Physicians for a National Health Program September 2025

Removing the Middlemen from Medicaid

A Blueprint for Better Care and Lower Costs

Full Report:
pnhp.org/MedicaidBlueprint

Inquiries:
info@pnhp.org

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Executive Summary

Background: Medicaid is a joint federal and state health insurance program for people with low incomes. As of April 2025, Medicaid insured 71 million people, including people with disabilities, children and families, pregnant women, the elderly, and working adults without affordable insurance.[1] In addition, Medicaid supports the overall health infrastructure, funding safety-net and rural hospitals, as well as long-term care facilities that serve a large proportion of low-income individuals. In these ways, Medicaid stabilizes healthcare for entire communities.

Issue: The 2025 Budget Reconciliation Act (sometimes identified as the "One Big Beautiful Bill Act")[2] reduces federal Medicaid funding by $1 trillion over the next decade. A cut of this magnitude puts enormous pressure on states to end optional Medicaid benefits, cut eligibility, reduce provider payments, and/or raise taxes.

Solution: States that rely on managed care organizations ("MCOs") to administer their Medicaid programs can substantially offset the federal cuts if they stop MCO contracting and instead directly administer their Medicaid programs. **We estimate that if states shifted from MCOs to direct payment of Medicaid providers, they could reduce their Medicaid MCO expenditures by 10 percent to 17 percent.** Savings stem from reduced administrative costs and improved care coordination.

States can operate their Medicaid programs in a manner that encourages primary care practices to manage care. This is called "managed fee for service" (Connecticut Medicaid) or "enhanced Primary Care Case Management" (North Carolina and Oklahoma prior to recent conversion to MCOs). These models include enhanced payment to primary care practices, care coordination programs to improve management of complex and high-risk patients in the community beyond the doctor's office, and specialized programs for patients with complex care needs.

Rationale: States spend 4 to 6 percent of their Medicaid budget on internal state agency overhead, plus an additional 13 percent goes to MCOs for their overhead. States that bypass MCOs and pay providers directly can either retain much of what today goes to MCO overhead or re-invest some of those savings back into Medicaid.[3] When a state deprivatizes its Medicaid program, it obviously no longer has to fund MCO overhead. Total state overhead can drop to about 4 to 6 percent[4] or less.

A well-run managed fee for service program can attract primary care physicians back into Medicaid, as demonstrated in Connecticut.[5] This, in turn, can reduce urgent care, ER visits, and preventable hospitalizations, resulting in a net

[1] Centers for Medicare & Medicaid Services. (2025, July 25). *April 2025: Medicaid and CHIP eligibility operations & enrollment snapshot* [PDF]. U.S. Department of Health & Human Services. https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-aprl2025.pdf
[2] U.S. Congress. (2025). *H.R. 1—One Big Beautiful Bill Act*. 119th Cong. https://www.congress.gov/bill/119th-congress/house-bill/1
[3] Palmer, J., Pettit, C., McCulla, I., & Kinnick, C. (2025, June 30). *Medicaid managed care financial results for 2024* [Research report]. Milliman. https://www.milliman.com/en/insight/medicaid-managed-care-financial-results-2024
[4] Martinez, B. (2006, November 15). *In Medicaid, private HMOs take a big, and profitable, role. The Wall Street Journal.* https://www.wsj.com/articles/SB116354350983023095
[5] Burns, J. (2023, January 20). *MCOS—Connecticut bucks the Medicaid managed care trend. Mostly Medicaid.* https://mostlymedicaid.com/mcos-connecticut-bucks-the-medicaid-managed-care-trend

reduction in the cost of medical services. In 2012, Connecticut terminated its MCO contracts and implemented a state-run care coordination program. Physician participation improved by 33% in the first year after the change, and ER visits and hospitalizations declined,[6] with a reduction in total per member Medicaid cost of 15% five years after the conversion to state-run care coordination.[7]

Connecticut's switch from a privatized to a deprivatized program coupled with a new publicly run care coordination program improved quality of care. For example, the change was associated with a 4.7% increase in early cancer detection and 8% higher survival rates compared to New Jersey, which maintained its privately run Medicaid MCO program as Connecticut jettisoned it.[8] **In the 13 intervening years, the state of Connecticut has saved more than $4 billion of taxpayer money.**[9]

In Appendix F (Table 4), we provide a range of projections for the savings a state can anticipate if it moves to a managed fee for service model, varying based on how much care coordination they adopt. The projections are a first-order approximation that does not account for items identified in the notes section to the table that could imply either under-estimation or over-estimation. As one example of under-estimation, these projections are based on FY 2023 state data and do not account for medical inflation in FY 2026.

Table 4 also demonstrates the federal savings opportunity. Total federal MCO Medicaid spending in 2023 was $ 256 billion. **We estimate that nationwide deprivatization of Medicaid would have saved the federal government as much as $43 billion in 2023, in addition to the potential for $34 billion savings for individual states, for a total savings of $77 billion combining all state and federal fractions.**

Some states that decided to eliminate managed care from Medicaid have been able to move quickly into managed fee for service. For example, after two years of consideration,[10] the Oklahoma board overseeing Medicaid decided on November 7, 2003 to remove MCOs effective on December 31 2003, and fully transitioned to statewide Primary Care Case Management over the first four months of 2004.[11]

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[6] Connecticut Department of Social Services. (n.d.). *Precis of CT Medicaid program* (p. 7) [PDF]. Connecticut Department of Social Services. 2014. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Medicaid-Hospital-Reimbursement/precis_of_ct_medicaid_program.pdf

[7] Burns, J. (2023, January 20). *MCOS—Connecticut bucks the Medicaid managed care trend. Mostly Medicaid.* https://mostlymedicaid.com/mcos-connecticut-bucks-the-medicaid-managed-care-trend

[8] https://ascopubs.org/doi/10.1200/OP.23.00297?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

[9] Andrews, E. (2020, February 19). *Medicaid switch from MCOs saving taxpayers billions. CT Health Policy*. https://cthealthpolicy.org/medicaid-switch-from-mcos-saving-taxpayers-billions/ (published in 2020; average annual savings propagated forward for this report.)

[10] McGuigan, P. B. (2021, March 22). *Analyzing and stirring the pot: Fight over managed-care Medicaid expansion is serious business. The Southwest Ledger*. Capitol Beat OK. https://www.southwestledger.news/news/analyzing-and-stirring-pot-fight-over-managed-care-medicaid-expansion-serious-business

[11] Oklahoma Health Care Authority, SoonerCare Choice: Oklahoma's PCCM Program, ppt at slides 8, 11 (January 2008) No longer publicly posted at Oklahoma site but available at https://docs.google.com/presentation/d/1coKo9-U4y6WTxPiXpcG7loFa6xaLvsO4/edit?slide=id.p1#slide=id.p1

In this report we will frequently refer to the state of Connecticut where, in 2012, the state successfully removed MCOs from its Medicaid program. Although it is a small state with about a million Medicaid enrollees, it has actual, recent experience with deprivatization, and so the amount of money saved, administrative costs avoided and access improved there are highly instructive. **Connecticut is widely recognized as "the insurance capitol of the world".[12] If a state with Connecticut's legacy could remove the insurance industry from its Medicaid program, and reap significant rewards, any state should be able to do the same.**

[12] Connecticut Insurance and Financial Services. *Insurance capital of the world.* https://www.connecticutifs.com/insurance-capital-of-the-world

Section 1: Fundamentals of Managed Care

Section 1A: What are "Managed Care Organizations"?

Managed Care Organizations (MCOs) are insurance companies that are pre-paid per person for a defined set of health services for a defined period of time. Payments made to health insurance companies by private-sector buyers (individuals and employers) are typically called "premiums;" payments to health insurance companies by public programs like Medicaid are usually called "capitation payments" (described below).

The concept of managed care first gained widespread recognition in 1973 with the passage of the Health Maintenance Organization Act ("HMO Act") as an alternative to fee for service on the theory that HMOs could control healthcare costs and improve quality of care.[13] The label "Managed Care Organization" or "MCO" emerged in the 1990s as the distinction between insurers offering HMOs and traditional fee for service insurance companies became blurred. Continuing a process introduced in the early 1980s,[14] federal changes in the 1990s expanded the ability of states to introduce MCOs into their Medicaid programs.[15]

HMOs (health plans administered by corporate health insurers) are the prototypical insurance product of managed care organizations. HMO advocates claim that HMOs align the financial interests of an MCO with those of the funding source, driving reduced expenses for the state. By restricting the state's financial exposure to the contracted capitation rates, capitation theoretically could permit states to stabilize their budgets, control costs and improve population health outcomes. This nearly irresistible insurance industry proposition has been a key driver of the growth of HMOs across the health insurance landscape, including Medicaid.

Rather than investing in improved health outcomes, MCOs' incentive has been to maximize profits by spending less on care. They delay and deny care inappropriately, regardless of the dire health hazards. The frequent turnover of HMO membership, particularly in Medicaid MCOs, undermines any business case for MCOs to improve people's long term health and protects MCOs from the consequences of their delaying and denying care. If they can delay care long enough, the patient may leave the MCO's risk pool.

In some states, capitation also introduces opportunities for gaming the payment system by avoiding or ejecting sicker enrollees to secure a better risk pool and pressuring doctors and patients to up-code diagnoses used for risk adjustment. "Managed Care Organizations" prioritize financial expenses over patient care. In fact, for-profit MCOs have a legal obligation to put their shareholders' interests ahead of patient care.

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[13] U.S. General Accounting Office. (1978, March 3). *Implementation of the Health Maintenance Organization Act of 1973, as amended* (Report No. B-188898). https://www.gao.gov/assets/105122.pdf

[14] Hurley, R. E. (1986). *Status of the Medicaid competition demonstrations* (HCFA Grant No. 500-83-0156). Health Care Financing Administration. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191991dl.pdf

[15] Medicaid and CHIP Payment and Access Commission. (2011, June). *The evolution of managed care in Medicaid* (Report No. GPO-MACPAC-2011-06). U.S. Government Printing Office. https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf

> "When I was the medical director of a fully capitated medical group, I found myself thinking up strategies to make an expensive hemophiliac patient become dissatisfied with our group, hoping he would leave us and become someone else's financial burden. I never acted upon this, but the fact that I thought about it still haunts me many years later."

[16]

Section 1B: Are there alternatives to managed care organizations?

The Omnibus Budget Reconciliation Act of 1981 created "managed fee for service" or what is referred to as "Primary Care Case Management" as an alternative to Medicaid MCOs.[17,18] Medicaid Primary Care Case Management is done by primary care clinics, not insurance companies. The state pays primary care practices a modest monthly fee per patient or enhanced fee for service fees to provide care coordination services that ensure that other providers render appropriate care. In addition, the state pays directly for office visits on a fee for service basis. Managed fee for service allows for true care coordination and does not create the financial incentive to deny health care which capitation creates.

Note: "Care coordination" is described by the Agency for Healthcare Research and Quality as a key strategy with the potential to improve the effectiveness, safety, and efficiency of the health care system. It encompasses care management, teamwork, medication management, assistance with transitions of care, assistance with transportation, monitoring and followup, linkages to community resources, and multiple other activities.[19]

In this paper we draw a distinction between these "care coordination" programs and "care management programs." In a managed fee for service model, state Medicaid programs pay physicians and other health care professionals directly to participate in care coordination programs. In an MCO capitated model, states pay insurers to create care management programs that prioritize the management of healthcare expenses rather than patient care.

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[16] Personal note of Ed Weisbart MD, one of this report's authors
[17] United States Senate Special Committee on Aging. (1981, September). *Omnibus Budget Reconciliation Act of 1981: Selected provisions affecting the elderly* (Committee Print No. 97-681). U.S. Government Printing Office. https://www.aging.senate.gov/imo/media/doc/reports/rpt681.pdf
[18] 42 U.S.C. § 1396d(a)(25), 1396d(t).
[19] Agency for Healthcare Research and Quality. *Care coordination.* https://www.ahrq.gov/ncepcr/care/coordination.html

As just one of many other examples of care coordination, the medical and behavioral health administrative services organizations (ASOs) which contract with the Connecticut Medicaid agency provide care coordination to patients for whom a referral is made, or sometimes based on their own review of hospital utilization patterns. The ASOs are not paying for the actual health services – the state does that – but rather states pay ASOs to ensure that individuals are receiving appropriate treatment, which can include care coordination. Such care coordination may well result in substantial savings to the state's Medicaid budget. (An ASO is a business that provides a specified set of administrative services for a specified fee and does not bear financial risk.)

Section 1C: Connecticut eliminated its Medicaid MCOs in 2012, with resounding success

The state of Connecticut offers a solid example of the financial and health benefits of removing MCOs from Medicaid. In 2012, the state terminated its contracts with MCOs and began paying providers directly. **In the 13 intervening years, the state reports that it has saved taxpayers more than $4 billion.**[20] The state's administrative overhead no longer includes any MCO overhead – it is now defined by its own agency administrative overhead – which has continued to fall. In 2018, CT spent $395 million on overhead;[21] by 2022 it had fallen to $353 million.[22]

When Connecticut eliminated MCOs from its Medicaid program, the state also provided better support to primary care physicians managing their own patients' healthcare. Physicians are far more aware of their patients' overall medical and social circumstances than insurance companies. The state demonstrated an immediate reduction in total administrative costs after terminating its MCO contracts and reduced its total per-capita costs. Lower per-capita costs were largely attributable to both lower administrative costs and improved physician participation and thus improved access to primary care, associated with lower ER and hospitalization costs.[23] Six years out, in 2018, its total per-member costs including both administration and health care, were 14% less than in 2012, its last year with MCOs.[24]

More than a decade later in 2024, despite being an overall high cost state, Connecticut reported overall Medicaid costs that were 14% lower than all Northeast states (including New England, New York and New Jersey), almost all of which rely upon MCOs.[25]

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[20] Andrews, E. (2020, February 19). *Medicaid switch from MCOs saving taxpayers billions. CT Health Policy*. https://cthealthpolicy.org/medicaid-switch-from-mcos-saving-taxpayers-billions/ (published in 2020; average annual savings propagated forward for this report.)

