RESEARCH BRIEF

2026

mhpa Medicaid Health Plans of America

Enrollees in Medicaid Managed Care States Report Better Experience of Care Than Those in Fee-for-Service States

Medicaid managed care organizations (MCOs) partner with states to deliver high-quality health care for over 60 million (75%) Medicaid enrollees across 41 states, the District of Columbia, and Puerto Rico. One component of high-quality health care is a positive experience of care, including how enrollees interact with their health plan and providers.

This analysis explores how experience of care differs in predominantly MCO states vs. fee-for-service (FFS) states using a nationally recognized survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Each year, state Medicaid programs report statewide outcomes from CAHPS survey questions for the CMS Child and Adult Core Sets (Core Sets). In turn, the federal government publishes each state's outcomes, showing the share of enrollees who gave the highest possible ratings for each measure.

This research brief finds that enrollees in predominantly MCO states report a better experience of care than those in predominantly FFS states. These findings reflect how MCOs enhance enrollees' experience by supporting member needs, coordinating care across settings and services, building and managing provider networks, investing in innovations and value-added services beyond required benefits, and answering to state accountability standards for quality and performance.

Data and Methods

Data. This analysis used experience of care measures captured in the 2024 CMS Child and Adult Core Sets for the Medicaid population (excluding CHIP). The Core Sets publish state-level CAHPS for three separate populations: the general child population (GC), children with chronic conditions (CCC), and adults. Because the Core Sets report a single statewide result for each measure, most states' data included a mix of MCO and FFS enrollees.

Classifying MCO and FFS states. This analysis classified a state as a predominantly MCO delivery system if more than 65% of its Medicaid population was enrolled in a comprehensive, risk-based MCO, and as predominantly FFS if less than 35% was enrolled in MCOs. States between 35% and 65% MCO enrollment were considered mixed. Two mixed states for adults (GA and MS) were classified as MCO because state-specific notes indicated only MCO enrollees were sampled. Two other mixed states for adults (MA and ND) were excluded. MCO enrollment rates were calculated separately for children (ages 0–18) and adults (ages 19+) using 2023 T-MSIS data. All other state exclusions were the result of states not reporting CAHPS data for a specific population. In total, 47 states and DC reported data for at least one population; three states (AZ, ID, and MN) did not report data for any population. Appendix Table 1 lists the states in the GC, CCC, and adult populations.

Analysis. This analysis compared MCO and FFS states in two ways. First, each individual CAHPS measure with enough reporting states (at least 30 states, including at least 6 FFS states) was compared using a standard test for comparing two groups (Wilcoxon rank-sum). The analysis included a total of 21 measures across populations. Because the number of reporting states is relatively small (not exceeding 48), differences were treated as significant at the $p<.1$ level. Figure 1 shows the measures meeting that threshold.

Second, all CAHPS measures were pooled into a single model to assess overall performance, which is similar to comparing an average score across all measures. The model adjusts for four state characteristics that could otherwise confound differences across MCO and FFS states: Medicaid expansion status, the share of Medicaid enrollees living in rural areas, the share of need met in primary care shortage areas, and the prevalence of chronic conditions among enrollees. Control variables came from KFF State Health Facts (2023), except chronic condition prevalence, which was calculated using 2023 T-MSIS data. Results are reported as percentage point differences between MCO and FFS states for interpretability.

Robustness checks. Findings for state-level comparisons (Figure 1) are consistent with respondent-level comparisons of managed care and FFS product types reported in Appendix E of the 2025 CAHPS Chartbook. Results from the model that controlled for state differences were consistent across three alternative model specifications. First, the main model was re-estimated using continuous MCO penetration rates as the predictor variable instead of the categorical MCO/FFS classification. Second, the analysis was run excluding five states (CA, FL, IL, OH, and OR) that noted a portion of the CCC sample included both MCO and FFS enrollees. Third, the model was run using standardized versions of each measure (i.e., z scores) instead of using percentage points.

