

## Frequently Asked Questions About Medicaid Managed Care

Medicaid provides access to care and helps improve the health and financial security of millions of Americans every day, including people with disabilities, children, older adults, and more than 2 million veterans.

Medicaid enrollees increasingly receive care through managed care organizations (MCOs). MCOs work closely with states to improve quality and outcomes for patients and provide budget predictability for states. In fact, Medicaid MCOs improved their performance on 87% of key quality metrics related to patient satisfaction, provision of services, and health outcomes over four years.

### Q: What is Medicaid managed care?

Medicaid managed care programs are public-private partnerships between state governments and health insurance companies to provide accountability and comprehensive health coverage to Medicaid enrollees. States use Medicaid managed care as an alternative to fee-for-service, a less efficient arrangement where state Medicaid agencies pay provider claims generally without any accountability for cost or quality.

Managed care is the predominant way state Medicaid programs provide health services to people with Medicaid, with nearly [75%](#) of all Medicaid beneficiaries enrolled in an MCO. Between 2003 and 2020, total enrollment in MCOs [more than tripled](#).

### Q: Who relies on Medicaid managed care?

Forty states, the District of Columbia, and Puerto Rico [leverage MCOs](#) to provide health care services to Medicaid enrollees. In 2022, 36 states reported covering [75% or more](#) of all children enrolled in Medicaid through MCOs. While states are less likely to enroll adults over the age of 65 and people with disabilities in MCOs, states are [increasingly](#) including enrollees with complex needs in MCOs.

Across the country, individuals newly eligible for Medicaid through the Affordable Care Act also rely on MCOs. Of the 39 states that had implemented Medicaid [expansion](#) as of 2022, 35 states reported using MCOs to cover newly eligible adults.

### Q: What types of health services are provided by Medicaid managed care organizations?

While MCOs have provided comprehensive, acute, physical health care to Medicaid beneficiaries for many years, more and more states are also using MCOs for populations with more complex health care needs, including coordinating and managing care for patients in need of mental health, pharmacy, dental, and long-term services and supports (LTSS) services. These services have become increasingly common in MCO arrangements as states continue to recognize the value and advantages of managed care.

### Q: How does Medicaid managed care compare to traditional Medicaid fee-for-service arrangements?

Managed care provides health care services more efficiently and effectively than fee-for-service Medicaid plans by ensuring access, coordinating care, addressing chronic disease management needs, incentivizing high quality of care, driving state population health goals, and partnering with providers in value-based care contractual relationships.

Managed care organizations deliver innovative care and reduce costs through providing telehealth programs, addressing social barriers to health, and improving enrollee access to providers. An [analysis](#) of managed care organizations' innovative programs and solutions found that MCO innovation – such as telehealth services and efforts to reduce preventable hospital readmissions – exceeds anything available in fee-for-service Medicaid programs.

## **Q: Do Medicaid managed care programs provide value beyond traditional health services?**

Yes. MCOs work closely with [local leaders and community organizations](#) to improve overall health. Together, they help enrollees meet non-medical challenges that can affect individual health like secure housing, reliable transportation for doctor's appointments, access to nutritious foods, and even help with necessities such as home heating or air conditioning units.

## **Q: Is Medicaid managed care a cost-efficient use of taxpayer dollars?**

Yes. Medicaid MCOs deliver savings for taxpayers through care coordination, the use of primary care medical homes, reducing inappropriate use of emergency and inpatient services, and other effective solutions. Medicaid MCOs achieve cost stability, improve care and outcomes for beneficiaries, and shoulder many administrative responsibilities for states.

State Medicaid agencies hold MCOs accountable through requirements for access to providers, quality of care, caps on administrative costs, quality withholds, and limits on MCO profits. Medicaid MCOs publicly report performance metrics, and most states use independent ratings and accreditation to measure results.

For more information and personal stories from real people about how Medicaid and MCOs are enhancing care and bringing innovative services to enrollees, [click here](#).