

COMMISSION ON MEDICAID

Delivery, managed care, and the organizations the state contracts with

Thursday, August 27, 2026 · 12:00 p.m. – 6:30 p.m.

What today produces

1

A shared, evidenced picture

Every entity that sits between the state and the patient – what each is paid, what each does, and what job would remain without it.

2

The first decision action item

Each function marked keep, restructure or remove, with the Commission's reasoning recorded. This feeds the December report directly.

Anything we write down today is recorded as an individual member's interest for further work. It is not a Commission position, a finding, or a recommendation, and nothing is adopted today.

You will be asked for direction four times: after the national context, on your journey worksheet, at the close of the removal test, and at the end of the day.

How today runs

12:00	Welcome – where we are, what today produces	2:40	Contractor and partner panel
12:10	What we have heard – public input	3:25	Member questions to the panel
12:20	HCPF – the programmatic partner fact sheets	3:50	Break
12:55	Member questions	4:00	Public comment
1:25	Working session – follow one person	5:00	Break
2:00	National context – managed care across the states	5:10	Working session – the removal test
2:25	Member questions	6:05	Report back, and close

Please continue to share the survey and short form.

1

Office hours

They are on the Medicaid Commission webpage.

Virtual: September 3rd, 4 – 6pm

In-Person: September 10th, 11am – 1pm

2

Stakeholder survey

Targeted questions for hospitals, family caregivers, the disability community, and counties.



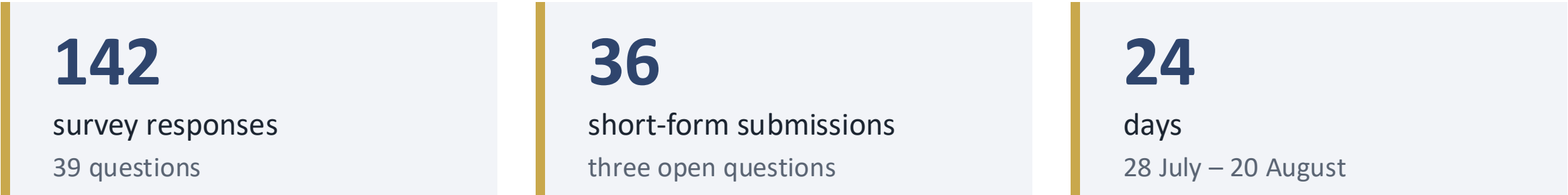
3

Share your experience

A short form for anyone who wants to tell the Commission what Medicaid has been like for them.



Two channels, still open



Who answered the survey

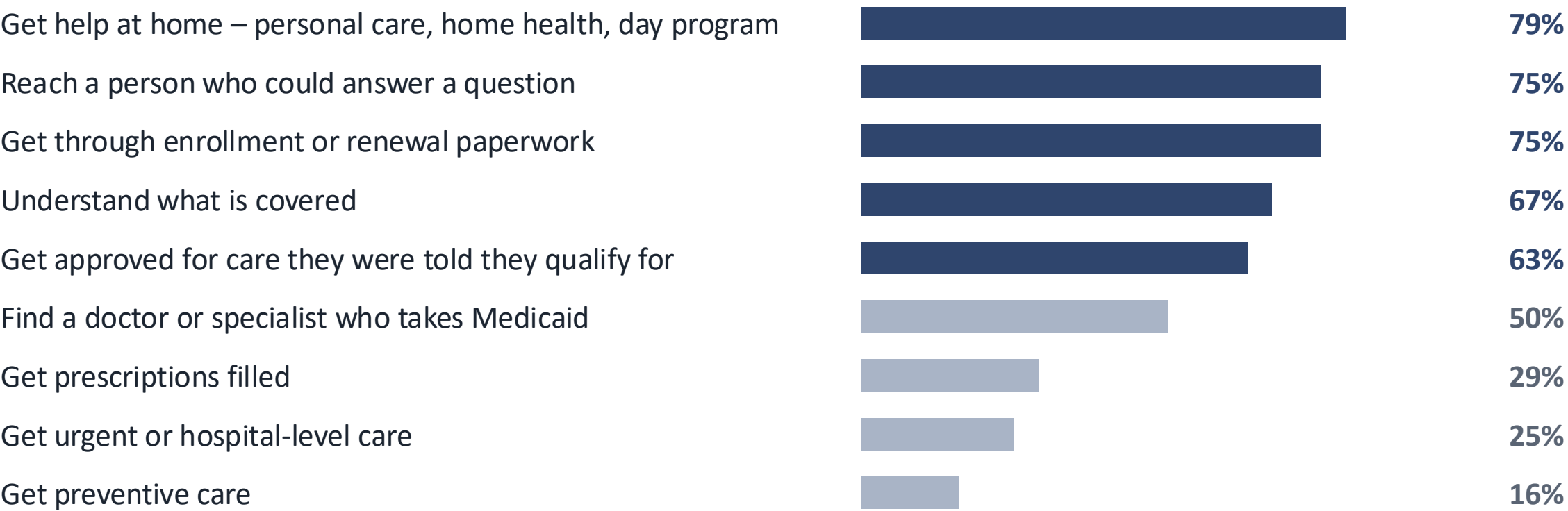
Paid family caregivers	52
Residents and taxpayers	39
Family members and unpaid caregivers	38
Currently covered by Medicaid	30
Providers, clinicians and health systems	40

