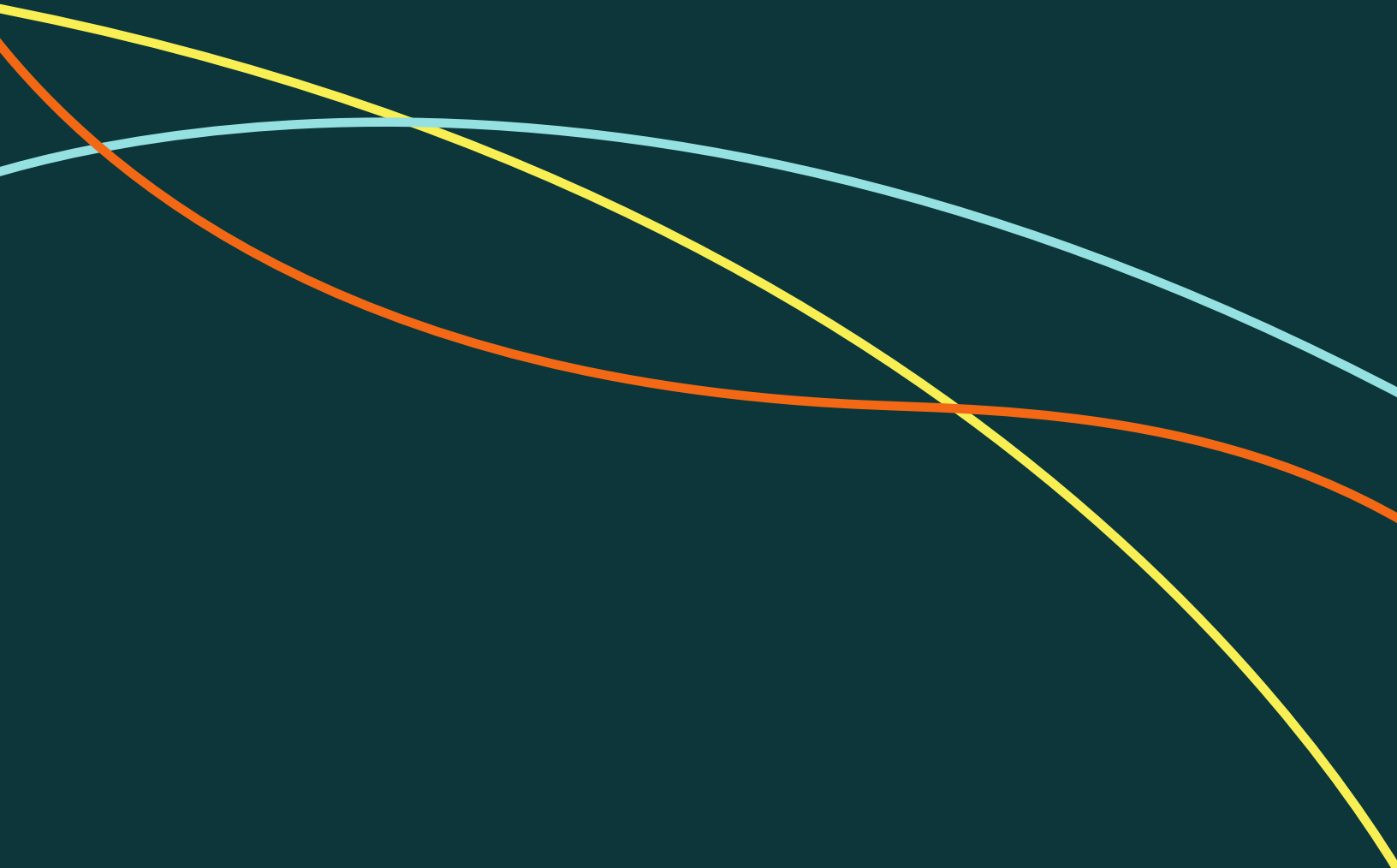


Any Card, Any Provider: Unifying Medi-Cal's Networks and Administration

by Naman Shah, MD, PhD



Contents

About the Authors

Naman Shah, MD, PhD, is the Director of Medical and Dental Affairs at the Los Angeles County Department of Public Health, where he oversees programs including health care consumer protection and clinical administration, and provides refugee and tuberculosis care. His work sits at the intersection of frontline public health and the broader health system serving nearly 10 million residents. The Medi-Cal fragmentation described in this paper shapes the daily experience of his patients, staff, and partners.

