs are charged with reducing financial risk for states, managing service utilization, building and maintaining provider networks, coordinating care across settings, overseeing and improving quality, and processing payments to providers. The promise of managed care is that these entities have advantages over traditional fee-for-service (FFS) Medicaid, in which beneficiaries use their Medicaid coverage to see any enrolled provider, and the state pays for each service directly. Understanding the core responsibilities of Medicaid MCOs and their performance in these areas is essential for assessing the value that MCOs may provide to states. Exhibit 1 summarizes the current state of MCO functions and identifies where alternative administrative approaches may be warranted. The following sections look at each function in depth.

Exhibit 1. Functions of Medicaid Managed Care Organizations: Status Quo vs. Alternative Approaches

Function	Status Quo	Alternative Approach
Reducing financial risk for states	Capitation theoretically shifts risk to MCOs, but actuarial rate setting often reprices prior costs rather than reducing them. Savings may flow to shareholders rather than taxpayers, while states remain exposed to rising rates.	Test whether capitation truly transfers risk through independent audits and rate reviews. Consider hybrid models — state-managed medical services with centralized pharmacy management — to achieve fiscal stability without excessive administrative layering.
Utilization management	MCOs use prior authorization and other supply-side controls to contain costs, but effects on access, outcomes, and overall value are mixed. These mechanisms also impose heavy administrative burdens on providers.	Standardize utilization management rules and integrate them with EHR systems for real-time decision support. Streamline approval processes statewide to reduce redundancy and shift oversight to evidence-based, transparent criteria.
Network formation	MCOs are responsible for building and maintaining provider networks. Network adequacy rules are intended to ensure access, but provider directories often include "phantom" listings, and networks across MCOs overlap significantly.	Centralize or standardize network formation at the state level through a single, verified provider directory and common adequacy standards. Focus on network transparency, provider stability, and targeted incentives for underserved areas rather than duplicative contracting.
Care management	MCOs and providers both operate care management programs, often duplicating efforts and confusing accountability. Evidence of superior outcomes under MCO-led models is limited.	Consolidate care management functions through state or regional platforms using shared risk-stratification tools. Allow provider-led teams to coordinate high-need cases, with states ensuring consistency and data sharing across plans.
Quality improvement	MCOs report on numerous metrics (e.g., HEDIS, CAHPS), allowing for comparisons across plans and states, but potentially creating an administrative burden and a fragmented focus without clear population-level gains.	Eliminate redundant measures, align incentives around one or two statewide priorities for several years, and "go deep before going wide" to standardize processes and achieve measurable improvement before scaling.
Paying for claims	MCOs adjudicate and pay claims under varied internal systems, sometimes with reports of delays, denials, and administrative friction for providers. States rely on plan reporting with limited transparency.	Establish shared or state-administered claims infrastructure to improve prompt payment, reduce administrative waste, and enhance oversight. Increase transparency through uniform reporting and independent audit capacity.

Abbreviations: CAHPS, Consumer Assessment of Healthcare Providers and Systems; EHR, electronic health records; HEDIS, Healthcare Effectiveness Data and Information Set; MCO, managed care organization.

Reducing Financial Risk for States

A fundamental role of Medicaid MCOs is to function as risk-bearing agents by accepting fixed, per-member, per-month capitation payments from state governments, in return for managing medical services for Medicaid enrollees. In doing so, MCOs take on responsibility for total cost management, providing states with greater budget certainty and a buffer against cost volatility. This model rests, in part, on the hypothesis that MCOs, bearing financial risk, will achieve savings through better care management than an FFS program or state agency could replicate. The capitation model also creates an inherent financial incentive for MCOs to manage costs below the capitated rate, which, when functioning as designed, can contribute to spending restraint over time.

The Evidence

Studies on the ability of Medicaid managed care to generate savings have been mixed:

- Several find that a shift from FFS to managed care did not reduce Medicaid spending and may have increased expenditures.[7–11]
- A study of a natural experiment in Louisiana, in which some enrollees were randomly assigned to managed care, found that managed care reduced total spending by nearly 6%. However, these savings were driven primarily by reductions in pharmacy costs through utilization management.[12] Savings on the medical side were modest, and the program was associated with lower quality and beneficiary satisfaction.