Read these as a map of where pressure is concentrated.

Respondents are self-selected. Paid family caregivers are the largest single group. Exactly one respondent works for a health plan or regional entity. That is worth holding in mind today, given how much of what follows is about them.

The hard part is the paperwork, not the medicine

Share who found each task hard or very hard, among those who tried it



When people reach care, care generally happens. The failures cluster at the front door and at the renewal date.

What to protect, and what to fix

PROTECT

75 of 138

ranked home- and community-based care that keeps people out of institutions as their single highest priority. No other item was ranked first by more than 20.

Expanding to more people ranked last of six.

Fix · Top five of twelve

1. Paperwork, prior authorization, administrative burden
2. How the Department is run
3. Getting and keeping coverage
4. Whether providers are paid enough
5. The direct-care workforce

Last of twelve: fraud by people enrolled in Medicaid.

39 of 136 respondents placed it dead last, which is more than placed any other item last. Where these respondents raise fraud, they locate it with providers, companies and administrative layers rather than with members.

On today's subject: the contractor layer

What respondents raised about the organizations between the state and the patient

Closed networks, and refusals to credential providers who already hold established Medicaid clients – which breaks continuity of care

Different fee schedules for the same service across regions

Contract cancellations and freezes described as arriving without stated cause

Mid-treatment rate and code changes on short notice

No published financial data showing how regional entities spend what the state pays them

Assignment changes a member cannot predict, with no continuity protection mid-treatment

And a defense of the regional model – respondents whose entity is responsive, present, and resolves problems. A minority in this input, and it should not be edited out.

Facilitator office hours

Two sessions since the last meeting – August 19th in person, August 20th virtual

Behavioral health providers – solo practice and clinic	Senior living and aging services
Home care and hospice	Local public health agencies
Disability advocacy organizations	Family caregivers of adults with high support needs
An FQHC psychiatry training programme	A national provider of a caregiving model

Nothing is attributed, quoted, or traceable to a participant or organization.

Participants are self-selected and several came with a specific ask. This is a map of where pressure is concentrated, not a measure of how common anything is.

From office hours: the contractor layer

Described independently by more than one provider

Members reassigned mid-treatment	A member seen by a provider in another region can be reassigned the following month. The provider learns days later. Single case agreements to finish a course of treatment are refused, and the alternative offered does not provide that service line.
“At network capacity”	Providers with established Medicaid clients refused credentialing – in one account, refused permission to move an existing practice to a new address.
Recoupments years after payment	Payments clawed back for periods already worked, including where other coverage surfaced later. The provider carries the administrative cost of contesting it.
A rate cut far larger than described	One service line reported cut by roughly a third, against a publicly stated figure in the low single digits.
Care coordination done and not paid for	Local public health agencies report absorbing care coordination and navigation pushed to them by capitated primary care providers, with no route to payment and no place in the Accountable Care Collaborative.
One rate for every kind of practice	A solo practitioner, a mid-size clinic carrying high-acuity clients, and a large community mental health centre are reimbursed on the same basis.