[21] Medicaid and CHIP Payment and Access Commission. (2019, December). *MACStats: Medicaid and CHIP data book* [Data book]. MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf

[22] Medicaid and CHIP Payment and Access Commission. (2023, December). *MACStats: Medicaid and CHIP data book* Exhibit 31. [Data book]. MACPAC. https://www.macpac.gov/wp-content/uploads/2023/12/MACSTATS_Dec2023_WEB-508.pdf

[23] Connecticut Department of Social Services. (n.d.). *Precis of CT Medicaid program* (p. 7) [PDF]. Connecticut Department of Social Services. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Medicaid-Hospital-Reimbursement/precis_of_ct_medicaid_program.pdf

[24] Connecticut Health Policy Project. (2019, January). *Medicaid 2019 brief* [PDF]. Connecticut Health Policy Project. https://cthealthpolicy.org/wp-content/uploads/2019/02/Medicaid-2019-brief-formatted-copy.pdf

[25] December 2024 Medicaid Landscape Analysis report for the CT Department of Social Services, at page 13, available at https://portal.ct.gov/dsshome/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf

Big Savings in a Small State

Christopher G. Donovan was the Speaker of the Connecticut House of Representatives at the time of the conversion of CT's Medicaid program from managed care run by risk-based insurers to managed fee for service, and in the years leading up to that conversion in 2011-2012.

Under the Medicaid managed care system run by capitated entities, Connecticut enrollees and their providers experienced difficulty receiving necessary care, and the payment for care provided. Legislators heard from constituents about inadequate provider networks and the routine denials of needed treatment by the MCOs. Insurers claimed to provide care coordination, but it seemed that their priority was managing their costs: every dollar of health care they denied increased their own profits. Obtaining information about how they were performing with the taxpayers' money was a major fight, involving litigation under the Freedom of Information Act and other frustrating efforts at holding them accountable.

One of the most problematic aspects of the relationship with the MCOs was their consistent demand for ever higher payments, with the express or implied threat of imminent departure if the state refused. Our Medicaid agency would sometimes negotiate to give them even higher capitated payments than we had authorized in budget legislation, because of this coercion.

Before the conversion to managed fee for service took place, I helped to draft legislation requiring our Medicaid agency to implement a pilot program of what was called primary care case management, as an alternative to having to enroll in an MCO. Under PCCM, primary care providers are paid a monthly fee to provide the care coordination, rarely delivered by the MCOs, as well as fee for service payment for office visits. While the pilot program was small, it served as a model for how to deliver quality care at a reasonable cost without the high insurance company overhead inherent with MCOs, and the conversion in 2012 included a commitment to broad use of accredited patient-centered medical homes providing care coordination, similar to the PCCM model.

(cont.)

After the conversion, our constituents on Medicaid began to see a significant improvement in access to care and their providers had far less grief in getting services approved or, once provided, in actually getting paid. Many providers newly signed up to participate in Medicaid — even those for whom the transition brought no increase in their reimbursement rates. While CT still does prior authorization for some services determined by the Medicaid agency, these reviews are conducted by non-risk administrative services organizations which have no financial incentive to deny needed care.

Our small state has literally saved billions in unnecessary MCO overhead dollars since the transition, while providing the meaningful care coordination our constituents needed. As Speaker, it was gratifying to work with Medicaid advocates in making the transition away from capitated managed care. While the program is not perfect, it is far superior to what we had under several incarnations of capitated managed care, an inadequate health care delivery system.

Christopher G. Donovan,
Member, CT House of Representatives 1993 to 2013
Speaker, CT House of Representatives 2009-2013

Section 2: Calculating the projected state savings from deprivatization

Section 2A: Calculating the overhead of MCOs today

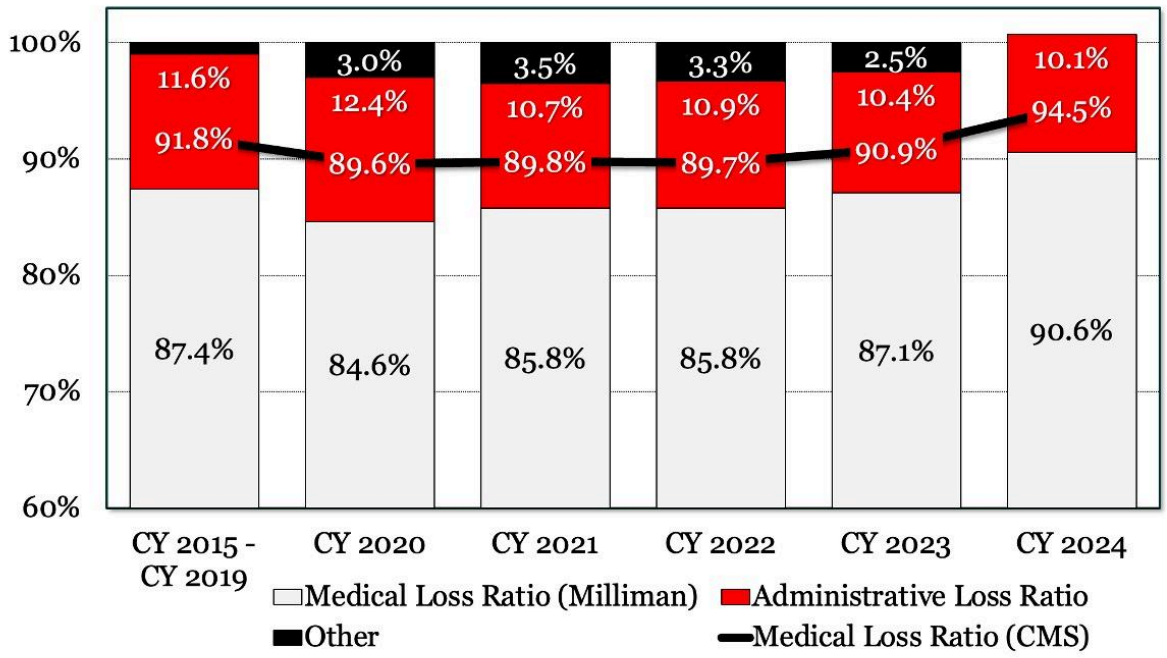
By eliminating MCOs from Medicaid programs, states will avoid the cost of MCO overhead (defined here as the sum of all administrative expenses and profits). According to a report by Milliman, an independent health policy research firm, an average of 87 percent of all Medicaid MCO revenues were spent on medical care between CY 2015 and CY 2024. This is depicted in Chart 1 as the MLR, or Medical Loss Ratio. MLR is an industry standard term for the portion of an insurance budget that is spent on medical, not administrative, expenses. There is some ambiguity as to which services fall into which category.

As described in the Milliman report, 87% is less than the 91.3% fraction calculated by CMS for the same time period due to differences in accounting for expenses such as those related to healthcare quality improvement, taxes, fees, and other items.

We interpret Milliman's reporting of an 87% MLR to mean that 13% of all MCO revenue was diverted to MCO overhead.[26]

[26] Palmer, J., Pettit, C., McCulla, I., & Kinnick, C. (2025, June 30). *Medicaid managed care financial results for 2024* [Research report; see Figure 3, p. 5]. Milliman. https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/6-30-25_Medicaid-managed-care-financial-results-2024.pdf

Chart 1: Five-year historical financial results, per Milliman ("Figure 3" in Milliman's report) [27]



We believe an estimate of MCO overhead at 13% to be conservative for several reasons:

- Milliman's analysis may fail to adjust for the capital reserves MCOs maintain, not directly replicated in a state-run Medicaid program. These are substantial, but vary widely by state.[28] These capital reserves can in some cases be treated for accounting purposes as expenses to be included in the Medical Loss Ratio calculations. This means that capital reserves may enable the MCO to clear minimum MLR hurdles in states that mandate them. If an MCO is running at an MLR of 82 percent, capital reserves can push the MCO above the regulator's 85 percent threshold.
- A 2022 Office of Inspector General report (OIG)[29] report describes widespread under-reporting of administrative expenses by Medicaid MCOs, a problem not addressed in Milliman's report.

[27] Ibid.
[28] Goldsmith, J. C., Mosley, D., & Jacobs, A. (2018, May 3). *Medicaid managed care: Lots of unanswered questions (Part 1). Health Affairs Forefront*. https://doi.org/10.1377/forefront.20180430.387981
[29] U.S. Department of Health and Human Services, Office of Inspector General. (2022, September 19). *CMS has opportunities to strengthen states' oversight of Medicaid managed care plans' reporting of medical loss ratios* (OEI-03-20-00231). U.S. Department of Health and Human Services. https://www.oig.hhs.gov/oei/reports/OEI-03-20-00231.pdf

- Milliman's estimate of 13% overhead is lower than the overhead seen in Medicare Advantage, the other large public health program with MCO intermediaries. Both the GAO (Government Accountability Office)[30] and MedPAC (the Medicare Payment Advisory Commission)[31] report Medicare Advantage insurers operate with an overhead of 14%.

The savings states will achieve from no longer paying MCOs' 13 percent overhead will be affected by changes in both state agency overhead and beneficiary utilization of medical services. We examine each of those factors in the next two sections.

Section 2B: Impact on agency overhead

As indicated in Tables 1 and 2, change in the Medicaid agency's overhead costs also affects the net savings for a state.

Deprivatization would reduce state overhead from no longer overseeing and managing MCOs, but states would also incur new overhead for assuming the operations of the MCO portion of their Medicaid programs, *e.g.,* claims adjudication and other basic functions. MACPAC provides data on each state agency's administrative costs, but there is little public information on what portion of these costs are attributable to regulating MCOs and what portion to other tasks.[32]

Federal law and regulations impose numerous regulatory obligations on Medicaid agencies that administer privatized programs. These obligations add to agency overhead. But agency overhead is reduced by the cost of functions assumed by MCOs instead of directly by the state Medicaid agency. MCOs assume the cost of claims processing, any prior authorization determinations the state chooses to adopt, consumer services, and other functions.

The 2024 MACPAC report shows spending on agency administration (federal plus state combined) in Connecticut represented 3.8% of total Medicaid expenses – the same as the national average.[33] This data is difficult to interpret as there is wide variation among Medicaid program design and implementation, but it suggests that Connecticut's comprehensive deprivatization will have minimal impact on overall state agency overhead.

Another way to look at this is to consider what Connecticut currently spends on the administrative functions that it took over from MCOs and now contracts to an ASO. Connecticut contracts with three ASOs, one to administer medical services, one to administer behavioral health services, and a third to administer dental services. Based on 2017 data from the CT Medicaid agency, the annual payments to all three ASOs equaled $107 million, or roughly 1.7% of the state's total $6.096 billion in Medicaid

[30] US Government Accountability Office, January 22, 2014 unnumbered page GAO-14-148, Medicare Advantage: 2011 Profits Similar to Projections for Most Plans, but Higher for Plans with Specific Eligibility Requirements
[31] Medicare Payment Advisory Commission, p. 373 Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf
[32] Medicaid and CHIP Payment and Access Commission. (2024, December). *MACStats: Medicaid and CHIP data book* [Exhibit 15]. https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf
[33] Medicaid and CHIP Payment and Access Commission. (2024, December). *MACStats: Medicaid and CHIP data book* [Exhibit 16]. https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf

expenditures that year.[34] A minority of this is for care coordination; most is for prior authorization, customer service, provider recruitment, etc., activities which are not optional even under a traditional fee for service program. In addition, there are new administrative costs for taking over claims processing from the MCOs.[35] We estimate that half of the claims processing costs shown in 2017 were new from deprivatization, based on the shifting of the child/family population out of MCOs, while the state was already providing claims processing for the smaller elderly/disabled population, which has higher claims experience. Total administrative cost for taking over the MCOs' mandatory functions is therefore estimated to be 1.9% of the Connecticut Medicaid budget that year, though the percentage of the CT Medicaid budget covering ASO contracts has since become lower.

Based on this experience, we estimate that the new administrative costs agencies incur after deprivatization will likely slightly outweigh the savings from no longer having to regulate MCOs. In the absence of research on this issue, we have chosen to add 1-2% percent to agency overhead. The states that move their Medicaid program from MCOs over to ASOs might add as much as 2% for new administration, at the high end, while also saving significant sums on avoided MCO oversight.

In summary, MACPAC data suggests a 1% decrease in Medicaid agency costs; CT's experience suggests no more than a 2% increase in new state agency administrative expenses related to health care delivery, even when a robust care coordination program is included.

Data on the overhead costs of North Carolina's Medicaid agency before and after privatization of its Medicaid program is very similar to the Connecticut data we just reviewed. Like Connecticut, the deprivatized (direct payment) program that North Carolina administered included a state-run care coordination program. After the North Carolina legislature privatized its Medicaid program, the agency's overhead remained unchanged: It was 5.5 percent before and after privatization.

Section 2C: Impact on utilization

The very limited research on the impact privatization has on utilization of medical services indicates MCOs reduce healthcare utilization by zero to five percent of spending compared to unmanaged fee for service.[36,37,38] Isolating the direct change in utilization,

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[34] Presentation of Connecticut Department of Social Services, Feb 9, 2018. Slides 16 and 39. DXC is the later name of the claims processing contractor used by CT Medicaid at the time of the conversion in 2012.
https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20180209/HUSKY%20Financial%20Trends%20Presentation.pdf

[35] Presentation of Connecticut Department of Social Services, Feb 9, 2018. Slide 16. DXC is the later name of the claims processing contractor used by CT Medicaid at the time of the conversion in 2012.
https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20180209/HUSKY%20Financial%20Trends%20Presentation.pdf

[36] Congressional Budget Office. (2020, December). *How CBO analyzes the costs of proposals for single-payer health care systems that are based on Medicare's fee-for-service program* (Working Paper No. 2020-08).
https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf

[37] Lange, A. (2012, March). *Beyond the Affordable Care Act: An economic analysis of a unified system of health care for Minnesota* [Report]. Growth & Justice.
https://www.mnsenaterepublicans.com/wp-content/uploads/2023/04/03-28-2012_Beyond_the_Affordable_Care_Act__Web_.pdf

[38] California Health and Human Services Agency. (2022, April). *Key design considerations for a unified health care financing system in California* [Final report].

as difficult as that is, only yields an incomplete picture of the true impact of changes in utilization. MCOs apply very blunt tools that reduce both medically necessary and unnecessary healthcare expenses. According to one report concerning Medicare Advantage, half of services denied by insurance companies are medically necessary care.[39]

States seldom oversee the appropriateness of MCO prior authorization. A 2023 report from the Office of the Inspector General (OIG) states:

> "[M]ost State Medicaid agencies reported that they did not routinely review the appropriateness of a sample of MCO denials of prior authorization requests, and many did not collect and monitor data on these decisions. The absence of robust oversight of MCO decisions on prior authorization requests presents a limitation that can allow inappropriate denials to go undetected in Medicaid managed care."

