ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

Medicaid Managed Care: A Platform for Better Value

Why Medicaid should retain managed care while modernizing state requirements that constrain integration, innovation, and value-based payment

Medicaid managed care is so much more than a health care payment mechanism. It provides states something beyond what traditional fee-for-service health care coverage cannot: a partner not only accountable for health care cost, quality, and access, but also supports coordination of care for an entire population. By bringing together responsibility for financing, access, quality, and care coordination, managed care gives states a powerful tool to improve the delivery of health care and ensure beneficiaries receive the right care at the right time. States can further leverage this model to protect taxpayer resources while improving health outcomes and helping beneficiaries navigate an often-complex health care system.

The model is straightforward. Managed care organizations (MCOs) receive a fixed per-member, per-month payment and assume financial risk for delivering covered services. This structure gives states greater budget predictability while creating strong incentives for health plans to prevent avoidable illness, steer care to the right setting, manage complex conditions, and intervene before health needs escalate into more serious—and more costly—crises. Beneficiaries, in turn, benefit from a system designed not simply to pay for individual services, but to help coordinate and manage their care. Unlike a straight fee-for-service system that simply pays each claim, managed care can add further value through connecting information across providers, identifying gaps in care and possible solutions, and taking steps to close them.

That value is especially important in behavioral health, where beneficiaries often need coordinated mental health (MH), substance use disorder (SUD) care, alongside physical health, pharmacy, and community-based services.[1] Managed care provides that coordination when supported by the appropriate responsibilities, resources, health care data, and the flexibility to develop solutions to improve care.

Importantly, states retain significant authority to shape their Medicaid managed care programs to meet the needs of their unique populations and health care systems, policy priorities, and program needs. State Medicaid agencies control eligibility and enrollment procedures and determine which services MCOs cover, which benefits are carved out, how much health plans are paid, how providers must be reimbursed, and

[1] https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative? Nearly 40 percent of adult Medicaid and CHIP beneficiaries under age 65 experience a mental health condition, a substance use disorder, or both, and many also have significant physical health and social needs.

which quality measures must be reported. States also determine how much flexibility health plans have to invest in new approaches to care. Within this framework, health plans are responsible for developing and delivering innovative approaches to provide high-quality benefits and services to Medicaid beneficiaries. Roles are complementary and clear.

This flexibility allows states to use managed care in different ways based on their individual circumstances and goals. Medicaid managed care, therefore, does not look the same in every state; states can tailor their programs and their relationships with MCOs to reflect their populations, delivery systems, and policy priorities.

The question should not be whether Medicaid should abandon managed care; rather, it should be how states can leverage the model more effectively. The key is pairing health plan accountability with sufficient authority and flexibility to manage care, improve outcomes, and deliver value. Five practical reforms would unlock greater value.

1. Set Clear Expectations—and Let Plans Deliver

States appropriately establish Medicaid benefits, consumer protections, access standards, quality expectations, and oversight. MCOs, in turn, are responsible for building networks, managing care, developing innovative approaches, and delivering high-quality services within that framework. Both roles matter.

Problems arise when State contracts prescribe nearly every operational and payment decision while still expecting plans to innovate. An MCO cannot be fully accountable for results if it lacks the flexibility to redesign care so that it is timely, clinically appropriate, safe, and effective, form partnerships, direct resources toward underserved areas, or reward providers for improvement.

States should establish clear expectations for what managed care should achieve, including timely access to care, better health and functioning, a positive beneficiary experience, program integrity, and responsible use of taxpayer dollars. Contracts should require transparent reporting and include appropriate safeguards to ensure beneficiaries receive medically necessary care and guard against inappropriate denials. Within those parameters, health plans should have sufficient flexibility to determine the most effective route. Longer, more stable contracting periods can also support investments that take time to yield results, such as workforce development, new care models, and data infrastructure.

2. Strengthen Quality, Program Integrity, and Fiscal Accountability

Managed care brings tools and accountability that are more difficult to deploy consistently in a fragmented fee-for-service system. Plans report on nationally recognized performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), operate under state and federal quality requirements, and often meet independent accreditation standards. They can compare performance across providers and regions, identify disparities, target quality improvement efforts, and track whether interventions are working.

MCOs also have claims, encounter, pharmacy, and clinical data that can help detect fraud, waste, and abuse. Sophisticated analytics can flag unusual billing patterns and excessive utilization. They can also flag potentially inappropriate combinations of services or providers whose billing patterns differ significantly from their peers. Plans can investigate potential issues, recover improper payments, and refer credible allegations to state and federal authorities.

CMS and states can strengthen this work by improving the timeliness and consistency of data and aligning reporting requirements. Clear processes for sharing information among MCOs, state Medicaid agencies, program integrity units, and federal authorities can also help identify patterns of fraud and prevent bad actors from simply moving across plans or programs. The goal should be a faster, smarter program-integrity system that protects legitimate access while focusing scrutiny where the risk is highest.

Managed care's fiscal value should not be judged solely by whether total Medicaid spending falls from one year to the next. Medicaid costs are affected by state and federal policies, enrollment, provider payment rates, new treatments, changes in benefits, and beneficiaries' health needs. A more meaningful metric measures whether states are purchasing the best possible outcomes with the resources available.