The commercial market's shift to managed care in the 1990s was accompanied by substantial savings.[13,14] However, those savings were primarily attributable to narrower networks and lower reimbursement rates,[15] approaches that may not be feasible in the Medicaid program, which is already challenged by provider acceptance and low reimbursement rates.

Although some Medicaid managed care plans place providers at financial risk for the total cost of care, prevailing payment arrangements have tended to remain FFS with layered, value-based incentives or limited risk sharing. As of 2022, only about 20% of Medicaid spending flowed through downside-risk or population-based payment models.[16]

An often-overlooked component of the managed care arrangement is that when plans experience financial losses, the state may not be fully insulated. Capitation rates must be actuarially sound,[11,17] meaning states may be forced to set higher future rates based on prior-year claims experience. As a result, financial risk to a state is often redistributed rather than eliminated. MCOs, meanwhile, have developed a sophisticated capacity to influence rate negotiations in their favor, leveraging proprietary data on utilization, claims experience, and risk adjustment. Rather than simplifying the state's administrative burden, managed care can introduce a well-resourced adversary into what might otherwise be a more tractable technical exercise.

Takeaway. There is a lack of strong, peer-reviewed studies to suggest that MCOs have made novel delivery system or payment innovations that substantially reduce the cost of care. Nonetheless, managed care may still be attractive to states because delegating coverage to MCOs could provide legislators with near-term fiscal insulation. In an FFS environment, unexpectedly high costs could more directly impact the state budget and the legislators responsible for it.

However, the extent to which outsourcing to MCOs truly mitigates financial risk for states warrants closer scrutiny. In theory, capitation shifts responsibility for the total cost of care from states to plans, rewarding efficiency when MCOs deliver services below their capitated rates. Yet it is unclear whether such savings translate into long-term value for taxpayers. Furthermore, the Medicaid managed care market is now dominated by large, national, for-profit firms. When these plans generate surpluses, a portion may accrue to corporate shareholders rather than being reinvested in the state's Medicaid program, particularly when vendors owned by the same parent company provide administrative or "medical" services that count toward minimum medical loss ratio (MLR) thresholds. (Federal rules require Medicaid MCOs to spend at least 85 cents of every premium dollar on medical care and quality improvement, with no more than 15 cents — the MLR threshold — retained for administration and profit. When a plan's parent company owns the vendors providing behavioral health carve-outs, pharmacy benefits, or care management services, payments to those vendors may count as medical spending — meeting the MLR floor on paper while effectively recycling dollars within the same corporate family.) Finally, the administrative costs of multiple competing plans — each maintaining its own utilization management, marketing, and care management infrastructure — raise questions about whether the current system delivers efficiency commensurate with its complexity.

Utilization Management

A fundamental tenet of the reliance on managed care is that it can deploy supply-side restraints to control costs. This point is particularly salient for the Medicaid population. Whereas commercial insurance can rely on cost sharing as a demand-side restraint, Medicaid enrollees typically face limited or no cost sharing.

The Evidence

Assessing the success of utilization management among MCOs is challenging. On one hand, studies of Medicaid FFS suggest that well-designed utilization management (e.g., prior authorization for imaging or high-dose opioids) appears to have reduced utilization and spending without detectable adverse access or outcome effects.[18–21] However, empirical evidence that MCOs' use of these mechanisms substantially improves value is limited.[18–21] Some research suggests that prior-authorization policies in Medicaid managed care reflect the for-profit status and state partisan context,[22] rather than a solid evidence base. Nonetheless, state legislative action to reform prior authorization has been bipartisan in recent years, suggesting the political dynamics are evolving.