About the Foundation

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- 1 Executive Summary
- 1 The Problem
- 1 Impact on Medi-Cal Members
- 2 Impact on Providers
- 2 Impact on Plans and the State
- 3 The Bold Idea
- 3 Novelty
- 4 Why This Is Feasible Now
- 4 How the Unified Network and ASO Would Operate
- 5 What the ASO Makes Possible
- 7 Should Plans Remain?
- 7 Evidence Supporting Consolidation
- 8 Key Policy and Regulatory Changes
- 9 Implementation Pathway
- 9 Financing and Affordability
- 10 Risks, Trade-Offs, and Unintended Consequences
- 11 Conclusion
- 12 Endnotes

Executive Summary

Medi-Cal managed care was designed to improve patient care, facilitate coordination, and save money. Instead, it has become a labyrinth of 24 plans with separate networks that delegate administrative and clinical responsibilities to intermediaries. Plan assignment, which has nothing to do with clinical need, determines which doctors, therapists, and hospitals a patient can visit. Medi-Cal managed care has become a source of the health care fragmentation it was meant to solve. This paper proposes decoupling network and administrative functions from care management: A single Medi-Cal provider network for managed care services. A new Administrative Services Organization (ASO) for credentialing, claims processing, and prior authorization. Any credentialed provider could see any patient, regardless of plan assignment. If plans remain in the structure, they could retain financial risk and quality accountability, competing on care management and outcomes rather than on network restrictions.

The impacts would extend broadly. The majority of Medi-Cal's more than 14 million enrollees live in counties with multiple plans or single plans that delegate responsibilities to other entities — and are affected by the fragmentation those arrangements create. The patients who stand to gain the most are those with complex health and behavioral health needs who require coordinated services across multiple providers and service types. But any enrollee who has struggled to find a provider accepting patients, or who has lost a doctor after a plan change, would see improvement. Safety-net providers drowning in administrative tasks would benefit. This transformation would dramatically reduce the administrative burden on providers, foster stable provider-patient relationships regardless of plan assignment, and limit out-of-network exposure.

This is not a return to the fee-for-service system California moved away from in the 1990s before it established the digital infrastructure and institutional knowledge of running complex systems. That has changed. California has consolidated Medi-Cal pharmacy benefits,

centralized eligibility processing, and learned hard lessons about what large-scale public systems require to succeed. This proposal extends that rationale to the central functions of Medi-Cal. A centralized administrative platform would enable other capabilities that do not exist today. The platform could, over time, integrate the mental health, dental, and developmental services currently carved out of managed care. A single claims stream could better monitor compliance with California's statewide spending benchmarks. And the platform, in conjunction with a unified network, could support a Medi-Cal product offered through Covered California, allowing people to keep their doctors when their income shifts across the eligibility line.

Recently enacted federal legislation threatens billions of dollars in California's federal Medi-Cal funding, and California cannot afford to pay for duplicative administrative costs. The promise of whole-person care under CalAIM (California Advancing and Innovating Medi-Cal), itself a multibillion-dollar investment, cannot be realized under policy architecture whose competitive logic incentivizes fragmentation. And the upcoming managed care plan procurement cycle provides an implementation window. This paper offers a road map for how to get there.

The Problem

Over three decades, the managed care plan (MCP) architecture California built to deliver and administer most Medi-Cal benefits has become a primary source of the problems it was meant to solve. The consequences fall on members, providers, and the state.