Also raised – and where it lands

September 2nd

Exposure of Medicaid funding to measures outside the program, and the rural health transformation grant.

September 17th

Case management under the conflict-free transition. Post-eligibility treatment of income newly applied to adults living at home. What happens to adults with high support needs when a parent dies. Conditions of participation for private duty nursing. Local minimum wage against a statewide rate. Employment classification of family caregivers.

October 7th

Behavioral health capitation, and duplication between the behavioral health organizations and the regional entities.

Two layers are not before you today

Behavioral health

Returns October 7th with the Behavioral Health Administration. The fact sheet is in your packet and will be recirculated for that meeting.

Case management

Arrives September 17th – the whole function, not only what it costs.

What is in your packet

Regional accountable entities – primary care support and care coordination

Fee-for-service administration – HCPF policy, the fiscal agent and the MMIS

Physical health managed care organizations

CHP+ health plans

Pharmacy benefit management system

Dental administrative services organization

Also in the packet

HCPF's assessment of the Accountable Care Collaborative – what improved, what did not, and what cannot be measured

The Milbank review

All Payer Claims Database fact sheet

The fact sheets say what each function does. They do not say what would be lost without it, which will be part of our discussion today.

Follow one person through the layers

1:25

The question, the one rule, and what is already filled in for you.

1:30

Check the entity column against the fact sheets. Correct what is wrong, add what is missing, and mark which steps had to happen at all.

1:40

At your table: where did a layer do something that had to be done – and where did it add a step?

1:55

No report back. The synthesis returns at 5:10.

You are not solving this person's case. You are counting who touched it.

Where these journeys come from

How the four composites were built, and what they are not

Built from the public input as of August 20th

None is an individual's case, and none is drawn from documentation submitted to the Commission by a family

Four journeys, four different failure modes – a coverage transition, an application, an attribution gap, and a denial at the point of service

The entity column is filled in from the fact sheets: a starting point, not an answer

Behavioral health and case management are deliberately absent – October 7th and September 17th

If a step looks wrong to you, say so. That is a finding in itself, and we want it marked on the sheet.

The four journeys

A**A child moves from CHP+ to Medicaid**

County · eligibility system · CHP+ plan · RAE · fiscal agent

B**An adult applies for the buy-in program**

PEAK · county · contact centre · pharmacy benefit · fiscal agent

C**Specialty care without a primary care home**

RAE · contact centre · provider enrollment · utilization management · MMIS

D**A prescription is refused at the counter**

Pharmacy · pharmacy benefit manager · prescriber · drug list · fiscal agent

Composites, built from public input. None is an individual's case.

What states have learned from managed care

The Milbank Memorial Fund review of state experience with Medicaid managed care.

Which of these do you want to look at further?

Reducing financial risk	Utilization management
Network formation	Care management
Quality improvement	Paying for claims

Not a decision, and not a position.

Recorded as individual member interest.

Which is worth Colorado looking at – and is there one you would take off the table now?