[40]

We recommend that states implement their own care coordination interventions and enhancements to care delivery, including recruiting more primary care practices to participate in Medicaid. If states introduce or expand these programs, they can reverse any increase in utilization stemming from the removal of MCOs. They can improve utilization of preventive medicine, decreasing ER visits and hospitalizations. One extensive review suggests improved access to primary care produces significant reductions in overall expense.[41]

Although the transition into MCOs thirty years ago led to about a 5% decrease in utilization, the reverse is unlikely. States need not anticipate a comparable increase in utilization when they move from MCOs to fee for service, particularly if they adopt our recommendation for managed fee for service.

It is unclear how much, if at all, utilization would rise absent MCO programs. Medical practice patterns have shifted since the introduction of managed care, and at least one test of a temporary pause in utilization management programs did not demonstrate any

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https://www.chhs.ca.gov/wp-content/uploads/2022/05/Key-Design-Considerations-for-a-Unified-Health-Care-System-in-California-Final-Report.pdf

[39] Curto, V., Einav, L., Finkelstein, A., Levin, J., & Bhattacharya, J. (2019). Health care spending and utilization in public and private Medicare. *American Economic Journal: Applied Economics, 11*(2), 302–332. https://doi.org/10.1257/app.20170295

[40] U.S. Department of Health and Human Services, Office of Inspector General. (2023, July). *High rates of prior authorization denials by some plans and limited state oversight raise concerns about access to care in Medicaid managed care* (OEI-09-19-00350; Report in Brief). U.S. Department of Health and Human Services. https://www.oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf

[41] Shi, L. (2012). The impact of primary care: A focused review. *Scientifica*, 2012, 432892. https://doi.org/10.6064/2012/432892

rise. In 1989, New York City and its unions temporarily switched 50% of the participants in its health insurance's comprehensive utilization management programs into sham programs. "Actual utilization review and sham review may both have decreased the use of hospital services, with patients or their physicians choosing more efficient treatment when they believed that care would be reviewed."[42]

The limited supply of physicians in a geographic area constrains increases in utilization, as was documented both with the expansion of the population of Americans with insurance after the enactment of Medicare and Medicaid in 1965 and the Affordable Care Act in 2014.

- Per capita physician visits for the periods before and after Medicare and Medicaid were enacted were virtually identical (427/100 person years from 1963 to 1965 versus 425 /100 person years in 1966-1970). The small increase in visits for seniors and people with low income (399 to 408) was balanced by a decrease in visits for everyone else (450 to 442).
- The same pattern was observed with the enactment of the Affordable Care Act with 372 physician visits / 100 person years in 2011 - 2013 and the identical 372 visits / 100 person years in 2014 - 2016.[43] We infer that physicians are already working at capacity; eliminating managed care from Medicaid is unlikely to drive a meaningful increase in utilization.
- When Connecticut deprivatized their Medicaid program, the number of physicians didn't increase – but physicians participation in Medicaid increased a lot. If a state doesn't enhance primary care pay and implement real care coordination programs there may be no increase in physician participation in Medicaid, and therefore minimal increase in utilization with de-privatizing alone.

We project up to a 2% increase in utilization in states that shift to unmanaged fee for service, roughly half of which is likely to improve the health of Medicaid recipients, which in turn may reduce future spending. Because these savings develop over time, our projection in Table 2 includes a range for the impact on utilization.

For a more in depth discussion of the impact of state-run care coordination programs on utilization, see Appendix E: "The truth about Medicaid managed care."

Section 2D: Impact on total state spending

An analysis of CMS data from 2004 to 2015 in counties that moved their high-risk Medicaid population from fee for service into mandatory managed care found a sustained increase in total spending on Medicaid. "We find that while fiscal costs decrease by $29 (2.2%) per member per month (PMPM) during the first mandate year, they continuously increase afterwards. By the fourth post-mandate year, counties with

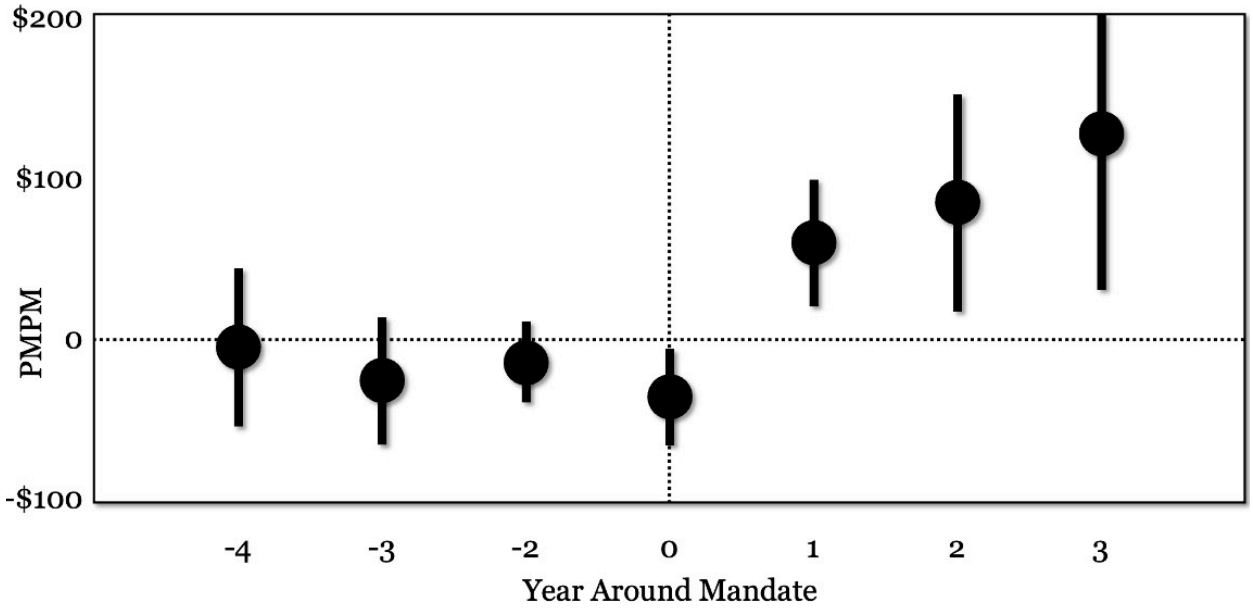
[42] Rosenberg, S. N., Allen, D. R., Handte, J. S., Jackson, T. C., Leto, L., Rodstein, B. M., Stratton, S. D., Westfall, G., & Yasser, R. (1995). Effect of utilization review in a fee-for-service health insurance plan. *The New England Journal of Medicine, 333*(20), 1326–1331. https://doi.org/10.1056/NEJM199511163332006

[43] Gaffney, A., McCormick, D., Bor, D., Woolhandler, S., & Himmelstein, D. (2019). Coverage expansions and utilization of physician care: Evidence from the 2014 Affordable Care Act and 1966 Medicare/Medicaid expansions. *American Journal of Public Health, 109*(12), 1694–1701. https://doi.org/10.2105/AJPH.2019.305330

an enrollment mandate experience higher fiscal costs of $132 (9.8%) PMPM, compared to counties that maintain the public FFS system for disabled beneficiaries. …

These results provide no support to the claim that managed care mandates save costs for the Medicaid program, outside of the first implementation year. Instead, they suggest that mandates lead to a dynamic pattern of increasing spending."[44]

Chart 2. Total spending before and after managed care enrollment mandates [45]



Note: Chart shows the difference in total spending between treatment counties and control counties, relative to the year before the mandate. Year zero is the first year in which the mandate is in place (denoted by a vertical dashed line) and shows the dollar differences between treatment and control in the total Medicaid spending PMPM.

These findings are similar to an analysis of state and local mandates from 1991 to 2009 that required most Medicaid recipients to enroll in an MCO, concluding "shifting Medicaid recipients from fee-for-service into MMC [Medicaid Managed Care] did not on average reduce Medicaid spending. If anything, our results suggest that the shift to MMC increased Medicaid spending and that this effect was especially present for risk-based HMOs."[46]

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[44] The dynamic fiscal costs of outsourcing health insurance - evidence from Medicaid. National Bureau of Economic Research, working paper 33302, December 2024. https://www.nber.org/system/files/working_papers/w33302/w33302.pdf
[45] Ibid.
[46] Duggan, M. Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates. Journal of Policy Analysis and Management, Vol. 32, No. 3, 505–535 (2013) https://onlinelibrary.wiley.com/doi/abs/10.1002/pam.21693

Section 2E: The bottom line

As Medicaid is jointly funded by states and the federal government, a portion of the savings accrue to each party.

Table 1. Calculation of net savings to states from deprivatization in states that adopt unmanaged fee for service (not recommended)

Medicaid MCO overhead	13%
Net impact on administrative spending by the state*	-1% to 0%
Projected increase in utilization in states that adopt unmanaged FFS	-1% to -2%
Projected net savings	**= 10% to 11%**

**Some costs increase, others decrease.*

Table 2. Calculation of net savings to states from deprivatization in states that adopt managed fee for service (recommended)

Medicaid MCO overhead	13%
Net impact on administrative spending by the state*	-2% to -1%
Improved access to primary care and other enhancements typically leads to a decrease in expense over time**	-1% to +5%
Projected net savings	**= 10% to 17%**

***Just as in unmanaged fee for service, utilization in managed fee for service may increase in the short term but, under well-managed fee for service, is likely to decrease over time. Connecticut demonstrated improved physician participation and reduced ER and hospital costs, even in the first year.[47] (A poorly managed program might have less positive results.)*

[47] Connecticut Department of Social Services. (n.d.). *A précis of the Connecticut Medicaid program* [PDF]. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Medicaid-Hospital-Reimbursement/precis_of_ct_medicaid_program.pdf

Section 3: The impact of capitation on Medicaid budgets, access, and quality

Section 3A: Capitation does not protect state budgets

The basic model of insurance is the distribution of the expenses of infrequent high-cost care across a wide population. In the pursuit of market competition and patient choice, and as required by federal Medicaid law, states capitate multiple MCOs, fragmenting their large state-wide risk pool into smaller populations. This can introduce wider swings in average medical expenses. In a fragmented system, the cost of one large case, *e.g.*, an organ transplant or an extended stay in a burn unit, has fewer people to be distributed across and creates larger fluctuations in total population costs. **This fragmentation into smaller subpopulations for the distribution of insurance risk reduces budgetary predictability** and therefore requires larger "rainy day" financial reserves, eroding one of the efficiencies of a single state-wide program.

States do not control costs effectively by paying an MCO on a per enrollee basis. The two largest drivers of a state's Medicaid budget are changes in enrollment and benefit design. States cannot save money on these changes by paying MCOs a capitated rate.[48]

Much of the information required for states to regulate managed care contracts effectively, such as how much the MCOs are paying their contracted providers, is considered proprietary by the MCOs and deliberately remains opaque to both regulators and legislators.

[48] Zewde, N., Edwards, R., & Gordon, K. (2023, July 18). *Reconsidering Medicaid privatization: Weighing the evidence and the alternatives*. Roosevelt Institute. https://rooseveltinstitute.org/publications/reconsidering-medicaid-privatization/

> "Many contracting MCOs are subsidiaries of large regional or national health plans. Key aspects of the relationship of those local subsidiaries to the national parent are opaque. Investor-owned national firms do not report their plans' profitability by state Medicaid program to investors. One large national plan does not even break out its overall Medicaid profits or losses from its commercial or Medicare Advantage business. In many states, there is less than optimal communication between the Medicaid agency and the insurance commission that regulates the plans [along with CMS]. It should not be surprising that individual states may have difficulty determining what happens to their tax dollars if they seem to disappear into a large black box."

[49]

Some lack of transparency in MCO behaviors may be mitigated by the Budget Reconciliation Act, but implementation is always a challenge with legislation.

Given the upheaval in federal Medicaid funding, this is an opportune moment for states that privatized their Medicaid program to reconsider the design of their Medicaid delivery model. The potential financial savings to the states is substantial. Fortunately, there are successful examples to learn from.

Section 3B: Capitation creates perverse incentives to obstruct access to care

MCOs are allowed to retain all or significant portions of the difference between their capitation revenue and actual medical expenses. This creates a financial incentive to reduce all healthcare services – including care generally considered as medically necessary.[50]

Proponents of privatization argue that capitation encourages more prevention and other health maintenance services. Unfortunately, Medicaid MCOs know that **their typical enrollee will remain in Medicaid for less than ten months**, meaning the MCO

[49] Hughes, R. I., & McClellan, M. B. (2019, May 3). *Medicaid managed care: Lots of unanswered questions (Part 1). Health Affairs Forefront*. https://www.healthaffairs.org/content/forefront/medicaid-managed-care-lots-unanswered-questions-part-1
[50] U.S. Department of Health and Human Services, Office of Inspector General. (2022, April). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260). https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

gets no benefit from avoiding future medical expenses.[51,52] Investments in a program that might improve long-term health outcomes exposes an MCO to the cost of the program but guarantees none of the savings. In addition, publicly-traded MCOs tend to focus on the immediate quarter's profits, so possible returns in the future from investments in an individual's health are unlikely to be motivating, even if the individual stays in the MCO's plan. In contrast, MOCs often see immediate cost-savers, such as denying prior authorization requests, as more reliable sources of remuneration.

Additionally, the 2025 Budget Reconciliation Act will require more frequent eligibility determinations, increasing the turnover rate among Medicaid enrollees and further eroding the relevance of long-term health improvements. Before the Budget Reconciliation Act, states typically reevaluated Medicaid eligibility on an annual basis. Under the new law, states will be required, starting in 2027, to repeat this process at least twice yearly for their Affordable Care Act expansion populations (primarily childless adults). They also are required to impose new frequent work reporting requirements on expansion population enrollees. Given the complexity of meeting those demands, millions of people who are eligible for Medicaid are expected to lose their insurance. Among other major concerns, this is likely to further shorten how long individuals remain enrolled in Medicaid, further reducing any financial benefits the MCO could reap by improving the long-term health of the population.