Impact on Medi-Cal Members

Most Medi-Cal beneficiaries are enrolled in one of multiple competing plans or in a single plan that delegates responsibility to independent practice associations (IPAs) and Management Services Organizations (MSOs). A patient's primary care doctor may be in the

plan network, but the specialist they need may not be. The behavioral health provider or durable medical equipment supplier their doctor recommends may be contracted with a different plan. The effects on access and quality are predictable. A study of California provider directory accuracy found that Medi-Cal patients could not verify or schedule appointments with 24%–41% of certain specialists, depending on the specialty and year.¹ An analysis of California’s most fragmented managed care markets found that 27% of enrollees in counties with five or more competing plans reported difficulty finding specialty care, compared with 17% in comparable counties with one or two plans.²

When patients change plans, move to a different county, or experience administrative churn, they lose relationships that matter. A 2022 study found a 50% increase in patients with chronic conditions who are hospitalized in the year following a key provider’s departure.³ Separately, when enrollees are forced to switch plans, hospital admissions rise 8% in the following year, prescription fills for conditions like diabetes and depression drop 16%, and primary care visits fall by 10% over two years.⁴

A decade-long review of Medi-Cal managed care performance found that more than half of quality measures remained flat or declined, including children’s access to primary care, well-child visits, and childhood immunizations — with enrollee ratings of their care experiences consistently below the national median.⁵ Counties with five or more competing plans performed worse on 22 of 30 quality measures compared with counties operating a single public plan or counties with two plans, and the performance gap was consistent across four consecutive years of measurement.⁶ In contrast, patients who experience ongoing continuity of care with a single primary care physician have better outcomes and lower costs.⁷ These burdens fall unevenly. Medi-Cal is a challenging system for any consumer to navigate, and the difficulty compounds for people experiencing homelessness, those working multiple jobs, and residents of rural and underserved communities where few providers practice.

Impact on Providers

Providers must maintain contracts with multiple MCPs, each with distinct credentialing requirements, utilization protocols, and claims systems. They must also navigate multiple IPAs and MSOs with different referral rules, plus separate vendors for durable medical equipment, behavioral health, and transportation. This burden falls hardest on Federally Qualified Health Centers, safety-net systems, and small practices, the providers most essential to Medi-Cal delivery. A 2024 American Medical Association survey found that practices complete 39 prior authorizations per doctor per week across all payers, consuming 13 staff hours on this task alone.⁸ A JAMA study of one academic health system estimated that billing and insurance-related activities consume up to 14.5% of professional revenue for primary care visits, with varying percentages for other encounter types.⁹ At the Los Angeles County Department of Public Health, which operates specialized but low-volume clinics with about 40,000 provider encounters annually, billing, credentialing, and contracting consume seven full-time employees — who could otherwise be improving the public’s health.

The analysis of California’s most fragmented managed care markets found that clinic staff described needing internal “road map” algorithms just to navigate each MCP due to “idiosyncratic and duplicative contracting and administrative requirements.” Quality incentive programs fared no better. When each plan runs its own pay-for-performance scheme with different metrics and payment structures, providers report that the programs become “a jumble to understand and effectuate” and that “one plan’s QI or population health initiative won’t get my attention.”¹⁰

Impact on Plans and the State

Value-based payment models, which reward providers for keeping patients healthy and not the volume of services they deliver, are undermined by this fragmentation. A primary care doctor’s panel is split across

plans, each running its own quality incentive programs with different metrics and payment structures. When a patient is reassigned to a different plan, the care management relationship resets with a new care manager, a new care plan, and a new set of referrals for CalAIM's Community Supports. CalAIM's whole-person care vision depends on continuity, coordination, and aligned accountability. The current architecture works against all three. Parallel administrative infrastructure across plans and the entities to which they delegate responsibility consumes resources that could fund care.

States also pay a price. When a state contracts out core functions, it sheds the technical capacity needed to evaluate contractor performance, renegotiate terms, or build alternatives. Over time, the informational asymmetry between the state and its contractors grows and the state's leverage shrinks. A recent study found that the costs of Medicaid managed care to states increase over time as insurers accumulate negotiating power through the rate-setting process itself. Counties subject to managed care mandates experienced 9.8% higher costs for enrollees with disabilities four years after the transition to managed care, compared to those without mandates.¹¹ During California's most recent managed care competitive bidding process, the state awarded contracts to plans that were not initially chosen after they appealed the decision. Without reform, the system will become progressively less sustainable under fiscal pressure and less capable of delivering on California's own stated goals.