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

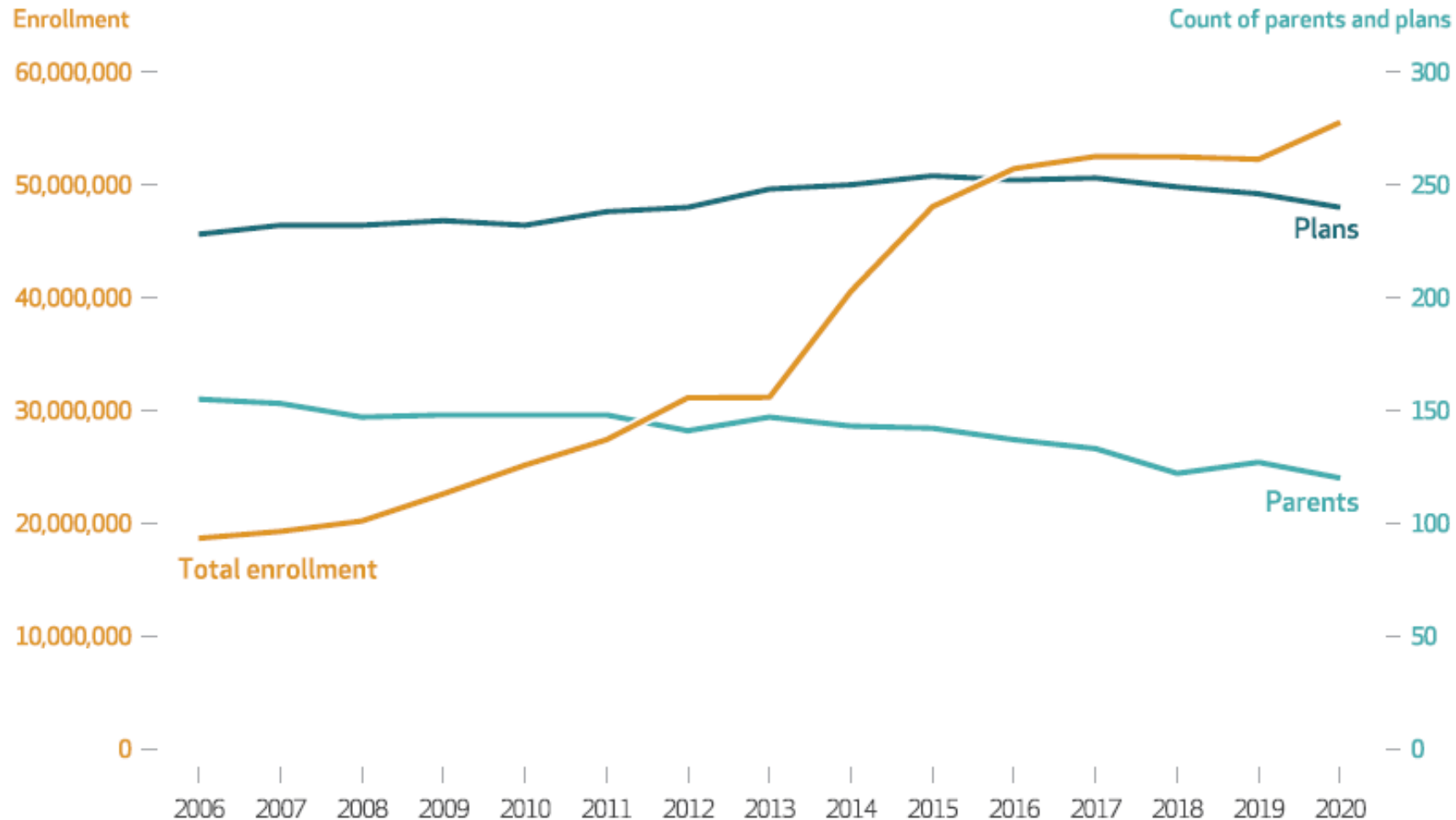
K. John McConnell, PhD

Center for Health Systems Effectiveness, OHSU

CEbP Joint Meeting | September 2026

Managed care has become the predominant Medicaid delivery system

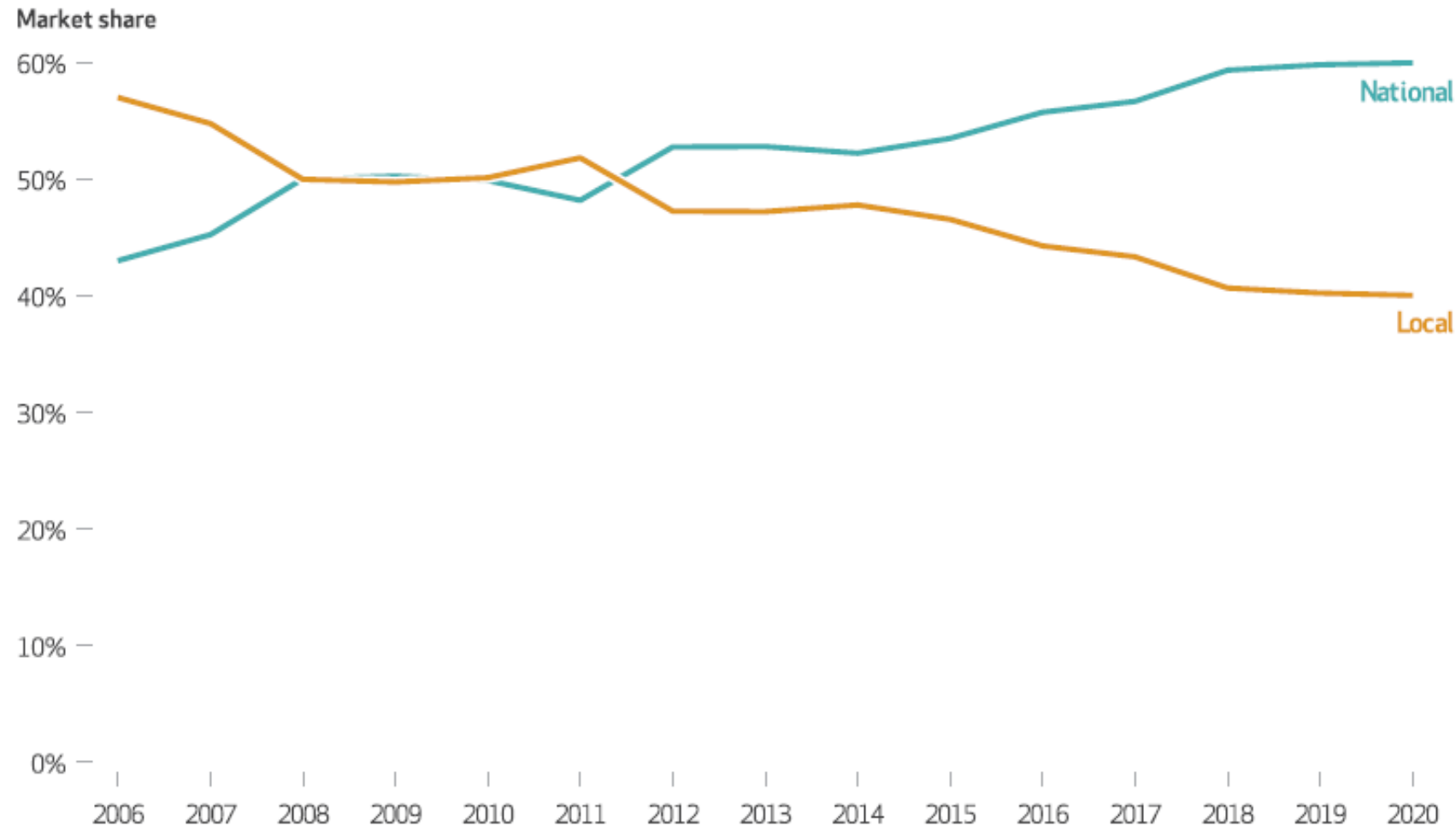
Enrollment in Medicaid managed care and number of parent payers and plans, 2006-20



Source: Li &
Layton, *Health
Affairs*, 2025

Growth has been in large, national, for-profit firms

Market share of national and local Medicaid managed care plans, 2006-20



Source: Li &
Layton, *Health
Affairs*, 2025

Questions

Has managed care become the default for states?

What are the core functions of MCOs? Are there some functions or arrangements that should be reconsidered?