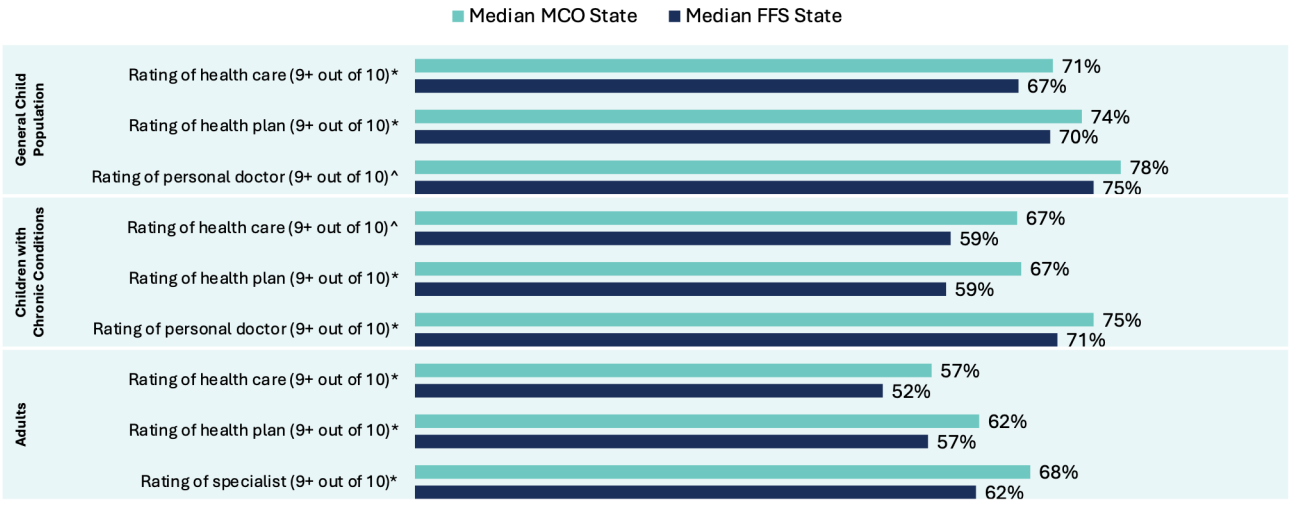
Findings

Enrollees in MCO states gave higher ratings than those in FFS states on nine experience of care measures, spanning their overall health care, their health plan, and their providers (Figure 1). There were no measures with significant differences that favored FFS states in any population.

Figure 1

MEDIAN MCO AND FFS STATE PERFORMANCE ON CAHPS SURVEY QUESTIONS

Percent of enrollees who gave a rating of 9+ out of 10



Note: *p < .05; ^p < .1. Only measures with a significant difference are shown. Respondents were asked to rate their health care, health plan, and providers on a scale of 0 (worst possible) to 10 (best possible). Surveys for child populations were completed by parents or guardians. See CAHPS 5.1H child and adult questionnaires for a list of all questions and exact wording. See Appendix Table 1 for a list of MCO and FFS states.
Source: MHPA analysis of 2024 CMS Child and Adult Core Sets.

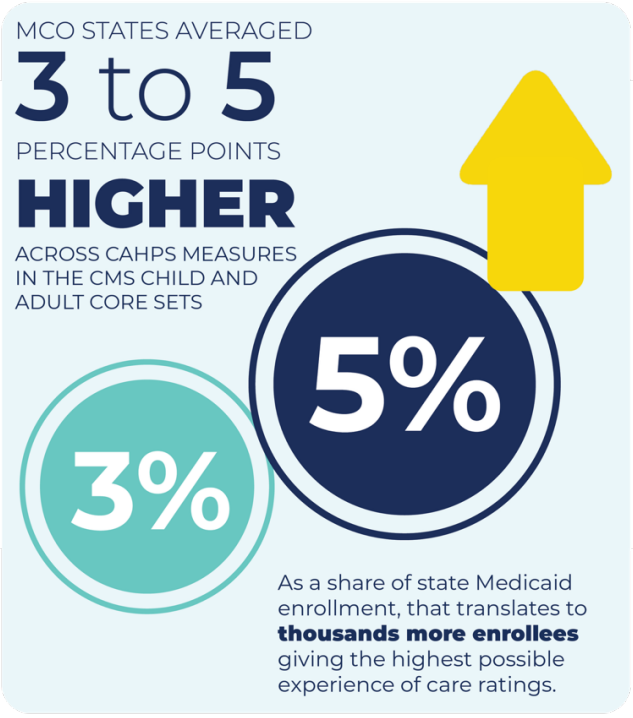
Among the general child (GC) population, which includes most children qualifying based on income, 71% of parents and caretakers in the median MCO state rated their child's health care a 9+ out of 10, compared to 67% in the median FFS state. Ratings for the GC population's health plan (74% vs. 70%) and personal doctor (78% vs. 75%) showed similar differences. While FFS enrollees are not enrolled in a comprehensive health plan, their health plan ratings reflect their interactions with the state Medicaid agency or a third-party administrator that manages specific benefits rather than coordinating overall care.