The Bold Idea

A Medi-Cal provider would become a Medi-Cal provider for managed care services, period. Once credentialed, a provider could serve any Medi-Cal enrollee. In this unified network, a change in an enrollee's plan assignment would no longer disrupt an existing provider relationship. Providers would interact with a single Administrative Services Organization (ASO) for credentialing, claims, and authorizations. Where plans participate, they would retain financial risk

and quality accountability but compete on care management rather than network design. Taking it a step further, limiting counties to a single plan and prohibiting assignment to subdelegated physician groups with limited networks would meaningfully reduce fragmentation for patients and providers. It would not eliminate statewide administrative duplication, create real-time utilization visibility, standardize quality measurement, or build the platform needed for forward-looking capabilities. The proposal addresses those challenges.

Novelty

This proposal is not without precedent in California's history. For decades before the managed care expansion of the 1990s, the California Department of Health Care Services (DHCS) operated Medi-Cal as a fee-for-service program with a centralized treatment authorization request system, field offices for claims adjudication, and a single claims processor through the Medicaid Management Information System, which is still active. For enrollment, the Provider Application and Validation for Enrollment (PAVE) system remains functional. In other words, the state ran or runs some of the administrative functions under consideration. The fee-for-service system had real problems. A 2003 California Health Care Foundation review found paper workflows that created delays and provider dissatisfaction severe enough that some subspecialists phased out their Medi-Cal panels.¹² The managed care transition was motivated in part by these failures. A single administrative system is not inherently better or worse than multiple plan-administered ones. Each can fail when underfunded, poorly designed, or both. This reform takes the administrative unification that the old fee-for-service system achieved by default and applies it deliberately with modern infrastructure. The approach is new to Medi-Cal and would represent a novel adaptation for Medicaid. Nationally, Medicare fee-for-service already functions as a universal provider network, and accountable care organizations layer population health management on top, taking responsibility for a defined population's total cost and quality outcomes while

patients retain provider choice. This bold idea applies a similar frame to Medi-Cal with a standardized network, state-led rate setting, and competition on service quality, care management, and outcomes.

Why This Is Feasible Now

California has already consolidated complex administrative functions at statewide scale. The most direct precedent is Medi-Cal Rx. Before 2022, each MCP maintained its own formulary, its own pharmacy network, and its own prior authorization criteria for medications. Providers navigated different drug lists depending on which plan a patient was assigned to. Medi-Cal Rx replaced each piece of that patchwork. The fragmented administrative functions were consolidated, and the system that emerged is simpler for providers, more transparent for the state, and stable for patients.

Other examples include the California Healthcare Eligibility, Enrollment, and Retention System, which consolidated eligibility determination across Covered California and Medi-Cal into a single platform, replacing fragmented county systems. The California Statewide Automated Welfare System unified public benefit eligibility processing across all 58 counties. Together, they demonstrate that California has the institutional capacity to consolidate high-volume administrative functions across a large and operationally diverse state — and that the results are durable. IT capabilities have also advanced dramatically since California operated a centralized Medi-Cal administration. Modern claims platforms, modular procurement practices, and a mature vendor market make large-scale government technology projects more manageable than the monolithic builds of earlier eras.

How the Unified Network and ASO Would Operate

The proposal's central goal is to unify Medi-Cal's provider networks and administrative infrastructure.

Critical questions remain regarding who bears financial risk, how much of the current managed care architecture is preserved, and how plans would be compensated if they remain involved. These are political and strategic judgments that require significant policy discussion and possibly legislative action. This paper does not resolve them. Instead, it explores illustrative models, discussed later, that convey the range of options. What follows describes how the core infrastructure would work, regardless of which model California chooses.

A provider would credential once through an expanded PAVE system and appear in a single statewide directory maintained against one data standard. This would solve the persistent problem of inaccurate plan directories, documented by the California State Auditor.¹³ When a provider's status changes, it would change once, everywhere. Any willing provider who meets DHCS credentialing standards and accepts the statewide contract could participate. The administrative barriers that currently deter providers would largely disappear. The ASO could not solve access problems driven by inadequate reimbursement. But if some portion of provider reluctance to participate in Medi-Cal reflects administrative burden, simplification would itself be a recruitment strategy.