Even if utilization management reduced inappropriate Medicaid expenditures, it often entails offsetting costs, including delays or frustrations for patients and administrative burdens on providers. A 2019 report from the Council for Affordable Quality Healthcare identified prior authorization as the most expensive administrative transaction for providers, with average costs of about $11 per manual request and $4 per request submitted through web portals.[23] Notably, prior authorization rates in Medicaid managed care are more than twice as high as the Medicare Advantage rate.[24] Still, the effectiveness of utilization management is likely to vary considerably across states and plans. Some states, including Tennessee, have reported sustained high member satisfaction alongside robust utilization management programs,[25] suggesting that the design of utilization management matters as much as the mechanism itself.

Takeaway. Some form of utilization management is likely needed to eliminate unnecessary expenditures and address variations in practice patterns across providers. A significant policy opportunity may exist in standardizing utilization management processes across carriers and integrating them with electronic health record systems to enable real-time decision support. Notably, the use of artificial intelligence and algorithmic tools in prior authorization has become a rapidly growing area of both MCO practice and state legislative attention, raising new questions about transparency, bias, and the appropriate role of automated decision-making in coverage determinations.[26]

Network Formation

Network formation refers to the process by which MCOs establish and maintain relationships with health care providers. This includes contracting for reimbursement rates and payment terms (including value-based payments), credentialing providers to ensure compliance and quality, and structuring the scope of services available to MCO enrollees. To ensure that enrollees have meaningful access to care, plans are required to meet federal and state "network adequacy" standards, which set minimum thresholds for provider availability and accessibility.[27,28] The emphasis on network adequacy reflects an ongoing concern that access to care in Medicaid (whether FFS or managed care) is insufficient, driven primarily by low provider participation rates.[29–35] The reasons for low participation may include low reimbursement rates[31,36–40] and regional provider shortages, but are likely to be multifactorial.[36,38,41–43]

The Evidence

Whether MCOs offer advantages in developing more robust provider networks depends heavily on state policy choices embedded in capitation rate setting. While some states have structured capitation rates to enable MCOs to pay providers above FFS levels — incentivizing network participation — this reflects deliberate state design rather than an inherent MCO advantage, and such rate incentives vary considerably across states. Furthermore, evidence suggests that payment delays are prevalent among Medicaid MCOs,[44,45] and state penetration rates of managed care do not appear to be associated with physicians' decision to accept new Medicaid patients.[46]

Compliance with network adequacy standards does not always translate into real access, as many MCO provider directories contain "ghost" or "phantom" providers who are listed but not accepting Medicaid patients.[47–51] MCOs themselves report difficulty in maintaining the accuracy of provider directories and little incentive to correct these deficiencies,[52] although new Medicaid managed care rules may provide some improvement.[53] Finally, one measure of MCOs' ability to add value could be the presence of highly defined networks of providers. However, research suggests that Medicaid managed care networks, although narrower than those of commercial insurers, tend to overlap more extensively, meaning that different plans often contract with very similar provider groups.[54]

MCOs may offer value beyond what state fee-for-service programs can replicate, particularly in their role as active conveners of provider networks.[52] Managed care plans vary meaningfully within states on measures such as appointment availability and provider retention, and they retain levers (differential contracting, value-based payment arrangements, and dedicated provider relations infrastructure) that allow them to shape network composition and engagement in ways a centralized state approach may struggle to match at the same level of granularity.[55]

Takeaway. If the central concern is improving access to care through broader provider participation, network adequacy may be less of an MCO-level performance issue than a system-level design problem. MCOs operate within state-defined payment rates and regulatory constraints and have limited ability to materially expand provider supply. In this context, a state-led approach that standardizes contracting, credentialing, and network reporting — and reduces the administrative burden on providers — may offer comparable or greater gains in access while avoiding the duplication inherent in multiplan network management. Some observers have nonetheless noted that MCOs likely add value through their ability to curate networks that would be difficult for a state agency to do. One possible alternative would be for states to contract with specialized entities for provider relationship management while retaining other functions at the state level.

Care Management

Care management in Medicaid managed care encompasses a wide range of activities designed to help enrollees navigate and coordinate their health care. At the lower-intensity end, this can include basic patient navigation, such as reminders, referral assistance, or help scheduling appointments. At the higher-intensity end, plans often implement complex case management, focusing intensive resources on a relatively small proportion of high-need enrollees whose medical and social circumstances place them at risk for poor outcomes and high costs.