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

BY K. JOHN MCCONNELL, HYUNJEE KIM, STEPHAN LINDNER, JANE M. ZHU,
DAVID DIGIUSEPPE, AND HAYDEN ROOKE-LEY

REPORT | July 2026

Milbank 
Memorial Fund
Using evidence to improve population health

Core functions of MCOs

1. Reducing financial risk
2. Utilization management
3. Network formation
4. Care management
5. Quality improvement
6. Paying for claims

What is the evidence on how MCOs are performing on these functions?

Reducing financial risk: what we know

Lack of strong evidence to suggest MCOs can generate true cost savings

Actuarial rules may create a dynamic where increased costs translate to increased rates in the future

“Savings” in for-profit MCOs may flow to shareholders rather than taxpayers, providers, or enrollees

Reducing financial risk: alternatives

Develop a better understanding of where and how capitation truly transfers risk

Independent audits/rate reviews

Hybrid models (state-managed medical services; managed pharmacy)

Test/study how MCOs are (theoretically) achieving savings

Savings in the commercial market's shift to HMOs in 2000s were driven by narrower networks and lower prices, not changes in utilization. What are Medicaid MCOs doing?

Utilization management: what we know

Prior authorization and other supply-side controls used to contain costs

Actual impacts on access, outcomes, value are mixed

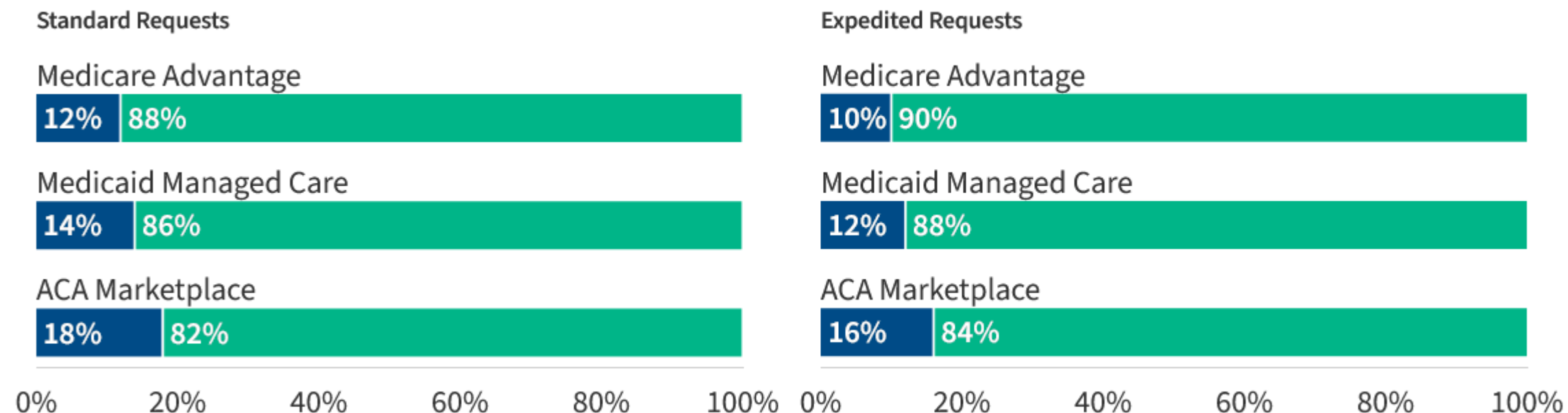
Heavy administrative burdens on providers

New data on prior authorization

On Average, Insurers Denied 12% to 18% of Standard Prior Authorization Requests

Share of prior authorization requests approved or denied, by type of request and market segment