Claims would go to one place, adjudicated against uniform rates, with encounter data routed to the patient's assigned care management entity. The provider would not need to know which plan a patient belongs to in order to bill correctly. Prior authorization would be preserved, standardized and more efficient, but still governing high-cost services. Requests would route through a single portal against statewide clinical criteria developed by DHCS. The same clinical scenario would produce the same authorization decision regardless of plan assignment. Approval timelines and appeals would follow one process.

Rate setting would shift to the state as a direct consequence of administrative unification. DHCS would set uniform statewide provider rates, whether

fee-for-service or capitated, replacing the current system in which plans negotiate rates individually or delegate to IPAs. The state already sets rates for Medi-Cal fee-for-service and for Medi-Cal Rx. The rate methodology would need to be transparent, evidence-based, and insulated from ad hoc political pressure. How providers are paid — whether fee-for-service with performance bonuses, capitation, bundled episodes, or hybrid arrangements — is a separate question from the administrative infrastructure. The important point is the ASO would create the foundation to implement any of these, shift among them as evidence accumulates, and increase sophistication over time without rebuilding the system.

The role of IPAs and Management Services Organizations would change. Their current administrative functions would move to the ASO. Physician groups whose value lies in clinical coordination, care management, and provider collaboration would retain those roles. What the ASO would not touch is equally important. Providers would retain full autonomy over electronic health records, clinical decision support tools, and practice management software.

A central question is who would operate the ASO. Competitive procurement for initial implementation may be the best way forward. Commercial ASO vendors already administer claims, credentialing, and utilization management for self-insured employers covering tens of millions of lives nationally. Medicare Administrative Contractors process the entire Medicare fee-for-service claims volume under federal contract. A contracted model would limit upfront state capital investment, shift operational risk to vendors with existing infrastructure, and allow faster implementation. DHCS would set standards, oversee performance, and hold the ASO accountable. The state would have to retain sufficient operational knowledge and data ownership to monitor contractor performance and bring functions in-house later if warranted.

What the ASO Makes Possible

California has already invested substantially in making member data more visible across the program. Medi-Cal Connect, the statewide population health platform launched under CalAIM, aggregates claims, enrollment, social determinants, and behavioral health data across plans and applies a standardized risk stratification methodology statewide. It is a genuine advancement. The Department of Health Care Access and Information's Healthcare Payments Data Program similarly aggregates discharge and claims data across payers statewide, but as an analytic tool. Both are built on top of a fragmented claims architecture, which defines what they can see and how quickly they can see it — with a three- to six-month lag. An ASO that can process all managed care claims in real time would produce something categorically different. The lag would disappear. A spending anomaly — an emerging utilization pattern concentrated in one region or one provider group — would become visible within weeks, not during the annual reporting cycle. Statewide spending benchmarks, which California has set through the Office of Health Care Affordability, could be monitored at the provider and service levels, not in aggregate, after the fact. The picture remains incomplete for services carved out to counties and other systems, a limitation that strengthens the case for eventual integration of those programs.

This visibility would extend to providers. Today, a primary care physician has limited sight into care delivered outside their own practice. A specialist visit through a different IPA, a behavioral health encounter billed through a different plan, or a screening completed at an urgent care clinic are all invisible unless the patient reports them. Under the ASO, the managed care claims history for any Medi-Cal member would be available to treating providers through the program's health information exchange infrastructure. Combined with clinical data exchange through California's Data Exchange Framework, this would give every treating provider a baseline picture of a patient's managed care history. For a primary care physician coordinating care

for a patient with diabetes, hypertension, and depression, who sees providers across multiple systems, this could mean the difference between coordinated care and guesswork.