MCOs are often assumed to have a comparative advantage in care management because of the capitated payment model. By bearing financial risk for the total cost of care, plans have a direct incentive to invest in interventions that reduce avoidable hospitalizations and improve management of chronic conditions. They can also use contracting incentives to align providers with disease management programs, incentive payments, and care coordination requirements. Indeed, care management programs within Medicaid MCOs have demonstrated notable successes in some domains.[56–58]

The Evidence

Studies of specific care management programs have noted the importance of design, targeting, and execution[56,59] — factors that are not unique to MCOs. Thus, while MCOs may be well positioned to deliver effective care management, the available evidence does not clearly indicate whether this potential has been fully realized.

Takeaway. In practice, care management efforts are often fragmented and duplicative, as MCOs, providers, health systems, and often public health entities maintain parallel infrastructures. Providers may be better positioned to manage care for patients with whom they have established relationships. At the same time, MCO-based programs can fill gaps for members who lack a regular primary care provider or who have multiple, unconnected providers or fragmented care. A potential policy opportunity lies in standardizing risk identification across plans — for example, by administering health risk assessments at the state level and combining with claims-based stratification or centralized analytics. Care management could potentially be centralized at the state or regional level, ensuring coordination while reducing administrative redundancy. Notably, these efforts could be independent of the decision for states to contract with managed care.

Quality Improvement

Quality oversight has become a central function of Medicaid managed care, mainly through state and federal requirements. MCOs are required to collect and report standardized quality measures (e.g., drawn from the Healthcare Effectiveness Data and Information Set [HEDIS] and Consumer Assessment of Healthcare Providers and Systems [CAHPS]), submit performance improvement projects, and participate in external quality reviews. These activities are designed to provide states with the leverage to monitor performance and tie payments to MCOs or MCO contract renewals to the achievement of quality measure targets or improvements in quality measurements. Although often driven by compliance rather than clinical transformation, quality oversight is now embedded in the structure of Medicaid managed care and serves as a significant mechanism for states to ensure accountability.

Unlike FFS programs, MCOs are subject to comprehensive, federally mandated quality oversight through required quality strategies, performance improvement projects, and annual external quality reviews — a level of systematic accountability that has historically not applied to FFS delivery systems, though recent federal rules have begun extending some quality measurement requirements to FFS programs as well.[60]

The Evidence

The evidence remains inconclusive on whether MCOs achieve consistently better access or quality compared to FFS models. A 2023 evidence review by the Medicaid and CHIP Payment and Access Commission (MACPAC) suggested that quality and access under managed care varied widely across services and plans, with no clear findings to conclude that managed care systematically improved or worsened access and quality of care for beneficiaries.[61] MCOs are often required to track and report standardized quality measures such as HEDIS and CAHPS. While these approaches were well intentioned, it is not clear whether these measures have produced the hoped-for improvements.

Some literature and MACPAC syntheses point out that focusing on specific, easily measurable metrics can lead to "teaching to the test," or gaming, in which quality efforts prioritize improving scores on measured dimensions rather than unmeasured but essential aspects of patient care.[62–64] These findings align with the broader literature on pay-for-performance programs, which has not found consistent positive associations.[65]

Takeaway. The proliferation of quality measures over time has created a significant administrative burden for both providers and plans, diverting attention to too many targets and often yielding incremental gains in process metrics without meaningful improvements in patient outcomes. Some experts argue that the system's reliance on a broad array of concurrent quality initiatives has undermined its own effectiveness. An alternative, but untested, approach could be for states to focus their incentives on a small number of high-priority conditions — ideally, one at a time, sustained over several years and applied consistently across Medicaid and other public programs. This approach – "going deep before going wide" – may concentrate efforts to promote systemwide learning, yielding measurable improvements in population health, and generating spillover benefits for other conditions. This type of approach could be implemented in MCO or FFS environments.