Section 3C: Capitation's impact on utilization of healthcare services

MCOs, especially Medicaid MCOs, frequently use prior authorization (PA) as a tool to regulate access to certain health care services and prescription drugs. MCOs claim that PA is necessary to limit unnecessary utilization and help control costs. However, the use of PA in Medicaid managed care has raised significant access concerns: higher denial rates, inconsistent oversight, and variability across states and plans. Medicaid MCOs deny services at much higher rates than Medicare Advantage MCOs or insurers in the private sector.[53] Some Medicaid MCOs had denial rates exceeding 25%, critically compromising access to care.[54,55]

Although the data show that Medicaid MCOs deny care at a high frequency, there is little research on the impact of these denials. However, there is robust data on the role of MCOs in the Medicare Advantage (MA) program. In 2024, MCOs enrolled roughly half of the Medicare population in Medicare Advantage plans[56] and required prior

[51] Office of the Assistant Secretary for Planning and Evaluation. (2021, April 11). *Medicaid churning and continuity of care* [Issue brief]. U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[52] Arreola, A.D., & Musumeci, M.B. (2025, June). *Reducing Medicaid churn: Policies to promote stable health coverage and access to care* [Issue brief]. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage

[53] Saunders, H., & Hinton, E. (2023, July 27). *New OIG report examines prior authorization denials in Medicaid MCOs*. Kaiser Family Foundation. https://www.kff.org/policy-watch/new-oig-report-examines-prior-authorization-denials-in-medicaid-mcos/

[54] Pollitz, K. (2022, February 4). *Network adequacy standards and enforcement* [Issue brief]. Kaiser Family Foundation. https://www.kff.org/affordable-care-act/issue-brief/network-adequacy-standards-and-enforcement/

[55] Kaiser Family Foundation. (2025, July 22). *10 things to know about Medicaid managed care*. https://perma.cc/M3QW-ZNA6

[56] Klees, B. S., Eckstein, E. T. II, & Curtis, C. A. (2024, November 15). *Brief summaries of Medicare & Medicaid: Title XVIII and Title XIX of the Social Security Act* [PDF]. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/brief-summaries-medicare-medicaid-november-15-2024.pdf

authorizations for 50 million services, compared to 400,000 services in traditional Medicare.[57] In MA plans, MCOs denied the request for authorization 6.4% of the time, creating 3.2 million battles for physicians to provide care to their patients.[58] Although MCOs are required by law to cover the same services as traditional Medicare, the OIG found that 13% of service denials in Medicare Advantage would have been accepted in traditional Medicare or were a flawed decision.[59]

When patients appeal a denial of services, Medicaid MCOs find many of their initial denials inappropriate. A recent report concluded that Medicaid MCOs overturn 46% of these denials.[60]

PA creates an unnecessary and overwhelming burden on physicians, not only taking an emotional toll, but also cutting into the time they have for direct patient care. . In a 2001 lawsuit brought by Connecticut doctors against MCOs, the plaintiffs identified the burdens imposed upon them by PA as a significant factor in their willingness to serve patients insured by MCOs.[61] **89% of physicians in a 2024 American Medical Association reported that prior authorization increases burnout.[62] Similarly, Medicaid MCOs impose excessive work on physicians and prevent the delivery of necessary care.**

Medicaid MCOs also make it challenging, if not impossible, for states to know how limited the MCOs' networks are because provider directories are inaccurate. There is a prevalence of "ghost networks"-- insurance directories that list healthcare providers who are not actually available to patients either because they have retired, moved, are no longer accepting the insurance, are not taking new patients, or have outdated contact information. MCOs have been aware of this problem and have allowed it to persist for many years. CMS has new requirements that attempt to address this, though it is too early to assess the impact and beyond the scope of this report to review.

In 2014, the OIG found that more than half of the providers listed by Medicaid MCOs as in-network were not able to offer appointments to enrollees. Notably, 35% of the providers were unable to be found at the location the MCO provided, 8% said they were not accepting any new patients, and 8% stated they were not even enrolled in the MCO plan.[63] A 2023 study of five large health insurers found that 81% of entries had inconsistencies, such as address errors or the wrong specialty being listed for a

[57] Colón-Emeric, C. S., McDermott, C. L., & Lee, D. S. (2024). Delays and denials in Medicare Advantage: Fixing the systemic conflict of interest. *JAMA, 334*(4), 299–300. https://doi.org/10.1001/jama.2025.9010
[58] Ibid.
[59] U.S. Department of Health and Human Services, Office of Inspector General. (2022, April). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260). https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf
[60] LaPointe, J. (2025, January 9). Breaking down claim denial rates by healthcare payer. *RevCycle Intelligence*. https://www.techtarget.com/revcyclemanagement/feature/Breaking-down-claim-denial-rates-by-healthcare-payer
[61] American Psychiatric Association. (2001). *Connecticut M.D.s turn to court to redress MCO problems. Psychiatric News, 36*(6), 1b. https://doi.org/10.1176/pn.36.6.0001b
[62] American Medical Association. (2024, July). *Prior authorization physician survey* [PDF]. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[63] U.S. Department of Health and Human Services, Office of Inspector General. (2014). *Access to care: Provider availability in Medicaid managed care* (OEI-02-13-00660). https://oig.hhs.gov/reports/all/2014/access-to-care-provider-availability-in-medicaid-managed-care/

physician.[64] A New York Attorney General's report found that 86% of mental health providers listed on health plans' directories were "ghosts."[65]

The existence of these "ghost networks" is directly tied to broader issues of network inadequacy in MCOs, causing care delays that harm patients,[66] including worsening health and death,[67] financial and emotional harm,[68] care abandonment, trust erosion,[69] and an increase in health inequities.[70]

It's harder to get care when there are relatively few physicians accepting Medicaid patients in most states, placing a burden on a small group of providers. Only 74% of physicians nationally accept any patients covered by Medicaid, compared to 88% for Medicare and 96% for private insurance.[71] Retaining physicians in the program is difficult; more than one third of providers exit within five years.[72] This lack of continuity poses a barrier to high quality care.

Physicians cite the administrative burdens of Medicaid managed care PA requirements, not low reimbursement rates, as the primary reason they do not accept Medicaid patients.[73,74]

In 2009, Hawaii converted most of its Medicaid population with serious mental illnesses to MCOs. Within four years, nearly all Hawaii psychiatrists in independent practice had stopped accepting new Medicaid patients. Hawaii's ER and hospital costs for serious mental illness had risen by 30%.[75]

The Connecticut experience suggests a better way forward. According to Ellen Andrews, PhD, executive director of the Connecticut Health Policy Project:

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[64] Butala, N. M., Jiwani, K., & Bucholz, E. M. (2023). Consistency of physician data across health insurer directories. *JAMA*, *329*(10), 841–842. https://doi.org/10.1001/jama.2023.0296
[65] James, L. (2025, July 21). *Attorney General James uncovers major problems accessing mental health care through insurance companies*. New York State Office of the Attorney General. https://perma.cc/Y8KY-5LYP
[66] NBC News. (2024, October 24). *Ghost networks: Health insurance companies and therapy*. https://www.nbcnews.com/health/health-care/ghost-networks-health-insurance-companies-therapy-rcna210591
[67] Coutinho, R. (2024, Sept 22). *How one patient got trapped in a health insurance ghost network*. NPR. https://perma.cc/R5TR-5D7P
[68] Busch, S. H., & Kyanko, K. A. (2020). Incorrect provider directories associated with out-of-network mental health care and outpatient surprise bills. *Health Affairs, 39*(6), 1012–1018. https://doi.org/10.1377/hlthaff.2019.01501
[69] Turban, J. (2025, July 15). *Ghost networks of psychiatrists hinder patients' access to care*. STAT. https://perma.cc/GBE4-GQ2L
[70] Yarrow, G. (2023, May 4). Congress urged to tackle 'ghost networks' amid mental health crisis. *The Hill*. https://thehill.com/policy/healthcare/3988563-congress-urged-tackle-ghost-networks-amid-mental-health-crisis/
[71] Medicaid and CHIP Payment and Access Commission. (2021, June). *Physician acceptance of new Medicaid patients: Findings from the National Electronic Health Records Survey*. https://www.macpac.gov/publication/physician-acceptance-of-new-medicaid-patients-findings-from-the-national-electronic-health-records-survey/
[72] Busch, S. H., & Kyanko, K. A. (2020). Incorrect provider directories associated with out-of-network mental health care and outpatient surprise bills. *Health Affairs, 39*(6), 1012–1018. https://doi.org/10.1377/hlthaff.2019.01501
[73] Gordon, S. H., Gadbois, E. A., Shield, R. R., Vivier, P. M., Ndumele, C. D., & Trivedi, A. N. (2018). Qualitative perspectives of primary care providers who treat Medicaid managed care patients. *BMC Health Services Research, 18*(1), 728. https://doi.org/10.1186/s12913-018-3516-9
[74] Dunn, A., Gottlieb, J. D., Shapiro, A., Sonnenstuhl, D. J., & Tebaldi, P. (2023). *A denial a day keeps the doctor away* (NBER Working Paper No. 29010). National Bureau of Economic Research. https://doi.org/10.3386/w29010
[75] Consillio, K. (2013, June 27). Loss of services drives up mental illness costs. *Honolulu Star-Advertiser*. https://www.staradvertiser.com/2013/06/27/business/loss-of-services-drives-up-mental-illness-costs/

> "In the first year after the state fired the MCOs … the number of participating physicians went up 33%. That's pretty clear evidence that it was managed care holding physicians back from participating in Medicaid."

[76]

According to a December 2024 review of Connecticut's managed fee for service program by Manatt Health, 97% of providers report being "satisfied… with the administration of the HUSKY Health program," compared with 65% reporting satisfaction in a broad national survey.[77]

Section 3D: Assessing quality in MCOs

Because capitation gives MCOs an incentive to deny and delay services, meaningful assessment of quality is a necessary component of a capitation contract.[78] Accurate measurement of MCO quality is difficult for several reasons and published reports are often discredited by academic reviewers:[79]

- **Incomplete MCO data for states to review***:* Medicaid agencies often cannot get complete data from MCOs on services MCOs provide and the outcome of those services. As private corporations, MCOs are allowed to obscure or limit the data they provide.
- **Bundled product problems:** Health insurance covers thousands of services, but MCO quality measures attempt to assess the quality of only a tiny fraction of all those services.
- **Risk adjustment problems:** Scores on quality measures need to be adjusted to reflect factors outside of MCO control. This is known as risk adjustment. But despite four decades of research on risk adjusters, accurate risk adjustment remains elusive. MCOs are known to manipulate the data reported on claim forms to justify higher capitation rates. In addition to the economic burden this imposes on states, it confounds objective measurements of quality.

[76] Burns, J. (2023, January 20). *MCOS- Connecticut bucks the Medicaid managed care trend*. Mostly Medicaid. https://mostlymedicaid.com/mcos-connecticut-bucks-the-medicaid-managed-care-trend/?utm
[77] Medicaid Landscape Analysis, December 2024, page 17. https://portal.ct.gov/dsshome/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf
[78] Medicaid and CHIP Payment and Access Commission. (2023, September 12). *Managed care's effect on outcomes*. https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/
[79] Ross, C., Herman, B., Bannow, T., & Lawrence, L. (2025, August 11). UnitedHealth Medicare Advantage studies raise bias concerns. *STAT*. https://www.statnews.com/2025/08/11/unitedhealth-medicare-advantage-studies-questioned/

"As the owner of an outpatient physical therapy clinic, I wanted to provide care to patients with Medicaid. Many of the people who found me often shared that I was the tenth provider they had contacted – just to find someone who would accept Medicaid. For every Medicaid patient I treated, I knew there was a risk I might never be paid. Even after completing every requirement for pre-authorization, more than 75% of the time I was denied payment for allegedly not obtaining prior authorization, an incredibly frustrating experience. The hours of administrative work required to gain authorization and to pursue payment, nearly led me to stop accepting Medicaid altogether.

"As an elected Missouri State Representative serving on the Budget Committee, I saw firsthand how managed care was added to the state budget in 2015 without any public hearings or opportunities for public comment. There was no chance to fully explore the pros and cons of whether managed care organizations (MCOs) would truly benefit patients or serve Missouri's budgetary needs. Nearly a decade later, Missourians' overall health has not improved—we currently rank among the worst states in healthcare outcomes.

"Not only have we failed to see improvements in health, year after year in budget meetings, there is no transparency regarding the cost of managed care. We are not provided with breakdowns of how funds given to MCOs are spent—whether on actual healthcare, medical equipment, medications, versus how much the MCOs spend on general administration and overhead, staff time to deny pre-authorization, advertising, or their profit.

"As many states have utilized MCOs, and some have not, comparisons between these states provide growing evidence that MCOs do not improve the health of our citizens. In fact, there are strong incentives for them to delay care, deny pre-authorization, and underpay providers in order to maximize profit.

"Just as they refused my patients the healthcare they needed, they also refused legislators the information needed to oversee them. They claim it's 'proprietary,' but as we're the ones paying them, we should be entitled to their information.

"If Missouri is going to continue spending taxpayer dollars on managed care, we need honest, public conversations about whether we are truly getting what we're paying for."