Visibility makes accountability possible. A single claims stream and measurement framework would produce comparable quality data across all care management entities, providers, and regions. The metrics would use the same methods instead of arriving in separate

reports, at different intervals, with varying degrees of completeness. Performance on process measures, completed risk assessments, timely care plans, medication adherence, and emergency department follow-up would be attributed to specific plans, providers, and any other participating entity in ways the current architecture does not allow. Medi-Cal's high annual member turnover has long been cited as a reason care management entities cannot invest in population health. But when accountability measures capture effort along with outcomes,

Table 1. How Administrative and Strategic Functions Would Shift Under the ASO

FUNCTION	CURRENT SYSTEM	UNDER THE ASO
Credentialing	Plan-by-plan processes. IPAs may add requirements.	Single gateway. Credential once, serve any Medi-Cal member.
Provider directory	Plan-specific directories with IPA subdirectories.	Single statewide directory. One data standard, one verification process.
Claims processing	Coding edits, bundling rules, and payment timelines vary.	Uniform rates, coding rules, and payment timelines.
Rate setting	DHCS sets capitation. Plans negotiate rates or delegate to IPA	DHCS sets uniform statewide provider rates paid through ASO.
Utilization management	Plan-specific criteria, portals, and timelines.	Single portal, statewide criteria, standardized timelines.
Quality measurement	Cross-plan comparison difficult. IPA quality largely invisible.	Standardized measures. Comparable data across the board.
Provider oversight	By plans and IPAs. Quality and cost motivations difficult to distinguish.	Objective, program-wide criteria.
Member attribution	Plan-specific methodologies. Inconsistent across plans and IPAs.	Single statewide methodology.
Value-based payment	Plan-specific with varying metrics.	Standardized statewide framework and expectations for providers.
Data and reporting	Encounter data sent to DHCS with lag. IPA data often opaque.	Real-time claims, longitudinal record, cross-plan visibility.
Care management	Varied in capacity. Competes with network design for attention.	Primary competitive function for participating entities.
Role of IPAs/MSOs	Administrative intermediaries.	Clinical coordination and care management roles.

Source: Author's analysis, 2026.

Notes: *IPA* is independent practice association. *DHCS* is the California Department of Health Care Services. *ASO* is administrative services organization. *MSO* is management services organization.

organizations that do the work would get credit even when a member moves or falls out of the system.

Centralized infrastructure would shift provider quality oversight from network-level decisions to program-wide standards. Provider performance would be measured against objective criteria such as licensure, quality metrics, and patient safety events. If plans participate, they could flag concerns based on their data, but the ASO would retain sole authority to remove providers from the Medi-Cal network, preventing quality complaints from becoming a mechanism for cost-based network limiting. The unified claims stream would also make cost management tools more feasible. Value-based payment could be scaled on a single statewide framework with standardized attribution and measures, rather than splintering along the current patchwork of niche programs.

CalAIM's Enhanced Care Management and Community Supports would interact differently with this infrastructure. Enhanced Care Management is a core care management function and a natural fit for the entities that would bear responsibility. Community Supports, delivered by community-based organizations that serve enrollees across regions and plans, would be well-suited to the ASO, which could maintain a single network of community providers without requiring each care management entity to build its own.

In the future, a unified provider network could support a Medi-Cal product offered through Covered California, allowing enrollees to keep their providers when income shifts move them across the eligibility line. The ASO could, over time, absorb services that have been carved out to counties and other systems, reducing fragmentation beyond what the initial reform addresses. And a single claims stream would give the state the foundation to monitor compliance with Office of Health Care Affordability spending benchmarks and even support global budgets. Each would become feasible because the infrastructure exists.

Should Plans Remain?

With an ASO handling credentialing, claims, prior authorization, and the provider directory, the reasonable question is why plans would be needed at all. The best case rests on four arguments. First, multiple plans distribute financial risk. If one entity bears all risk and fails, or if the state bears risk and a bad budget year arrives, there is no backup. Second, different plans can try different approaches to care management, including complex care coordination, peer-support models, and community health worker programs. Third, some plans are genuinely good at this. Some MCPs, often local initiatives and mission-driven plans, have built real care management capabilities, community relationships, and provider integration. Excluding them would eliminate the benefits of this work along with the infrastructure. Fourth, preserving plans preserves transition flexibility. The system could evolve in multiple directions.