Paying for Claims

Managed care organizations are responsible for ensuring that providers are reimbursed accurately and promptly for services delivered to Medicaid beneficiaries. This function involves adjudicating claims in accordance with state contracts, federal regulations, and established payment methodologies. MCOs also conduct prepayment and postpayment reviews to verify accuracy and compliance, and they are expected to detect and prevent fraud, waste, and abuse. While some of these activities also occur under FFS Medicaid, managed care arrangements generally place greater accountability on plans to monitor payment integrity and address irregularities proactively.

Most large, national Medicaid MCOs maintain their own in-house claims-processing systems, while smaller or regional plans sometimes contract with third-party administrators or vendors. By contrast, state FFS programs almost universally outsource claims processing to fiscal agents that run the Medicaid Management Information System. Thus, while both models may rely on vendors, MCOs often retain more direct operational control over adjudication and payment. Medicaid MCOs are generally contractually required to meet, and in some cases exceed, the prompt-pay standards applied to FFS programs, with compliance monitored through state reporting and external review.

The Evidence

There is limited empirical evidence at the national level to indicate whether MCOs consistently pay claims more quickly or more slowly than state-administered FFS programs, and at least some anecdotal reports suggest concerns over the frequency of claims denials and delays among Medicaid MCOs.[45,66]

Takeaway. The absence of clear evidence that decentralized, plan-level claims administration improves payment timeliness, accuracy, or provider experience raises a broader question about how claims processing should be organized in Medicaid. While managed care assigns formal responsibility for payment integrity to MCOs, states ultimately remain accountable for ensuring access to care and maintaining provider participation, both of which are sensitive to payment delays, denials, and administrative friction. This creates an inherent tension: states rely on plans to manage claims operations yet often lack direct visibility into the performance of those systems, beyond aggregate reporting. From a design perspective, this suggests that claims payment may be an area where standardization or shared infrastructure could yield benefits without undermining core elements of managed care. Nonetheless, managed care arrangements generally place greater accountability on plans for fraud, waste, and abuse detection, and MCOs' prepayment review capacity may offer advantages over state-administered FFS programs in identifying and preventing improper payments. Uniform claims submission rules, standardized denial codes, and standard reporting specifications could reduce administrative burden for providers who contract with multiple plans, while improving states' ability to monitor payment performance in real time.

KEY DESIGN QUESTIONS FOR MEDICAID MANAGED CARE

States may benefit from a reassessment of which functions are best performed at the MCO level and which might be more effective if standardized or coordinated across plans or by the state. This question is relevant, in part, because the traditional benefits of competition do not hold in Medicaid managed care and because the MCOs generally operate through the same constrained provider network.

What Are the Benefits of Centralization vs. Plan-Level Variation?

States should consider centralizing functions that do not yield demonstrable value through MCO competition and differentiation — for example, standardized utilization-management rules and workflows, a single statewide provider directory, common data and reporting specifications, and consolidated pharmacy benefit management (where state contracts, rebate structures, and administrative capacity permit). Doing so could potentially trim duplicative administrative infrastructure and expense across multiple MCOs, lower providers' contracting and paperwork burdens, and allow plans to focus on execution rather than adhering to bespoke rules. Centralization could take the form of a single outsourced vendor performing the function, outside of the MCO arrangements. Effective centralization requires that states invest substantially in contract oversight infrastructure, including dedicated managed care oversight divisions with analytical capacity and enforcement authority. The absence of this capacity may be directly related to substandard MCO performance, suggesting that state investment in oversight may be as important as the choice of administrative model.

Is Risk Transfer Actually Doing What We Think?

Capitation does provide states with meaningful protection against year-to-year cost volatility, and this fiscal predictability has value to states. What is less clear is whether managed care delivers long-run cost containment, or whether annual rate setting and actuarial soundness requirements largely accommodate past trends rather than bending them. Transparent, independent audits could clarify the extent to which managed care delivers net savings versus cost redistribution. If results show limited fiscal benefit, states could pilot hybrid models, retaining direct state management of medical services while carving out pharmacy or other components for specialized risk-bearing entities.

Who Should Manage Care, and at What Scale?