Differences were largest among children with chronic conditions (CCC), which includes children who need more health care services than other children because of an ongoing physical, developmental, behavioral, or emotional condition. In the median MCO state, 67% of CCC's parents and caretakers gave the highest ratings (9+ out of 10) of their health care and health plan,

compared to 59% in the median FFS state. Ratings of the child's personal doctor were four percentage points higher (75% vs. 71%).

Among adults, 57% in the median MCO state rated their health care a 9+ out of 10, compared with 52% in the median FFS state. Adults in MCO states also gave higher ratings of their health plan (62% vs. 57%) and of the specialist they saw most often (68% vs. 62%).

These differences persisted in the model that accounted for state characteristics. The model pooled all CAHPS measures together, and results represent an overall score across CAHPS measures, similar to an average CAHPS score. The model controlled for state Medicaid expansion status, rurality, primary care shortage areas, and chronic condition prevalence.



Based on this model, MCO states averaged about three to five percentage points higher than FFS states across CAHPS measures, after controlling for state characteristics. Specifically, the share of enrollees giving the highest possible ratings was about three percentage points higher in MCO states than in FFS states for the GC and adult populations. The gap was largest for the CCC population, in which the share was approximately five percentage points higher (see Appendix Table 2 for model outputs). As a share of state Medicaid enrollment, this translates to thousands more children and adults reporting the highest possible experience of care ratings.

How are MCOs Enhancing Enrollee Experience?

Several features of managed care programs are designed to support enrollees, connect them to providers, and hold plans accountable for the care they deliver. These features help explain the MCO advantage reflected in higher enrollee experience scores, particularly among children with chronic conditions who depend most on care coordination and support accessing care.

Member supports. MCOs are responsible for coordinating care for all enrollees and providing additional support for enrollees with complex conditions or other barriers to accessing needed care. This includes employing case managers, care coordinators, and licensed medical professionals to help enrollees navigate appointments and other medical needs. MCO care

coordination reduces care fragmentation by linking medical, behavioral health, pharmacy, social service, and community systems. Plans also maintain customer service lines and conduct outreach to members through multiple modalities, such as phone, text, and email, to keep them up to date about their care.

Provider networks and connections to care. MCOs build and manage the networks their enrollees rely on, including screening and credentialing providers as well as partnering with them (and the state Medicaid agency) to monitor and improve quality of care. Plans also connect enrollees to those networks directly by assigning enrollees to a primary care provider or through care coordination. Research has shown that MCO enrollees are more likely to have a usual source of care and to have a preventive health visit compared to FFS enrollees.

Innovations and value-added services. MCOs have flexibility to invest in services beyond the standard benefit package, typically to prevent future health complications. Many MCOs offer value-added services such as non-emergency transportation, nutrition supports and meals, and wellness incentives. MCOs are also required to participate in externally validated quality improvement projects, in which they test new approaches to address key health priorities set by state officials.

State incentives and oversight. State contracts with MCOs typically set detailed requirements for customer service, care coordination, performance metrics, and network adequacy standards. Many states also tie payments to performance by withholding a portion of an MCO's payment and returning it only if the plan meets or exceeds specific metrics.