■ Denied ■ Approved



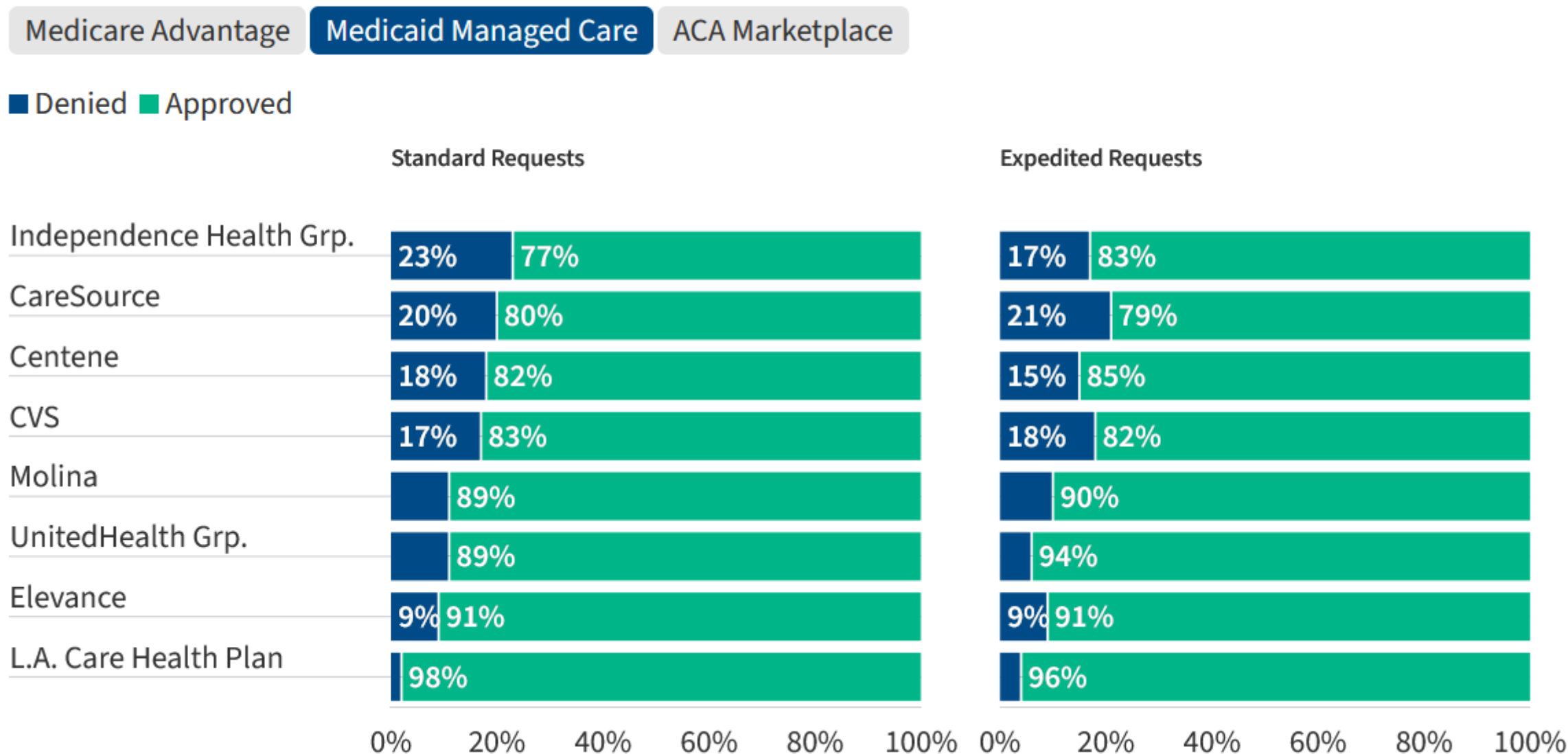
Note: ACA Marketplace data are for insurers in states that use the federally facilitated Marketplace (28 states in 2025). Standard requests are for non-urgent services and expedited requests are for urgent services.

Source: "Prior Authorization Metrics Provide New Insights into Insurer Practices, but Gaps Remain" KFF

KFF

Prior Authorization Denial Rates Varied Widely Across Insurers

Share of prior authorization requests that were approved or denied, by type of request and insurer



Source: "Prior Authorization Metrics Provide New Insights into Insurer Practices, but Gaps Remain" KFF

Utilization management: alternatives

Standardize utilization management rules and integrate them with HER systems for real-time decision support.

Streamline approval processes statewide to reduce redundancy and shift oversight to evidence-based, transparent criteria.