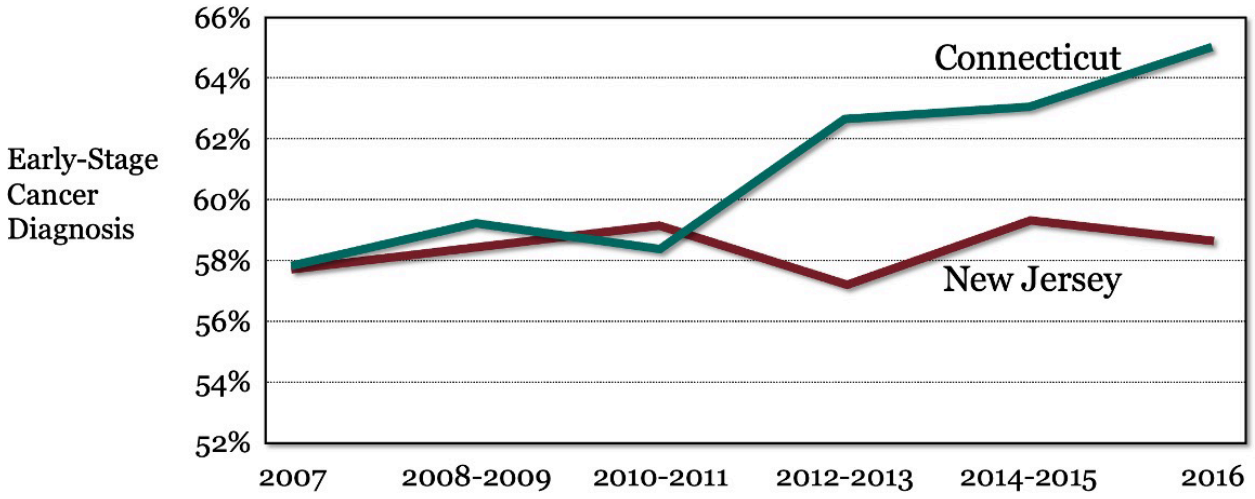
Deb Lavender (Physical Therapist and former Missouri State Representative)

Section 3E: Capitation conflicts with investing in improving healthcare quality and clinical outcomes

Connecticut's experience demonstrates that states can perform well without MCO middlemen. The state's Medicaid program scores above the national average on 68% of federal quality measures and in the top quarter for almost half (47%) of the measures. Its Medicaid program (called "HUSKY") ranks very well on primary/preventive care, maternal/parental health, and oral health.[80] CT generally performs well on the core set of measures applied by CMS compared with other states. A 2024 report found that CT's program demonstrated "[s]trong performance on most national adult and child performance measures compared to median state performance."[81]

New Jersey maintained its Medicaid MCO program at the same time that CT ended its MCO contracts in 2012. As seen in Chart 1 below, prior to the change in CT, the two states had comparable rates of early cancer diagnoses. After they made their change, **CT saw a 4.7% increase in early cancer detection and an 8% higher survival rate compared to New Jersey.**[82] The difference in these outcomes has been attributed to reducing prior authorization delays and other MCO-driven delays in accessing cancer care.[83]

Chart 3: Early-Stage Cancer Diagnosis[84]



[80] Connecticut Department of Social Services. (2025, February 4). *Report regarding the HUSKY Health program pursuant to Section 17 of Public Act 23-171* (p. 17). https://cthealthpolicy.org/wp-content/uploads/2025/02/DSS-HUSKY-Health-Report-Feb-2025.pdf

[81] Connecticut Department of Social Services. (2024, December 13). *Medicaid landscape analysis: Medical Assistance Program Oversight Council (MAPOC) meeting* [Slide 4]. Council on Medicaid Managed Care. https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20241213/Landscape%20Analysis%20Report.pdf

[82] Sunkara, P. R., Waitzman, J., Lenze, N. R., Brenner, M. J., & Cramer, J. D. (2024). Association of Medicaid privatization with patient cancer outcomes. *JCO Oncology Practice, 20*(5), 708–716. https://doi.org/10.1200/OP.23.00297

[83] Andrews, E. (2024, December 11). *Materials from webinar on improved HUSKY cancer survival in CT without MCOs*. CT Health Policy Project. https://cthealthpolicy.org/materials-from-webinar-on-improved-husky-cancer-survival-in-ct-without-mcos/

[84] Sunkara, P. R., Waitzman, J., Lenze, N. R., Brenner, M. J., & Cramer, J. D. (2024). Association of Medicaid privatization with patient cancer outcomes. *JCO Oncology Practice, 20*(5), 708–716. https://doi.org/10.1200/OP.23.00297

Research on the privatization of CA's Medicaid program and the deprivatization of OK's Medicaid program confirm CT's experience with deprivatization.

- **California** Medicaid enrolled older adults and those with disabilities in MCOs between 2011 and 2012, affecting ~240,000 enrollees. This resulted in a rise in emergency department visits and a 12% increase in mortality over the next three years.[85]

- **Oklahoma** started moving its Medicaid population from MCOs into Primary Care Case Management in 2003. This resulted in improved access to preventive services, primary care, and early prenatal care, along with an expansion of the rural provider network. Over the next three years, ER utilization in Oklahoma Medicaid fell by 5% while increasing in Medicaid nationally by 9%,[86] demonstrating the value of better care coordination and access to timely services.

[85] Duggan, M., Garthwaite, C., & Wang, A. Y. (2021). Heterogeneity in the impact of privatizing social health insurance: Evidence from California's Medicaid program (NBER Working Paper No. 28944). National Bureau of Economic Research. https://doi.org/10.3386/w28944

[86] Verdier, J., Colby, M., Lipson, D., Simon, S., Stone, C., Bell, T., Byrd, V., Lipson, M., & Pérez, V. (2009). *SoonerCare 1115 waiver evaluation: Final report* (MPR Reference No. 6492-005). Mathematica Policy Research, Inc. https://oklahoma.gov/content/dam/ok/en/okhca/documents/a0301/9990.pdf

Section 4: The transition to managed fee for service can be relatively rapid

- **Every state currently has some operational capacity for fee for service Medicaid, typically for their aged and disabled populations.** In 2023, 25.4% of the country's Medicaid enrollees were not covered by MCOs and were managed through already existing state-run infrastructure.[87] This infrastructure, expanded and enhanced with care coordination, can provide an operational foundation for deprivatization.

- After two years of consideration,[88] the **Oklahoma** board overseeing Medicaid decided on November 7, 2003 to remove MCOs effective on December 31 2003, and fully transitioned to statewide Primary Care Case Management over the first four months of 2004.[89]

- **Connecticut** demonstrated that removing MCOs from Medicaid and strengthening its fee for service operation can be successful in the first year. In February of 2011, the Governor announced the decision to terminate the state's MCO contracts and instead contract with non-risk ASOs supplemented with "Patient Centered Medical Homes," a team-based expansion of primary care intended to improve outcomes (with mixed evidence).[90] [91] In January of 2012, 11 months after the governor's announcement, the transition from MCOs to managed fee for service and the ASO structure was completed.[92] Benefits were seen in the first year.

[87] Medicaid and CHIP Payment and Access Commission. (2024). *MACStats: Medicaid and CHIP data book* (December 2024 edition). https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf
[88] McGuigan, P. B. (2021, March 22). *Analyzing and stirring the pot: Fight over managed-care Medicaid expansion is serious business*. *The Southwest Ledger*. Capitol Beat OK. https://www.southwestledger.news/news/analyzing-and-stirring-pot-fight-over-managed-care-medicaid-expansion-serious-business
[89] Oklahoma Health Care Authority, SoonerCare Choice: Oklahoma's PCCM Program, ppt at slides 8, 11 (January 2008) No longer publicly posted at Oklahoma site but available at https://docs.google.com/presentation/d/1coKo9-U4y6WTxPiXpcG7l0Fa6xaLvsO4/edit?slide=id.p1#slide=id.p1
[90] National Committee for Quality Assurance. (n.d.). *Patient-centered medical home (PCMH)*. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
[91] Sullivan, K. The verdict is in. The Healthcare Blog. June 7, 2018. https://thehealthcareblog.com/blog/2018/06/07/the-verdict-is-in-all-three-of-cmss-medical-home-demonstrations-have-failed/
[92] Fitzpatrick, M., & Dwyer, K. M. (2015). *Medicaid managed care in Connecticut* (OLR Report No. 2015-R-0010). Connecticut General Assembly, Office of Legislative Research. https://www.cga.ct.gov/2015/rpt/2015-R-0010.htm

Section 5: Pharmacy is both an opportunity and a challenge

An important consideration for some states interested in deprivatizing their Medicaid programs is the potential for political opposition from local hospitals and clinics that participate in the federal 340B Drug Pricing Program. The 340B program enables "covered entities" (defined in statute as hospitals in under-resourced communities, Federally Qualified Health Centers, and a few other entities[93]) to buy medications at a deep discount and retain the difference between the reimbursement paid to them by MCOs and their discounted purchase price.

Current federal rules do not allow covered entities to earn 340B "savings" from Medicaid fee for service programs, but 340B covered entities can earn 340B "savings" from MCOs.[94] This provides a financial incentive for local hospitals and clinics to oppose any state reform that would place more Medicaid enrollees under fee for service. This political dynamic was seen in recent Medicaid deprivatization efforts in California[95] and New York,[96,9798] as well as failed Medicaid deprivatization efforts in Minnesota and Utah.

Some states have been stymied in their efforts to mitigate hospital concerns. One state's anecdotal proposal to "keep the hospital whole" by passing any savings they collect back to the hospitals was countered by two concerns: hospitals see the current 340B model as reliably ensured by federal statutes and therefore do not consistently trust their states to continue their promises indefinitely. Hospitals also are unsatisfied by "being kept whole" as they anticipate continued growth in the program. Indeed, the 340B program funding is expanding rapidly, increasing by 23.4% ($12.6 billion) from 2022 to 2023.[99] Some analysts describe the 340B program as having "gone off the rails" with "unchecked growth and unintended consequences."[100]

These increases may not last forever; states have multiple mechanisms to decrease or eliminate the ability for 340B covered entities to earn 340B revenue from MCOs through variations on which types of covered entities, which type of pharmacies, and which types of claims are allowed under Medicaid Managed Care.

The intense lobbying from covered entities to defeat Medicaid deprivatization and protect their access to 340B rebates is understandable. Across the country, covered

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[93] Health Resources & Services Administration. (n.d.). *340B eligibility and registration*. U.S. Department of Health & Human Services. https://www.hrsa.gov/opa/eligibility-and-registration

[94] See Q and A # 20 on page 5 of CMS-2345-FC at https://www.medicaid.gov/federal-policy-guidance/downloads/faq070616.pdf

[95] Aguilera, E. (2019, October 4). Gov. Newsom's prescription plan pits state against Medi-Cal providers. *CalMatters*. https://calmatters.org/health/2019/10/gavin-newsom-prescription-drug-buying-plan-threatens-nonprofit-medi-cal-providers/

[96] Evergreen Health. (2022, November 14). WNY community health centers launch coalition campaign "Leave340B" to bring patient voice into 340B carve-out debate. *Evergreen Health*. https://www.evergreenhs.org/news/wny-community-health-centers-campaign-leave340b/

[97] WGRZ Staff. (2023, March 25). Community health organizations file lawsuit against NYS over 340B policy. *WGRZ*. https://www.wgrz.com/article/news/local/new-york/evergreen-green-health-harlem-based-provider-file-lawsuit-against-nys/71-11ae156a-0b59-481b-8d68-66f060ef914a

[98] Lisa, K. (2023, February 28). Protestors arrested, interrupt state health budget hearing. *Spectrum Local News*. https://spectrumlocalnews.com/nys/central-ny/politics/2023/03/01/protestors-arrested--interrupt-health-budget-hearing

[99] Fein, A. J. (2024, October 22). *The 340B program reached $66 billion in 2023—Up 23% vs. 2022: Analyzing the numbers and HRSA's curious actions*. Drug Channels. https://www.drugchannels.net/2024/10/the-340b-program-reached-66-billion-in.html

[100] Snow, D. (2025, July 17). *The 340B program has gone off the rails: An Illinois case study of one federal program's unchecked growth and unintended consequences*. Pricepoints Health. https://www.pricepoints.health/p/il-340b

entities stand to lose $6.5 billion in revenue. Because a large portion of the Medicaid program is federally funded, $4.2 billion of this would be new federal revenue and the remaining $2.3 billion would be distributed among the states, as broken out in Table 3 below.[101] **As state Medicaid budgets become increasingly fraught, states may simply find it unacceptable to continue to ignore these funding opportunities.**

The competition for these 340B rebates (between state agencies and covered entities) demonstrates how fragmentation can create conflict between groups who may otherwise be allies.

Table 3: Managed Medicaid Rebates Ineligible Due to 340B Drug Pricing Program (estimated as of 2024)[102]

States	Total Ineligible Managed Medicaid Rebates	Ineligible Managed Medicaid Rebates (state share)
Alabama	N/A	N/A
Alaska	N/A	N/A
Arizona	$322,100,000	$78,100,000
Arkansas	$4,200,000	$900,000
California	$220,000,000	$96,300,000
Colorado	$53,900,000	$23,600,000
Connecticut	$20,100,000	$8,800,000
Delaware	$37,900,000	$13,400,000
District of Columbia	$17,800,000	$4,200,000
Florida	$520,300,000	$175,600,000
Georgia	$120,200,000	$33,400,000
Hawaii	$84,100,000	$31,800,000
Idaho	N/A	N/A
Illinois	$544,300,000	$238,400,000
Indiana	$337,400,000	$94,900,000
Iowa	$116,700,000	$35,800,000
Kansas	$31,400,000	$10,700,000
Kentucky	$52,500,000	$11,300,000
Louisiana	$116,200,000	$30,800,000
Maine	N/A	N/A

[101] Blalock, E., & Launsbach, C. (2025, July). *The financial impact to Medicaid from the 340B drug pricing program*. Berkeley Research Group. https://media.thinkbrg.com/wp-content/uploads/2025/07/11131151/Financial-Impact-to-Medicaid-from-340B_July-2025.pdf
[102] Ibid.

States	Total Ineligible Managed Medicaid Rebates	Ineligible Managed Medicaid Rebates (state share)
Maryland	$202,000,000	$88,500,000
Massachusetts	$433,500,000	$189,900,000
Michigan	$302,200,000	$87,900,000
Minnesota	$89,600,000	$38,500,000
Mississippi	$30,000,000	$4,800,000
Missouri	N/A	N/A
Montana	N/A	N/A
Nebraska	$67,000,000	$24,100,000
Nevada	$42,400,000	$13,200,000
New Hampshire	$9,400,000	$4,100,000
New Jersey	$203,600,000	$89,200,000
New Mexico	$16,700,000	$3,400,000
New York	$129,500,000	$56,700,000
North Carolina	$167,200,000	$43,600,000
North Dakota	N/A	N/A
Ohio	$212,200,000	$64,100,000
Oklahoma	$600,000	$200,000
Oregon	$302,600,000	$101,300,000
Pennsylvania	$634,800,000	$265,300,000
Rhode Island	$31,700,000	$12,600,000
South Carolina	$63,100,000	$14,700,000
South Dakota	N/A	N/A
Tennessee	$34,200,000	$9,500,000
Texas	$559,000,000	$189,700,000
Utah	$69,200,000	$19,300,000
Vermont	N/A	N/A
Virginia	$105,900,000	$45,700,000
Washington	$187,100,000	$82,000,000
West Virginia	$13,500,000	$2,700,000
Wisconsin	N/A	N/A
Wyoming	N/A	N/A
Total	**$6,505,700,000**	**$2,338,900,000**

"N/A" indicates that the structure of these states' Medicaid programs means that they do not incur costs due to the 340B program

Section 6: State examples

Section 6A: North Carolina

North Carolina has gone back and forth on privatization of its Medicaid program. During both stages, its program has been known as Community Care of North Carolina (CCNC).