Under models that preserve plans, several forms are possible. These range from full capitated risk with supplemental value-based payment arrangements to budget-based accountability similar to Medicare's accountable care organizations (ACOs), in which plans share in savings or losses without directly paying providers. At the other end of the spectrum, the state could eliminate plans entirely and contract with specialized administrators for care management, or shift risk to provider-based ACOs. These options are not mutually exclusive across regions or over time, and the choice among them is a political and strategic judgment this paper does not attempt to resolve. The ASO infrastructure is valuable under any of them.

Evidence Supporting Consolidation

Managed care's advantages over alternative structures are not clear cut. A synthesis of available research by the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission found mixed and inconclusive evidence on whether Medicaid managed care improves access or quality compared

to fee-for-service, with findings varying by state, population, and service type.¹⁴ Where patient experience data exists, it cuts against the managed care advantage. Within California, plans in Geographic Managed Care counties, where multiple plans compete, performed worse on quality compared to plans run by County Organized Health Systems and in Two-Plan Model counties, with no access advantage and higher grievance rates, according to the previously referenced analysis of the state's most fragmented managed care markets.¹⁵ Another analysis of California's managed care data similarly found that quality of care was consistently higher in counties served by a single public plan than in counties with multiple competing plans, and that competition further narrowed already thin provider networks rather than improving access.¹⁶ These comparisons cannot fully control for differences in demographics, provider supply, or county infrastructure, but suggest that plan fragmentation does not produce better outcomes.

Next, administrative consolidation reduces costs and improves quality. When Connecticut eliminated managed care in 2012 and contracted with specialized administrators for medical, behavioral health, and dental services, administrative costs fell sharply. By 2024, the state's Medicaid administrative costs were an estimated 3.8% of total expenditures, less than half the 9.4% average in states that embed administrative costs into managed care capitation payments.¹⁷ Monthly per-member costs dropped 16% in the first three years, though some portion of this decline reflects the concurrent Affordable Care Act Medicaid expansion.¹⁸ Costs later rose after a 2019 hospital rate settlement, but remained nearly 10% below the pre-reform baseline.¹⁹ Primary care provider participation rose 37% in the first full year, though a federal primary care rate increase also contributed.²⁰ By 2022, Connecticut scored above the national median on roughly 70% of adult and child quality measures reported to the US Centers for Medicare & Medicaid Services (CMS). Another study found increased early-stage cancer diagnosis rates after the reform, with no comparable change in demographically similar New Jersey.²¹

Other states have taken partial steps. Washington legislated statewide centralized credentialing in 2009 and withholds 2% of managed care capitation payments pending quality performance.²² North Carolina requires plans to contract with any willing provider who meets state quality standards and accepts network rates, though providers must still execute separate contracts and each plan has its own claims and prior authorization process.²³ Notably, as North Carolina prepares its next managed care procurement cycle, the state has concluded that the proliferation of plans fragments provider administration and causes member decision paralysis, and is planning to reduce the number of plans.²⁴ Full administrative consolidation remains untested, but these states demonstrate that unified credentialing, standardized quality accountability, and open provider networks are feasible.

Finally, care management can generate savings without restricting provider choice. Medicare accountable care organizations provide the strongest test. ACOs operate within Medicare's open network — where beneficiaries are free to see any participating provider — and have developed care management, provider engagement, and member navigation strategies that generate measurable savings. In 2024, ACOs saved \$651 per enrollee.²⁵ In addition to these savings, patients reported quality measures and care experiences better than those of enrollees whose physicians received general incentive payments alone.²⁶ None of this evidence is perfectly analogous to what California would undertake, and several caveats apply. But taken together, the evidence supports the possibility that care management and administrative consolidation are separable functions.

Key Policy and Regulatory Changes

The federal pathway is simpler than it appears. Under 42 CFR Part 438, states have broad authority over managed care contract structure, including network standards and the scope of functions delegated to plans. Nothing in federal law requires plans to maintain

their own provider networks. Network adequacy is a state-defined standard that can be met through a unified statewide network or plan-specific ones. CMS would need to approve amended managed care contracts, but this falls within existing waiver frameworks California already uses. The federal picture grows more complex depending on plan participation. If plans no longer directly pay providers, their classification as managed care organizations could be challenged, and state-directed payment arrangements could face additional regulatory requirements. If the state eliminates plans entirely, the managed care classification question disappears and the state would administer Medi-Cal through fee-for-service or administrative services arrangements, both of which have established federal frameworks.