Network formation: what we know

Network adequacy rules intended to ensure access

Provider directories often include “phantom” listings

28% of “in-network” physicians in Medicaid provide no care (Zhu et al., Health Affairs 2026).

Networks across MCOs overlap significantly

Network formation: alternatives

Centralize or standardize network formation at the state level through a single, verified provider directory, unified credentialing process, and common adequacy standards

Care management: what we know

MCOs and providers both operate care management programs, often duplicating efforts and confusing accountability.

Evidence of superior outcomes under MCO-led models is limited.

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Care management: alternatives

Consolidate care management functions through state or regional platforms using shared risk-stratification tools.

Connecticut ASO approach

Quality improvement: what we know

MCOs report on numerous metrics (e.g., HEDIS, CAHPS), allowing for comparisons across plans and states

May create administrative burden without clear population-level gains

Providers may

Eliminate redundant measures, align

incentives around one or two statewide

priorities for several years, and

“go deep before going wide” to standardize

processes and achieve measurable

Quality improvement: alternatives

Can states “go deep”? Big incentives around one or two statewide priorities for several years to really move the needle?

What would be learned?

Paying for claims: what we know

MCOs have varied internal systems

Reports of delays, denials, and administrative friction for providers

Estimated losses to physicians for denials and delays: losses of 18% of Medicaid revenue, compared with 4.7% for Medicare and 2.4% for commercial insurance (Dunn et al., *Quarterly Journal of Economics*, 2024)

Paying for claims: alternatives

Shared or state administered claims infrastructure to improve prompt payment, reduce administrative burden

How many MCOs do you need?

On average, most counties have more than 2 MCOs

Competition happens on two levels – competing on value and competing through selection

For commercial plans, value translates to price (co-pays, premium)

For Medicaid, it means quality, access, provider relationships.

How much of this is observable?

If risk adjustment is flawed, plans may compete by avoiding high risk enrollees and attracting low risk enrollees

Do states need more than 2 plans per county? Pros/Cons?

Contractor and partner panel

5 min	Framing	No presentations. You have read the fact sheets; the panel is for what a fact sheet cannot carry.
15 min	Opening round	Three minutes each. The same question to every panellist, timed.
50 min	Questions	Facilitated, and driven by what you surfaced in the working session.

**What is one thing your organization did in the last month
that a member would never see...**

...and what would have happened without it?

Three minutes each.

Public comment

< 60
minutes

Comment is invited on today's subject: the organizations between the state and the patient.

Upcoming:

- Behavioral health organizations: October 7th.
- Case management: September 17th

The removal test

5:10

What you found

The Block C synthesis, read back. How many entities touched one person.

5:15

Round one – on your own

For each function: if this entity did not exist, what job would still need doing, and who would do it?

5:35

Round two – at your table

Mark each function keep, restructure or remove. Say what the state gives up, and what it gains.

6:00

Round three – one line each

For each function you marked restructure – what does it do that the current one does not?

Nothing is adopted. No vote is taken. Disagreement is recorded, not resolved.

Write the job. Not the consequence.

A JOB

“Someone has to enroll and credential dentists.”

Something that would still have to be done.

A CONSEQUENCE

“Members would lose dental care.”

A conclusion you have not tested yet.

Round one asks only for the job, and who would do it (i.e., the State, another contractor, the provider, the member, or no one).

What you are marking

Regional accountable entities	K / R / Rm	Fee-for-service administration	K / R / Rm
Physical health MCOs	K / R / Rm	CHP+ health plans	K / R / Rm
Pharmacy benefit management	K / R / Rm	Dental administrative services	K / R / Rm
Behavioral health capitation – 7 October			
Case management – 17 September			

Keep · Restructure · Remove – and what the state gives up, and gains.

What today produced

- The Commission's informative discussion on the delivery system
- What each function does, and what job would remain without it
- Where members disagree – recorded, not resolved
- One thing each – a direction you would want explored, recorded as individual member interest

Next: Wednesday, 2 September – financing.