As a deprivatized model, CCNC was a partnership between Medicaid, primary care physicians, and other local health care providers. CCNC was a grassroots response by physicians, community health care leaders, and state policymakers to meet the challenge of providing cost-effective high-quality care for Medicaid patients, and for years it worked well.

CCNC initially started in 1988 as a demonstration project in Wilson County, funded through a charitable trust. When that project was successful, the state applied and was approved for a 1915b Medicaid waiver to roll out the demonstration project more widely to other counties. The model that the state found to be most successful, and was eventually the structure that the entire program was modeled after, required participation by enough practices to care for at least 70% of Medicaid patients in the community. Additionally, local hospitals, county health departments and departments of social services were required to participate. These entities created fourteen individual networks that were able to respond to the specific needs of their region. Physicians in medical management committees developed initiatives and monitored the statewide progress of these initiatives, making revisions as needed.

The driving impetus behind North Carolina having a deprivatized state-run model came from discussions about block grants and managed care systems taking over the North Carolina Medicaid system. This pushed physicians, who were worried about severe cuts in reimbursement and loss of independence, to try to maintain local control through a community care model.

According to a 2015 report from the North Carolina state auditor, "Between 2003 and 2012, CCNC saved about $312 annually for each Medicaid recipient, while keeping people out of the hospital…. The report showed upwards of $122 million in savings in the first year and a 9% reduction in spending over the entire time period, which works out to **more than $320 million in 2012 alone.**"[103]

North Carolina achieved its largest savings in ED utilization, outpatient care, and pharmacy expenditures. The program received accolades and in 2007 was awarded the Annie E Casey award and Harvard University's Innovations in American Government Award.

In addition to the financial impact of deprivatization in North Carolina, deprivatization also drove a marked increase in the number of primary care physicians willing to treat patients with Medicaid. As described by Thomas White MD, president of the North

[103] Hoban, R. (2015, August 21). Report: Medicaid care management program saved millions. *North Carolina Health News*. https://www.northcarolinahealthnews.org/2015/08/21/report-medicaid-care-management-program-saved-millions/

Carolina Academy of Family Physicians in a press release after the report was made public, "Today [2015], over 90 percent of our state's primary care physicians serve Medicaid patients. They do so in part because of the efficient delivery system we've built."[104]

Despite these achievements, in 2015 North Carolina Governor Pat McCrory signed House Bill 372 (Senate Bill 574) into law, which began the process of privatizing the state's Medicaid program.[105] The state claimed that this change aimed to improve budget predictability, control costs, and promote better health of enrollees by paying insurers based on health outcomes rather than individual services rendered.

Privatization began in 2015 and was officially completed on July 1, 2021[106] (during the COVID pandemic), covering most Medicaid enrollees through commercial health plans, although like most states they retained their high-risk population in the state-run fee for service program called "NC Medicaid Direct."[107]

MACPAC reports that North Carolina's administrative expenses as a portion of the total cost of their Medicaid program has remained flat at 5.5% in FY 2015, FY 2021, FY 2022, and FY 2023.[108] This spans several years prior to transitioning to a privatized system and persisted at least two years after the transition. On balance, the expense of Medicaid administration in the state of North Carolina was unchanged by the switch to a privatized system. Logically, the inverse would also be true for a state that moved in the opposite direction.

We infer that **a state that deprivatizes its Medicaid program and adds a publicly run care coordination program would see little change in the overhead of the Medicaid agency.**

An Urban Institute analysis of the first year of North Carolina's Medicaid MCO transition reported numerous predictable problems:[109]

- Individuals with complex behavioral or physical health conditions faced difficulties finding plans that covered their preferred providers and specialty services, among other challenges. Some enrollees with complex behavioral health needs had to be re-enrolled in Medicaid Direct to maintain access to necessary benefits.

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[104] Hoban, R. (2015, August 21). Report: Medicaid care management program saved millions. *North Carolina Health News*. https://www.northcarolinahealthnews.org/2015/08/21/report-medicaid-care-management-program-saved-millions/
[105] North Carolina General Assembly. (2015). *House Bill 372: An act to transform and reorganize North Carolina's Medicaid and NC Health Choice programs* (Version 8). https://www.ncleg.gov/Sessions/2015/Bills/House/PDF/H372v8.pdf
[106] North Carolina Department of Health and Human Services. (2021, June 30). *NC Medicaid managed care to launch statewide on July 1*. https://www.ncdhhs.gov/news/press-releases/2021/06/30/nc-medicaid-managed-care-launch-statewide-july-1
[107] North Carolina Department of Health and Human Services. (n.d.). *NC Medicaid Direct services*. https://ncmedicaidplans.gov/en/nc-medicaid-direct-services
[108] Medicaid and CHIP Payment and Access Commission. (2024, December). *MACStats: Medicaid and CHIP data book*. https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf
[109] Allen, E. H., Verdeflor, A., & Alvarez Caraveo, C. (2022, October). *Findings from the first year of Medicaid managed care in North Carolina*. Urban Institute. https://www.urban.org/sites/default/files/2022-11/Findings%20from%20the%20First%20Year%20of%20Medicaid%20Managed%20Care%20in%20North%20Carolina.pdf

- Many providers limited participation to certain health plans as a result of administrative burdens associated with contracting and billing with MCOs. This affected access to care, as enrollees sometimes struggled to find in-network providers.

- Enrollees reported disruptions in their access to prescription medications. An increase in prior authorizations caused delays and denials that affected high-need patients. Enrollees also faced unexpected out-of-pocket costs as a result of having to turn to providers outside of the MCO network.

- The added administrative complexity led to confusion for both the providers and the patients. Providers expressed frustration because of the different coding, billing, and prior authorization requirements of each health plan.

Section 6B: Other states

A 2004 review of California's mandate for the majority of Medicaid beneficiaries to enroll in an MCO demonstrated "the average effect of the switch in enrollment induced by the mandate was to increase Medicaid spending by approximately 17%."[110]

In 2022, Ohio removed pharmacy benefit managers from their Medicaid program. Milliman reports that Ohio saved $140 million net over a two-year period – $330 million in total administrative cost savings – while boosting the dispensing fees they pay to retail pharmacies by 1200% and significantly expanding their network of Medicaid-participating pharmacies.[111]

Reports from the privatization of Medicaid in both Kansas and Iowa describe a failure to achieve projected cost savings, reduced access to medically necessary care, a lack of oversight and transparency, and a loss of due process.[112] In both Kansas and Iowa, privatization of Medicaid resulted in an increase in claim denials, reduction in services, and delays in payments to providers. [113,114]An Iowa survey of 400 doctors, hospitals, local clinics and non-profit health care providers showed that only four months into privatization, 90% reported that privatization had increased their administrative costs, 79% were not getting paid on time, 66% said they were paid lower rates than was agreed upon, and 61% said privatization reduced the quality of services they could provide.[115]

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[110] Duggan, M. (2004). Does contracting out increase the efficiency of government programs? Evidence from Medicaid HMOs. *Journal of Public Economics, 88*(12), 2549–2572. https://doi.org/10.1016/j.jpubeco.2003.08.003

[111] Schladen, M. (2025, April 17). Ohio Medicaid got rid of big middlemen, paid pharmacies more and saved $140 million, report says. *Ohio Capital Journal*. https://ohiocapitaljournal.com/2025/04/17/ohio-medicaid-got-rid-of-big-middlemen-says-it-paid-pharmacies-a-lot-more-and-saved-140m/

[112] In the Public Interest. (2018, March). *Privatizing the VA: Lessons from privatized Medicaid in Kansas and Iowa*. https://www.inthepublicinterest.org/wp-content/uploads/ITPI_PrivatizingVAMedicaid_March2018.pdf

[113] Peter Hancock, "LMH accuses KanCare contractors of systematically denying legitimate claims," Lawrence Journal-World, December 29, 2015. http://www2.ljworld.com/news/2015/dec/29/lmh-accuses-kancare-contractors-systematically-den/.

[114] Managed Care Ombudsman Program, Office of the State Long-Term Care Ombudsman, "Managed Care Ombudsman Quarterly Report," July/August/September 2017. https://www.legis.iowa.gov/docs/publications/SD/865777.pdf

[115] Bisignano, T. (2016, August 2). *Iowa Senate should reject privatized Medicaid*. Des Moines Register. https://www.desmoinesregister.com/story/opinion/2016/08/02/tony-bisignano-iowa-senate-private-medicaid/87947626/

Section 7: Conclusion

Winston Churchill is often quoted as saying "Never let a good crisis go to waste."[116] The cuts to Medicaid that were authorized in the 2025 Budget Reconciliation Act are indeed a crisis for patients, physicians, and state governments. The Budget Reconciliation Act unfortunately targeted patients in need of Medicaid coverage rather than waste and fraud among insurance companies with documented patterns of gaming federal health programs like Medicaid and Medicare out of hundreds of billions of dollars. States can respond to the reductions in federal Medicaid funding with their own austerity measures that target individual patients and wreak profound harm on their most fragile population. Or states that have privatized their Medicaid programs can find savings by enacting reforms to deprivatize Medicaid and improve the health and finances of their state. We propose the latter, and hope this report guides the way.

States' reliance on MCOs in their Medicaid programs has raised costs and deprioritized the long term health of their Medicaid populations. This experiment should be recognized as a failure. Insurance companies have not fulfilled their key promises. Fortunately, managed fee for service is a proven alternative. Rather than returning to a traditional direct payment Medicaid model, deprivatizing Medicaid is best organized in conjunction with a modest investment in care coordination programs that both lower total expense and improve health outcomes. Patients would have fewer barriers to care, greater access to teams of providers, meaningful coordination of care across the complex healthcare landscape, and would reap the diverse benefits of improved health.

[116] Stopka, G. (2020, August 14). *Never waste a good crisis: How human resources, networking, and training are changing during these turbulent times*. Engaging Local Government Leaders (ELGL). https://elgl.org/never-waste-a-good-crisis-how-human-resources-networking-and-training-are-changing-during-these-turbulent-times/

Appendices

APPENDIX A: Glossary

ASO (Administrative Services Organization) is a business or non-profit entity that provides administrative support to other businesses or governmental agencies for a specified fee. In health care, ASOs are often contracted to provide administrative services such as claims processing or prior authorization reviews but do not take on financial risk for the cost of healthcare.

Care Coordination is identified by the National Academy of Medicine as a key strategy with the potential to improve the effectiveness, safety, and efficiency of the health care system, encompassing care management, teamwork, medication management, assistance with transitions of care, assistance with transportation, monitoring and followup, linkages to community resources, and multiple other activities.[117] These services are typically performed by physicians and other health care professionals and are paid directly by a state Medicaid program.

Care Management programs are often included in capitation contracts with the intention of improving the delivery of patient care, but being part of the capitation leads to prioritizing the management of healthcare expenses rather than patient care.

FFS (Fee for Service) is a payment model where healthcare providers are directly paid a separate fee for each unit of service they deliver.

FMAP (Federal Medical Assistance Percentage) is the fraction of a state's Medicaid program costs that are funded by the federal government. Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%.[118] The Affordable Care Act enhanced the state FMAP to 90% for the portion of a state's Medicaid population that was added under that law's Medicaid expansion.[119] The Families First Coronavirus Response Act provided a 6.2 percentage point increase to states's FMAP, effective from January 1, 2020 until the end of the COVID public health emergency.[120]

Managed Care Organizations (MCOs) are health insurance plans intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased patient cost

[117] Agency for Healthcare Research and Quality. (2024, November 15). *Care coordination.* U.S. Department of Health and Human Services. https://www.ahrq.gov/ncepcr/care/coordination.html
[118] Mitchell, A. (2025, April 2). *Medicaid's Federal Medical Assistance Percentage (FMAP)* (CRS Report No. R43847) [PDF]. Congressional Research Service. https://crsreports.congress.gov/product/details?prodcode=R43847
[119] Kaiser Family Foundation. (2025, May 9). *Status of state Medicaid expansion decisions.* https://www.kff.org/status-of-state-medicaid-expansion-decisions/
[120] Centers for Medicare & Medicaid Services. (n.d.). *Medicaid CMS-64 FFCRA and CAA increased FMAP expenditure data collected through MBES.* U.S. Department of Health and Human Services. https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes/medicaid-cms-64-ffcra-and-caa-increased-fmap-expenditure-data-collected-through-mbes

sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases.[121]

Managed Fee for Service is a healthcare payment model that retains the fee for service payment structure but adds initiatives to enhance clinical practice, improve coordination of care, and improve quality, likely resulting in a reduction of avoidable costs.[122]

MACPAC (Medicaid and CHIP Payment and Access Commission) is "a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP)."[123]

MedPAC (Medicare Payment Advisory Commission) "is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program."[124]

MLR (Medical Loss Ratio) is defined by the Affordable Care Act as the share of health care premium revenue that health insurance companies spend on clinical services and quality improvement expenditures. The Congressional Research Service discusses what CMS considers allowable quality improvement to be included in the MLR.[125] There is a substantial difference between a statutory definition of MLR for CMS vs the actuarial definition of MLR for business applications.[126]

Overhead of an insurance company is generally the inverse of MLR and encompasses all non-medical expenses, such as administrative costs, employee salaries, office rent, marketing, advertising, and profits. Overhead excludes the cost of clinical services.[127]

There is some ambiguity in the calculation of MLR vs overhead. *This distinction has both clinical and financial implications. "For the purposes of the MLR calculation, 'medical care' consists of clinical services and quality improvement efforts. Since the MLR must be 80-85%, there is an incentive for insurers to spend more, up to a certain point, on medical care and 'quality improvement.' Prior authorizations, where an insurance company must approve a proposed medical service before the provider executes it, count as quality improvement. However, there is little evidence*

[121] National Library of Medicine. https://www.ncbi.nlm.nih.gov/mesh?term=managed%20care
[122] Centers for Medicare & Medicaid Services. (2011, July 8). *Financial models to support state efforts to integrate care for Medicare-Medicaid enrollees* (SMDL #11-008) [PDF]. U.S. Department of Health and Human Services. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
[123] Medicaid and CHIP Payment and Access Commission. (n.d.). *About MACPAC*. U.S. Department of Health and Human Services. https://www.macpac.gov/about-macpac/
[124] Medicare Payment Advisory Commission. (n.d.). *What we do*. https://www.medpac.gov/what-we-do/
[125] Wreschnig, L. A. (2015, January 29). *Medical loss ratio requirements under the Patient Protection and Affordable Care Act (ACA): Issues for Congress* (CRS Report No. R42735) [PDF]. Congressional Research Service. https://www.congress.gov/crs-product/R42735
[126] Milliman Research Report: Medicaid managed care financial results for 2024. June 2025. https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/6-30-25_Medicaid-managed-care-financial-results-2024.pdf
[127] Chang, E., & Kasey, J. (2022, December 29). *Focusing on health plan administrative cost*. Milliman. https://www.milliman.com/en/insight/focusing-on-health-plan-administrative-cost

that the majority of prior authorizations result in higher quality care or improved health outcomes, and in fact, many providers believe it does the opposite."[128]

PMPM (Per Member Per Month) is a metric used in the healthcare industry to express the average monthly cost for each individual covered under a health insurance plan. It is calculated by dividing the total healthcare costs for one month by the number of people enrolled in the plan during that month. It is used to establish the rates at which capitated MCOs are paid based on the number of enrollees in a plan in a given month.