States may benefit from assessing whether care management is best housed within MCOs or whether these functions could be streamlined at the provider or state level. Currently, both MCOs and providers operate parallel care management infrastructures, often targeting the same high-risk members. Consolidating or better coordinating these efforts — potentially through a shared, state-run data platform that identifies high-need individuals using claims and health risk assessment data — could reduce redundancy and clarify roles. States might test models in which providers, not MCOs, take the lead in care management, with the state supporting shared analytics and accountability frameworks. States could also consider expanding their capacity to analyze data and to provide oversight and evaluation.

Do Multiple, Overlapping MCOs Add or Reduce Value?

Most states require or permit multiple MCOs to operate within the same service area. Where competition does function well, it may drive plan-level innovation in care delivery, provider engagement, and member services that a single administrator would need to replicate through other means. However, because Medicaid members are typically not exposed to premiums or cost sharing, competition among MCOs may center largely on enrollee selection while adding administrative complexity for states and providers. States should rigorously evaluate whether multiple competing MCOs in the same region yield better performance than a single coordinated entity. Comparative analyses could determine whether competition meaningfully improves quality, access, or cost growth, or whether fragmentation increases administrative overhead. Depending on the findings, states might pilot consolidated regional purchasing entities or single-administrator models that preserve accountability through performance-based contracts rather than relying on plan competition.

States may find that some functions suit MCOs well, while others are better suited to the state level. The goal should be to avoid default offerings and strive to match function to structure.

Exhibit 2 imagines a new approach to Medicaid through the lens of a hypothetical state, Carelandia, illustrating how states could potentially reduce their reliance on managed care while strengthening accountability and improving access for their enrollees.

Exhibit 2. A New Model for Medicaid in the State of Carelandia

Carelandia's Medicaid program departs from the traditional managed care model by returning most medical services to a state-administered, fee-for-service structure. Pharmacy benefits are consolidated under a single statewide contract with uniform formulary and utilization management protocols — preserving the clinical controls that evidence suggests drive pharmacy savings, while eliminating the fragmentation and spread pricing that characterize multi-MCO pharmacy arrangements. Similarly, the state contracts with a utilization management vendor to automate the adjudication of prior authorization requests by directly communicating with provider electronic health record systems. The state invests in core administrative infrastructure, including centralized claims processing, a unified provider directory, and improved transparency over drug pricing and rebates. This design preserves key purchasing and utilization controls while reducing redundant administrative layers across multiple MCOs.

Carelandia also undertakes a focused, time-limited statewide quality initiative. Over three years, the state aligns incentives and data systems around a single objective: ensuring that individuals with acute behavioral health needs receive a clinical response within 24 hours of first contact. By focusing on a single measurable goal, the state seeks to reduce delays and standardize handoffs across the care continuum.

Rather than relying primarily on risk transfer through capitation, Carelandia manages fiscal exposure through transparent rate setting, predictive analytics, and targeted quality payments. Together, these elements illustrate how states could simplify Medicaid administration while strengthening accountability and improving access for high-need populations.

CONCLUSION

States' reliance on managed care has grown by default rather than by deliberate design. The principles that initially justified its expansion — paying differently than fee for service, taking a population view, identifying high-need individuals, and coordinating care — remain sound. But the institutional form through which those principles are now expressed — the multiplan, privately administered MCO market — has accumulated layers of complexity, redundancy, and weak accountability that warrant reexamination.

Many of the functions MCOs perform, including care management, quality oversight, and utilization control, could be carried out more transparently and at potentially lower administrative cost through centralized, standardized processes. These processes could take the form of different types of vendor or contracting arrangements, new state-run capacity, or provider-based systems. Reforms should test these alternatives' ability to perform these functions more cost-effectively than the status quo, rather than assume that the MCO model is the only option to fulfill a state's goals.

The next phase of Medicaid policy should therefore focus less on preserving managed care as an institution and more on clarifying which elements of it truly add value. States, the Centers for Medicare and Medicaid Services, and researchers should treat the design of the administrative layer itself — not just the delivery system — as a core lever for improving equity, efficiency, and accountability.

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