Conclusion

Enrollees in MCO states gave higher ratings of their overall health care, their health plans, and their doctors in all three populations. Even after adjusting for key state differences, Medicaid enrollees in MCO states reported a better experience of care than those in FFS states, scoring three to five percentage points higher across CAHPS measures, on average. This percentage point difference translates to thousands more enrollees in a state giving the highest possible experience of care ratings.

These findings demonstrate that Medicaid MCOs' support for enrollees, by coordinating services, connecting enrollees to providers, and providing other innovative and tailored services, leads to a more positive care experience. A central part of that work is maintaining an ongoing relationship with enrollees by reaching out to them directly, helping them establish a usual source of care, and supporting them as needs change. These findings also reflect multiple accountability mechanisms built into managed care programs so that states and MCOs have a measurable, effective partnership to provide the best experience possible for Medicaid enrollees.

About MHPA

Founded in 1995, the Medicaid Health Plans of America (MHPA) is the only national association that solely represents the interests of the Medicaid managed care industry. Through its advocacy and research work, MHPA supports innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA works on behalf of its 160+ member health plans, known as managed care organizations (MCOs), which serve nearly 48 million Medicaid enrollees in 40 states, Washington, D.C., and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market. Visit medicaidplans.org for more information.

Appendix Tables

Appendix Table 1

Classification of MCO and FFS States			
Population	**MCO States**	**FFS States**	**Excluded or Did Not Report***
General Child (GC)	33 states: CA, DE, FL, GA, HI, IL, IN, KS, KY, LA, MD, MA, MS, MO, NE, NV, NH, NJ, NM, NC, OH, OR, PA, RI, SC, TN, TX, UT, VA, WA, WV, WI, DC	12 states: AL, AK, AR, CO, CT, ME, MT, ND, OK, SD, VT, WY	6 states: AZ, IA, ID, MI, MN, NY
Children with Chronic Conditions (CCC)	26 states: CA, DE, FL, HI, IL, KS, LA, MD, MA, MS, MO, NE, NV, NH, NJ, NM, OH, OR, PA, RI, SC, TN, VA, WA, WV, DC	6 states: AK, AR, ME, ND, OK, VT	19 states: AL, AZ, CO, CT, GA, IA, ID, IN, KY, MI, MN, MT, NY, NC, SD, TX, UT, WI, WY
Adult	34 states: CA, DE, FL, GA, HI, IL, IN, IA, KS, KY, LA, MD, MI, MS, MO, NE, NV, NH, NJ, NM, NY, NC, OH, OR, PA, RI, SC, TN, TX, VA, WA, WV, WI, DC	9 states: AL, AK, AR, CO, CT, MT, OK, SD, VT	8 states: AZ, ID, ME, MA, MN, ND, UT, WY

Note: *Only two states (MA and ND) were excluded from the adult analysis due to having between 35% and 65% of their adult population enrolled in MCOs. All other excluded states did not report specific populations.

Appendix Table 2

Estimated Effects of MCO Delivery Systems on Experience of Care Measures, 2024 CMS Child and Adult Core Sets						
	GC		**CCC**		**Adult**	
Model	**Estimate**	**P Value**	**Estimate**	**P Value**	**Estimate**	**P Value**
Unadjusted Model	1.67	0.185	3.52^	0.084	3.05^	0.062
Adjusted Model	3.14*	0.021	4.89*	0.047	2.98*	0.048

Note: * p < .05. ^ p < .1. An estimate above 0 indicates MCO states performed better than FFS states on experience of care measures; negative estimates indicate worse performance for MCO states. The unadjusted model includes a random intercept for reporting state, but no other control variables. The adjusted model includes state-level control variables for Medicaid expansion status, rurality, primary care health professional shortage areas, and the prevalence of chronic conditions among enrollees. Estimates represent the percentage point difference in pooled CAHPS measures; in the fully adjusted model, MCO states performed 3 to 5 percentage points better than FFS states across the three populations.