[128] Hogg, A. S. (2024, August 20). *Is the medical loss ratio an innovation friend or foe?* Christensen Institute. https://www.christenseninstitute.org/blog/is-the-medical-loss-ratio-an-innovation-friend-or-foe/

APPENDIX B: Guidelines for states developing legislation to deprivatize Medicaid

The specific circumstances of each state's current Medicaid program, combined with their local culture, politics, and economics, make it beyond the scope of this report to propose model legislation for each state to adopt. In this section we provide guidelines and recommendations for what states need to consider in drafting their own legislation, understanding that some states may wish not to be very prescriptive.

An example of a starting point for a state wishing to develop a managed fee for service program, the 2025-2026 Minnesota state legislature is considering a similar bill, SF1059.[129]

As another example, Connecticut authorizes the state's Medicaid agency to "contract with one or more ASOs to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under the HUSKY Health program. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner."[130]

1) States must prohibit the initiation or renewal of contracts with MCOs and all other entities that bear any financial risk.

2) Providers should be paid directly by the state entity managing the new Medicaid program.

3) The legislation needs to define care coordination (which must include physicians, community health workers, nurses, and other licensed care providers that are essential to a properly functioning care coordination system) that can respond flexibly in the community to the needs of individual patients.

4) States should authorize their Medicaid agencies to pay health care professionals for care coordination and related services. Examples include a managed fee for service program similar to Connecticut's model using ASOs, or through an enhanced primary care case management system similar to North Carolina's former system without ASOs. With either approach, there should be no intermediaries that bear financial risk. Key features for a successful care coordination program:

    a) Ensure that providers will be fairly compensated in a timely manner.

    b) Practices that are approved by the State to coordinate care may receive extra funding for documented care coordination services.

    c) Create funding streams for community outreach to help create care coordination programs within communities.

[129] Minnesota Legislature. (2025, March 21). *SF 1059: Patient-Centered Care program establishment.* https://www.revisor.mn.gov/bills/text.php?number=SF1059&version=0&session=ls94&session_year=2025&session_number=0
[130] Conn.Gen. Stat. § 17b-261m at https://codes.findlaw.com/ct/title-17b-social-services/ct-gen-st-sect-17b-261m/

d) Care coordination teams should include licensed community-based human resources that are readily accessible to primary care practices, with a mission to interact with primary care practitioners and their patients.

e) Care coordination teams should also serve specialty and subspecialty consultants in collaboration with primary care practices.

5) Public health functions should continue to be provided directly by the state for population health needs (e.g., vaccinations and disease control).

6) Administrative functions need to be provided directly by the state or a contracted ASO for oversight functions such as quality improvement, customer service, and review of grievances. (Grievances about an ASO itself would need to be handled directly by the state Medicaid department.) If the state chooses to contract with ASOs, the ASOs should be prohibited from establishing their own provider networks; there should be only one statewide provider network available to all enrollees, though the ASO may assist enrollees in obtaining access to providers in the unitary network.

7) States should develop regional hubs that meet periodically to discuss community health needs and equitable access to care within their own region as identified by providers, nurses, and patients rather than insurance interests or other industry agents. This helps ensure that all communities are being served adequately and the state Medicaid agency is well informed. As developed by North Carolina, these regional hubs should convene state-wide annual meetings to discuss the state outlook, identification of best practices, opportunities for improvement, and efforts to achieve these improvements. These annual meetings should include representation from the state Medicaid agency to ensure that everyone is on the same page and that the program remains fiscally sound while ensuring that the needs of all enrollees are being met. All meetings should be open to the public.

APPENDIX C: Alternatives to deprivatization of Medicaid

States have at least five other potential responses to the federal Medicaid budget reductions. Each of these alternatives would either be politically highly unpopular or would undermine the health and well-being of a state's most fragile population and should not be adopted.

1. **Not recommended: Cut Medicaid eligibility**

   The 2025 Budget Reconciliation Act requires states to end Medicaid coverage for many categories of legally present immigrants in October of 2026, and to introduce work reporting requirements and more frequent redeterminations for all expansion populations in January 2027. This, plus other cuts, including the major additional cuts to states from cutting back on their provider taxes which currently leverage additional federal Medicaid dollars, is anticipated to reduce Medicaid eligibility by 7.8 million people.[131] Due to budget constraints, some states may be considering additional strategies to reduce eligibility.

2. **Not recommended: Cut Medicaid services**

   Most states include coverage for a range of "optional" services beyond the minimum statutory requirements for participation[132]. Optional services include pharmacy, dentistry, physical therapy, occupational therapy, and hospice care, among other vital benefits. Ironically, optional long-term home health services are among the first to go, which results in higher hospitalization and ER utilization.[133] As one example, California eliminated its comprehensive dental coverage from Medicaid in 2009 and saw a 32% increase in dental ED visits and increasing average yearly costs of dental ED visits by 68%.[134]

3. **Not recommended: Cut Medicaid reimbursement rates**

   Many states already pay providers at rates that are so low it is difficult for people covered by their program to maintain reasonable access to care.[135] There is thus very little room to reduce these rates and still have a functioning program.

4. **Not recommended: Reduce funding for state programs outside of Medicaid**

   This approach puts states under pressure to choose among competing funding priorities.

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[131] Congressional Budget Office. (2025, May 7). *Estimates for Medicaid policy options and state responses* [PDF]. https://www.cbo.gov/publication/61377

[132] Ives-Rublee, M. (2025, May 16). *Federal Medicaid cuts would force states to eliminate services for disabled adults, older adults, and children.* Center for American Progress. https://www.americanprogress.org/article/federal-medicaid-cuts-would-force-states-to-eliminate-services-for-disabled-adults-older-adults-and-children/

[133] Centers for Medicare & Medicaid Services. (n.d.). *Benefits.* Medicaid.gov. https://www.medicaid.gov/medicaid/benefits

[134] Singhal, A., Caplan, D. J., Jones, M. P., Momany, E. T., Kuthy, R. A., Buresh, C. T., Isman, R., & Damiano, P. C. (2015). Eliminating Medicaid adult dental coverage in California led to increased dental emergency visits and associated costs. *Health Affairs, 34*(3), 404–410. https://doi.org/10.1377/hlthaff.2014.1358

[135] American Hospital Association. (2023, June 28). *AHA comment letter on CMS' proposed rule to ensure Medicaid services access.* https://www.aha.org/lettercomment/2023-06-28-aha-comment-letter-cms-proposed-rule-ensure-medicaid-services-access

5. **Not likely to be politically feasible: Raise general state taxes**

   Although some states may turn to this approach, many states have existing statutes or political climates that make this difficult, if not impossible.

Other than deprivatization, each of these alternatives either cuts services for individuals or increases taxes.

APPENDIX D: Research on Medicaid MCOs is difficult

- **Comparisons are deeply confounded.** Unlike Medicare Advantage, which has traditional Medicare as a control group (an imperfect one, to be sure), Medicaid MCOs have no such comparison group. Interstate comparisons are confounded as states vary widely in the details of their programs. Longitudinal trends within single states are complex as benefit designs and eligibility are often shifting. Intrastate comparison of Medicaid MCO patients with the state's Medicaid FFS patients is confounded as states generally exclude their higher risk groups (*e.g.*, aged, blind, and disabled) from MCO capitations.

- **States adopted Medicaid MCOs without rigorous testing or evidence of their efficacy.** There are no studies done prior to Medicaid MCO adoption to show that MCOs would save money; additional comprehensive research would be helpful. Research on the true impact of MCOs on the financing of Medicaid remains neglected.

- **Researchers sometimes fail to distinguish multiple causes of utilization or cost variance**, conflating other changes with the impact of privatization. For example, in Texas, mandatory enrollment into MCOs was associated with a reduction in inpatient utilization.[136] The reduction in inpatient utilization is thought to be a consequence of improved access to prescription medications, which helped prevent the need for additional services, and not from capitation. "Prior to privatization, the state imposed strict rationing of drugs among public plan enrollees through a monthly limit of three prescriptions, while not imposing this limit on private plan enrollees and instead allowing the private plans to use their own utilization management methods… As rationing was relaxed for drugs and outpatient care in Texas, we find clear evidence that inpatient spending decreased by at least 8%."[137]

[136] Layton, T. J., Maestas, N., Prinz, D., & Vabson, B. (2019, July). *Private vs. public provision of social insurance: Evidence from Medicaid* (NBER Working Paper No. 26042). https://www.nber.org/system/files/working_papers/w26042/w26042.pdf
[137] Duggan, M., Garthwaite, C., & Wang, A. Y. (2021, June). *Heterogeneity in the impact of privatizing social health insurance: Evidence from California's Medicaid program* (NBER Working Paper No. 28944). https://www.nber.org/system/files/working_papers/w28944/w28944.pdf

APPENDIX E: Comparison of MCOs vs managed fee for service

Section E1: Contracting with MCOs does not reduce a state's financial risk or create predictable budgets. Perhaps one of the most frequently presented arguments by MCOs and state agencies which contract with them is that making capitated payments to insurers ensures predictability for the state and avoids spikes due to very high care needs by a few expensive patients. The MCOs argue that protecting the states from such fluctuations is a valuable service. In reality, however, most of the fluctuation in expenditures under Medicaid are due to enrollment increases, not costs per person, and this risk is not borne by the MCO in any way; it stays with the state.

In Connecticut, when replacing the capitated MCOs with non-risk ASOs and care coordination through patient-centered medical homes, state officials considered and rejected the argument that continuing to pay the MCOs to take on the minimal risk of fluctuating costs per member per month (PMPM) was worth it. ("PMPM" is an industry standard way to measure costs and should not be confounded by fluctuations in membership.) The large pool of all Medicaid members assured the state of significant predictability for the per member costs of all of its enrollees combined.

Medicaid populations in every state are large. If included in one risk pool, there is very limited fluctuation in PMPM costs that occurs even with a few unpredicted very expensive patients per year. Those uncommon costs are distributed across a large pool. As described earlier, fragmenting the state into multiple smaller risk pools demands larger capital reserves, which ultimately are funded by the state.

Section E2: Managed fee for service offers states better control over their Medicaid program. States that engage with MCOs are required by federal law to provide a choice of MCOs throughout the state (except under certain circumstances in rural areas).[138] States dependent on a small number of MCOs are beholden to those MCOs, particularly if there are only two operating in parts of the state. Because of the threat – expressed or implied – during negotiations that they will depart the state if hefty annual increases are not provided, contracting with MCOs does not avoid long-term risks to the state's budget from annual increases in the MCOs' capitation rates. Contracting with MCOs may give a small amount of increased predictability for PMPM costs, but only for one year until rates are renegotiated. Managed fee for service eliminates this undue leverage.

Section E3: The managed fee for service model contains utilization in ways that are transparent without denying care inappropriately. In stark contrast, several independent sources find that MCOs deny care inappropriately. MCOs fail to disclose complete, accurate or timely data to demonstrate otherwise. In fact, they hide their data, rendering them effectively unaccountable for their bad acts. Without good data or any independent research to support their claims and with evidence of widespread inappropriate delays and denials of care, MCO performance should be suspect.

[138] 42 C.F.R. § 438.52). *See* Former Medicaid Official shares troubled MCO history - CT Health Policy

An OIG report found that MCOs denied 1 out of every 8 requests for prior authorization.[139] This can lead to overall wasted money and time, ultimately damage the health of the patient, promote worse health outcomes, and raise the cost of Medicaid spending.

This pattern is widely recognized by practicing physicians. In a 2024 survey by the American Medical Association, 90% of physicians reported that prior authorization leads to an *increased* use of healthcare through ineffective initial step-therapy treatments (69% reported), additional office visits (68% reported), emergency department visits (42% reported), and hospitalizations (29% reported).[140] Increased access to outpatient care, especially primary care, can also result in lower ER and hospital utilization, with savings that can more than offset the increase in out-patient care.

For example, in Connecticut, the shift away from MCOs to less burdensome managed fee for service brought a 14.6% increase in primary care provider enrollment, and an 11.4% increase in specialist participation, even though only primary care provider rates went up around the same time; specialists rates were unchanged. At the same time, ER usage was reduced by 15.1% and hospital inpatient readmissions were reduced by 44.4% for enrollees who engaged with the medical ASO's care coordination and intensive discharge planning programs, respectively, while the overall enrollee hospital readmission rate dropped by 2.9% within 30 days.[141]

Section E4: The blunt approach MCOs apply to utilization can lead to increased overall utilization. In states like Hawaii, the aged blind and disabled population (including most of the seriously mentally ill) was moved into private MCOs in 2009. A review of the immediate period after this demonstrated the collapse of the state's Medicaid psychiatry network:

[139] U.S. Department of Health and Human Services, Office of Inspector General. (2023, July 17). *High rates of prior authorization denials by some plans and limited state oversight raise concerns about access to care in Medicaid managed care* (OEI-09-19-00350). https://oig.hhs.gov/reports/all/2023/high-rates-of-prior-authorization-denials-by-some-plans-and-limited-state-oversight-raise-concerns-about-access-to-care-in-medicaid-managed-care/

[140] American Medical Association. (2024, August 9). *Prior authorization delays care—and increases health care costs.* https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care

[141] Connecticut Department of Social Services. (n.d.). A precis of the Connecticut Medicaid program [Referencing p. 7]. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Medicaid-Hospital-Reimbursement/precis_of_ct_medicaid_program.pdf

> "A problem facing Hawaii is how few practitioners are willing to see new Medicaid patients. The Medicaid population in Hawaii is growing, while the number of providers willing to see Medicaid patients is shrinking. Many providers explained on the phone that though they used to see some Medicaid patients, they are unwilling to see new ones due to low reimbursement rates, burdensome restrictions on care, and the ongoing effort required to attain reimbursement. Hawaii is in an interesting position as nearly all Medicaid options are hybrid HMO plans with private companies. Oftentimes the private companies oversee reimbursement and treatment care plans. In practice since the mid-1990s, area doctors surmise that since this came into being, many stopped, or largely cut down, seeing Medicaid-receiving patients."