Managed care gives states several tools for answering that question. Capitation establishes a predictable per-member cost and transfers the risk of unexpected utilization to the health plan. Medical loss ratio requirements identify how much of each Medicaid dollar is spent on care and quality improvement. Encounter data allow states to examine where services are being delivered, identify potentially avoidable hospital and emergency department use, and compare performance across plans. States can also tie a portion of what they pay health plans to how well the plans perform on measures such as access, quality, beneficiary experience, and health outcomes**.** Finally, states can structure contracts so that when a health plan's financial results exceed agreed-upon thresholds, a portion of those funds is returned to the state.

States should make these mechanisms more transparent and useful. Public dashboards should present cost, access, quality, and beneficiary experience measures together rather than in separate reports. States should compare plans on risk-adjusted total cost of care, avoidable utilization, timely behavioral health follow-up, and improvement in health and functioning. Contracts should also clearly explain how savings are calculated, shared with providers, reinvested in services, or returned to the state. Improved transparency would help policymakers distinguish genuine value from spending reductions that simply shift costs, restrict access, or postpone necessary care.

3. Match Network Accountability with Realistic Resources

Health plans play an important role in monitoring network capacity and helping beneficiaries access appropriate care. When gaps emerge, MCOs can contract with additional providers, expand telehealth, support collaborative care, contract with community organizations, and deploy targeted solutions for rural areas or high-need populations.

But network standards alone cannot create clinicians. Behavioral health workforce shortages are a system-wide challenge, and low or rigid payment levels can make participation in insurance networks unsustainable for providers. States should not hold plans accountable for network outcomes while simultaneously constraining the payment flexibility and resources plans need to support provider participation and respond to workforce shortages. At the same time, addressing behavioral health access requires longer-term strategies to expand workforce capacity. States should give plans flexibility to invest in approaches that can strengthen the workforce over time, including provider recruitment and retention, expanded use of the existing workforce, and innovative care delivery models**.** States should ensure that capitation rates reflect the cost of an adequate network and give plans flexibility to respond to local conditions. A uniform fee schedule may offer predictability, but it can also prevent a plan from directing needed resources to the specialties, communities, or services with the greatest shortages.

A stronger approach pairs meaningful access standards with adequate funding and flexible tools. That combination preserves accountability while allowing plans to solve the actual access problem at the local level, not merely document it.

4. Support Meaningful Results

Behavioral health remains heavily dependent on fee-for-service payment, which rewards the number of services delivered rather than whether a person gets better. Fee-for-service often does not reimburse providers for coordinating with primary care, following up when a patient drops out of treatment, reviewing patient-reported outcomes between visits, or ensuring a safe transition after hospitalization.

Managed care can change those incentives. Plans can make prospective care-management payments; reward timely follow-up; support measurement-informed care; and contract for improvements in symptoms, functioning, recovery, quality of life, stable community living, and progress toward goals chosen by the patient. States should encourage these arrangements and streamline approvals that delay them. The same principle applies to state requirements that prescribe how care must be delivered rather than the outcomes plans must achieve. Applied behavior analysis (ABA) provides one example and illustrates why flexibility matters. ABA can be beneficial when treatment is individualized, evidence-based, and regularly reassessed. A state-set number of treatment hours, however, can become a de facto floor or ceiling rather than a clinical benchmark. Some children may receive more care without evidence of added benefit; others may receive too little. A better policy holds plans accountable for access, quality, and outcomes while allowing intensity to reflect clinical need, measurable progress, and evidence. That is not a retreat from accountability. It is a more meaningful form of it.

5. Facilitate Whole Person Coordination Across Delivery Models

The design of health plan arrangements matters, but a behavioral health care carve-out is not inherently a barrier to whole-person care. States use different arrangements to administer behavioral health, physical health, pharmacy, dental care, and social supports. A comprehensive MCO can integrate these services under one contract. In many programs, a specialty managed behavioral health organization (MBHO) can bring

concentrated expertise in mental health and substance use disorders, dedicated provider networks, and focused clinical management, while coordinating with physical health and pharmacy partners.

Either structure can succeed when responsibilities are agreed upon, clear incentives are aligned, and clinical and administrative information moves reliably among entities. Fragmentation arises when responsibilities, incentives, or information are misaligned, not simply because behavioral health is administered under a separate specialty contract. States should support interoperable data, allow for shared care plans where appropriate, warm handoffs, common performance goals, and closed-loop referrals. They should also name the entity responsible for coordinating each transition, so beneficiaries are never left to navigate the system on their own.

Build on What Works

Medicaid managed care is an established, proven, and adaptable model. It gives states budget stability, places health plans at financial risk, adds quality and program-integrity infrastructure, and creates a single entity that can be held accountable for coordinating care. As policymakers consider changes to Medicaid's financing and delivery systems, they should preserve these core strengths. Alternative approaches will not, on their own, solve underlying challenges such as workforce shortages, fragmented benefits, or administrative complexity. Rather, it would remove an important mechanism for managing them.

States should continue to demand clear results, transparent performance, strong beneficiary protections, and stewardship of taxpayer dollars. At the same time, states should continue to strengthen the managed care model by ensuring that MCOs have adequate resources, usable data, stable contracts, and appropriate flexibility to respond to the needs of the Medicaid population. Pairing strong accountability with these tools will allow managed care to build on its existing strengths and deliver even greater value for beneficiaries and taxpayers.

Sincerely,

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