[142]

This collapse of the state's Medicaid psychiatry network has important ramifications. By 2013 Hawaii documented a 30% increase in mental health ER and hospital costs compared to 2009.[143]

Section E5: A far more serious problem than overutilization of healthcare services is a widespread lack of access. This is driven by profit-motivated prior authorization denials, inadequate provider networks, lack of English literacy or medical literacy, cultural resistance to seeking treatment for some kinds of medical needs, and the unaffordability of cost-sharing where it is already permitted. Each of these problems compromises health outcomes and drives up long-term expenses.[144,145]

Section E6: Modest increases in utilization may well be desirable. Take for example an elderly enrollee who had a stroke and needs help with activities of daily living from a home health aide to stay in their own apartment, something which is covered under state Medicaid programs. Such a person might need five hours/day or 35 hours per week of assistance, and yet the MCO in its own judgement might only approve 7 hours/week. The MCO's denial of those 28 hours per week could lead to an avoidable hospitalization, at greater overall expense. But even if not, the quality of life of the individual may be greatly enhanced by providing the full 35 hours needed, through not

[142] Aaronson, A., & Withy, K. (2017). Does Hawai'i have enough psychiatrists? Assessing mental health workforce versus demand in the Aloha State. *Hawaii Journal of Medicine & Public Health, 76*(3 Suppl 1), 15–17. https://pmc.ncbi.nlm.nih.gov/articles/PMC5375008/

[143] Walden, A. (2013, June 27). *June 27, 2013 News Read*. Hawaii Free Press. https://www.hawaiifreepress.com/Articles-Daily-News/ID/10002/June-27-2013-News-Read

[144] Faiz, J., Blegen, M., Nuñez, V., Gonzalez, D., Stokes, D. C., Truong, K., Ryan, G., Briggs-Malonson, M., & Kahn, K. L. (2024). Frontline perspectives on barriers to care for patients with California Medicaid: A qualitative study. *International Journal for Equity in Health, 23*, 102. https://doi.org/10.1186/s12939-024-02174-8

[145] National Academies of Sciences, Engineering, and Medicine. (2023). Chapter 5: Health care access and quality. In *Federal policy to advance racial, ethnic, and tribal health equity* (pp. 223–268). The National Academies Press. https://doi.org/10.17226/26834

being left unable to get to bed or in soiled diapers, or not going hungry due to an inability to prepare food on their own. As we have stated earlier, it is socially desirable, and in the public interest, that this appropriate utilization be available as needed.

Section E7: The business model of managed care focuses on short-term expenses and deemphasizes the value of improving clinical care to garner long-term reductions in expense. Rather than relying upon the conflicted interests of a capitated MCO, there is a ready solution for addressing overuse in Medicaid. Connecticut again demonstrates a highly effective solution.

In 2011, when Connecticut made the decision to end its contracts with capitated MCOs, effective in January 2012, it published a Request for Proposal for non-risk administrative services organizations (ASOs) to perform the state's prior authorization reviews. The state was thereby empowered to decide which specific services would be subject to prior authorization and the specifics of the criteria and workflow. The ASOs were charged with making these authorization determinations based on the state's statutory definition of medical necessity[146] and some publicly-available clinical guidelines developed by the ASO in conjunction with the state.

Unlike an MCO, the ASO has no financial incentive to grant or deny an authorization request. The ASO is simply responsible for operationalizing the parameters set by the state.

This is in contrast to other approaches to care management described earlier in this document.

Section E8: MCOs do not meaningfully coordinate the delivery of healthcare. MCOs claim that they provide quality care coordination which assures people receive appropriate care early on and thus avoid expensive hospital-based treatment which would then be at their expense. None of this is true.

MCO capitation rates often include explicit funding for care coordination, but it is in the MCO's financial interests to perform the least amount of such work. Despite contractual language, MCO "care coordination" is often little more than reviews of expensive institutional care, such as in hospitals and rehabilitation facilities, to terminate these expensive services early to benefit their bottom lines.

Proponents of managed care purport that capitation motivates MCOs to avoid the increased costs of preventable deteriorations in health status. MCOs, however, are predominantly concerned with their short-term financial performance. Delayed consequences of uncontrolled diabetes may not manifest until long after a patient is no longer part of that insurer's population. The savings from improving the health status of people enrolled in the MCO would then accrue to a different insurer.

[146] Conn. Gen. Statutes § 17b-259b.

> "Medicaid managed care organization care coordinators face frequent barriers to performing their jobs. These barriers to job performance fall into three main areas: accessing medical and social resources for Medicaid members, managing a large caseload within changing regulatory environments, and obtaining needed data to track and follow members."

[147]

[147] Marks, S. J., Vega, V., Zhu, D., Shadowen, H., Harrell, A., Lowe, J., Mitchell, A., Barnes, A. J., & Cunningham, P. J. (2025, June 6). Challenges faced by Medicaid managed care coordinators working with members with substance use disorder. *American Journal of Managed Care*. https://www.ajmc.com/view/challenges-faced-by-medicaid-managed-care-coordinators-working-with-members-with-substance-use-disorder

APPENDIX F: State-specific savings opportunity

A state's savings can be determined by the amount of its Medicaid spending that runs through an MCO, the fraction of that spending that is the state's responsibility after the federal government picks up its share ("Federal Medical Assistance Percentage" or "FMAP"), and the range of potential savings from 10% to 17% as described in Tables 1 and 2 earlier.

Table 4 reflects savings opportunities for individual states based upon their 2023 Medicaid MCO spending[148] and their standard 2023 FMAP.[149] Although this is the most currently available comprehensive data, there have been significant changes over the subsequent three years. For example, between FY 2023 and FY 2026, the state of Missouri's total Medicaid MCO spend increased from $5,442,500,000 to $6,560,000,000[150] while its FMAP decreased from 72% in FY 2023 to 64%.[151] The net effect for Missouri is that the upper bound of the opportunity rose from $259,000,000 displayed in Table 4 to $401,000,000 for FY 2026. A similar pattern applies across the country; the USA average FMAP in 2023 was 56.2%, but 50.0% in 2026. As the MO pattern reveals, a drop in FMAP means a larger fraction of the savings remains with the state.

Table 4 also demonstrates the Federal savings opportunity. Total Federal MCO Medicaid spending in 2023 was $ 256,605,428,133. **We estimate that nationwide deprivatization of Medicaid in 2023 would have saved the federal government $ 25,660,542,813, or potentially as much as $ 43,622,922,782.**

Authors: Ed Weisbart, MD; Stephen Kemble, MD; Kip Sullivan, JD; Mark S. Krasnoff, MD; Anu Dairkee, MD, JD; Nahiris M. Bahamón, MD, MPH, FAAP; Diane Archer, JD; Amelia Smith, MS and Medical Student; and Sheldon Toubman, JD

[148] Kaiser Family Foundation. (n.d.). *Total Medicaid MCO spending*. KFF. https://www.kff.org/medicaid/state-indicator/total-medicaid-mco-spending/
[149] Kaiser Family Foundation. (n.d.). *Federal matching rate and multiplier*. KFF. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/
[150] Missouri House of Representatives. (2025). *Conference Committee Substitute for Senate Substitute for Senate Committee Substitute for House Committee Substitute for House Bill No. 11 (Sections 11.770 and 11.845)*. 103rd General Assembly. https://documents.house.mo.gov/billtracking/bills251/hlrbillspdf/0011H.06T.pdf
[151] Ibid, 149.

Table 4: Potential savings per state, FY 2023

States	Total MCO spending (2023)	Standard FMAP	States responsibility	Low end savings estimate (10%)	High end savings estimate (17%)
Alabama	N/A	78.6%			
Alaska	N/A	56.2%			
Arizona	$17,015,149,551	75.8%	$4,124,472,251	$412,447,225	$701,160,283
Arkansas	$498,797,505	77.5%	$112,179,559	$11,217,956	$19,070,525
California	$54,399,406,974	56.2%	$23,826,940,255	$2,382,694,025	$4,050,579,843
Colorado	$540,894,805	56.2%	$236,911,925	$23,691,192	$40,275,027
Connecticut	N/A	56.2%			
Delaware	$2,670,415,016	64.7%	$942,923,542	$94,292,354	$160,297,002
District of Columbia	$1,917,149,557	76.2%	$456,281,595	$45,628,159	$77,567,871
Florida	$23,357,728,060	66.3%	$7,883,233,220	$788,323,322	$1,340,149,647
Georgia	$7,134,311,154	72.2%	$1,981,911,639	$198,191,164	$336,924,979
Hawaii	$2,266,439,201	62.3%	$855,354,154	$85,535,415	$145,410,206
Idaho	N/A	76.3%			
Illinois	$21,976,931,783	56.2%	$9,625,896,121	$962,589,612	$1,636,402,341
Indiana	$7,119,134,651	71.9%	$2,003,324,491	$200,332,449	$340,565,163
Iowa	$6,131,873,723	69.3%	$1,880,645,671	$188,064,567	$319,709,764
Kansas	$4,669,385,525	66.0%	$1,589,458,833	$158,945,883	$270,208,002
Kentucky	$11,608,076,809	78.4%	$2,510,827,014	$251,082,701	$426,840,592
Louisiana	$11,465,601,328	73.5%	$3,040,677,472	$304,067,747	$516,915,170
Maine	N/A	69.5%			
Maryland	$6,997,941,544	56.2%	$3,065,098,396	$306,509,840	$521,066,727
Massachusetts	$9,244,101,672	56.2%	$4,048,916,532	$404,891,653	$688,315,810

States	Total MCO spending (2023)	Standard FMAP	States responsibility	Low end savings estimate (10%)	High end savings estimate (17%)
Michigan	$11,205,231,514	70.9%	$3,259,601,847	$325,960,185	$554,132,314
Minnesota	$9,442,782,194	57.0%	$4,061,340,622	$406,134,062	$690,427,906
Mississippi	$2,703,638,949	84.1%	$430,960,048	$43,096,005	$73,263,208
Missouri	$5,442,500,385	72.0%	$1,523,355,858	$152,335,586	$258,970,496
Montana	N/A	70.3%			
Nebraska	$2,404,694,842	64.1%	$864,006,857	$86,400,686	$146,881,166
Nevada	$2,602,490,164	68.9%	$810,675,686	$81,067,569	$137,814,867
New Hampshire	$1,086,973,971	56.2%	$476,094,599	$47,609,460	$80,936,082
New Jersey	$14,786,641,100	56.2%	$6,476,548,802	$647,654,880	$1,101,013,296
New Mexico	$6,423,695,292	79.5%	$1,319,427,013	$131,942,701	$224,302,592
New York	$59,321,518,261	56.2%	$25,982,824,998	$2,598,282,500	$4,417,080,250
North Carolina	$7,033,661,888	73.9%	$1,835,082,387	$183,508,239	$311,964,006
North Dakota	$367,964,726	57.8%	$155,465,097	$15,546,510	$26,429,066
Ohio	$16,235,404,057	69.8%	$4,906,339,106	$490,633,911	$834,077,648
Oklahoma	N/A	73.6%			
Oregon	$8,462,134,373	66.5%	$2,833,122,588	$283,312,259	$481,630,840
Pennsylvania	$28,808,283,250	58.2%	$12,041,862,399	$1,204,186,240	$2,047,116,608
Rhode Island	$2,123,196,831	60.2%	$845,881,617	$84,588,162	$143,799,875
South Carolina	$4,253,504,228	76.8%	$987,663,682	$98,766,368	$167,902,826
South Dakota	N/A	62.9%			
Tennessee	$8,115,788,943	72.3%	$2,248,073,537	$224,807,354	$382,172,501
Texas	$38,674,085,619	66.1%	$13,122,117,251	$1,312,211,725	$2,230,759,933
Utah	$2,180,434,418	72.1%	$608,341,203	$60,834,120	$103,418,004
Vermont	N/A	62.0%			

States	Total MCO spending (2023)	Standard FMAP	States responsibility	Low end savings estimate (10%)	High end savings estimate (17%)
Virginia	$12,638,612,522	56.9%	$5,453,561,303	$545,356,130	$927,105,422
Washington	$17,292,205,130	56.2%	$7,573,985,847	$757,398,585	$1,287,577,594
West Virginia	$2,599,289,477	80.2%	$514,139,459	$51,413,946	$87,403,708
Wisconsin	$3,375,217,502	66.3%	$1,137,448,298	$113,744,830	$193,366,211
Wyoming	N/A	56.2%			
Total	$456,593,288,494	56.2%	$199,987,860,360	$19,998,786,036	$33,997,936,261

- **Notes:**
  - "N/A" indicates data is not available as the state had no contracts with comprehensive MCOs in 2023
  - State responsibility was calculated as ((100% - FMAP) x (Total MCO spending))
- **Adjustments not included in these projections:**
  - Based on 2023 data and not adjusted for medical cost inflation between 2023 and 2026, therefore underestimates the total savings opportunities.
  - Does not account for annual changes in FMAP, in particular loss of COVID bump to FMAP, therefore underestimates the savings to states and overestimates the savings by the federal government.
  - The standard FMAP is not adjusted for the 27% of the 2023 Medicaid population[152,153] who were eligible due to the ACA's expansion of Medicaid and had a 90% FMAP, which overestimates the savings to the states and underestimates the savings to the federal government.
  - Adjusting for the expansion population FMAP would be confounded by the absence of public data comparing the state-specific pmpm costs of the expansion population within an MCO vs the non-expansion population within an MCO. It is difficult to estimate the impact of that adjustment.

[152] Harker, L., & Sharer, B. (2024, June 14). *Medicaid expansion: Frequently asked questions*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0
[153] Kaiser Family Foundation. (2025, July 28). *Medicaid enrollment and unwinding tracker*. https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#93469f01-80b8-4f2a-b58e-f00496dff23f