At the state level, three routes are available and not mutually exclusive. First, DHCS could use the next managed care procurement cycle to include unified network participation and ASO administrative requirements as conditions of plan contracts. This requires no legislative change, but contractual requirements could be negotiated down under industry pressure and apply only for the contract term. Second, the California Department of Managed Health Care (DMHC) would need to adapt its oversight framework. The Knox-Keene Health Care Service Plan Act of 1975 assumes plans maintain their own networks. If that changes, DMHC must reinterpret or amend its regulations to allow plans to satisfy adequacy obligations through the unified network. This may require legislative amendment. Solvency oversight, consumer protections, and grievance processes would remain with DMHC. Third, legislation could codify the unified network requirement, establish ASO authority, clarify Knox-Keene applicability, and revise continuity-of-care rules that currently assume plan changes disrupt provider relationships. In practice, the state could begin with contractual requirements in the next procurement cycle, pursue regulatory alignment with DMHC, and seek legislation to codify the framework once a pilot demonstrates feasibility.

Implementation Pathway

The following sequence would allow the state to build capacity, test assumptions, and adjust before committing to statewide rollout. In the initial phase, the state would establish unified provider credentialing through an expanded PAVE system and build a single statewide provider directory. Simultaneously, the state would pilot ASO functions for a defined, lower-risk service category, such as durable medical equipment and ancillary services, in one or two regions.

In the next phase, the contracted ASO would expand to cover all claims processing, utilization management, and provider enrollment in the pilot regions, with California's Data Exchange Framework facilitating health information sharing. This is the phase when the state evaluates whether the unified infrastructure reduces administrative cost and improves provider participation. If plans remain in the structure, this is also when the state develops standardized contracts and value-based payment frameworks. The results would inform which model to pursue statewide, and whether to vary the approach by region.

In the final phase, the state would incorporate unified network participation as a requirement in the next cycle of MCP contracts. Statewide expansion could be sequenced by region or service type. This phase is also when the state addresses whether the number of plans in each county should be limited, and whether plans that do not demonstrate care management value under the new structure should be allowed to drop out or consolidate with other plans. A bolder alternative could compress the timeline.

Financing and Affordability

The proposal would redirect existing administrative spending instead of requiring new program dollars. A uniform administrative fee deducted from capitation before distribution to plans, or an explicit carve-out of administrative functions from plan rates, could fund the ASO.

The scale of potential savings is significant but imprecise. Actual medical loss ratios vary by plan, year, and state, but the 85% floor establishes the regulatory limit for non-medical costs. Applied to Medi-Cal managed care spending from the state's General Fund, which for 2025–2026 totaled \$99 billion annually, up to \$14.9 billion flows to non-medical costs, including administration, profit, care management investment, and regulatory compliance.²⁷ Not all of this is duplicative, and not all would be captured by consolidation. Even at a 90% medical loss ratio, \$9.9 billion in non-medical spending remains.

These figures understate total administrative spending because they exclude the overhead embedded in delegated physician groups and management companies that do not appear in loss ratio reporting. The portion devoted to maintaining parallel network management, plan-specific credentialing, duplicative claims infrastructure, and intermediary overhead represents spending that consolidation would directly reduce. Plans report spending on total administrative costs, but not by function — or how much flows to care delivery versus corporate structure. Requiring this transparency as a condition of contract renewal would be a valuable reform itself.

Start-up investment would be required during the transition. The operational model for the ASO, whether state-operated, contracted, or hybrid, is discussed earlier in this paper and has significant implications for upfront cost, implementation speed, and ongoing financing. Regardless of the model, initial costs would be due before savings materialize. The phased implementation pathway would limit this exposure by testing infrastructure on lower-complexity services before scaling. The consolidation proposed here makes fiscal sense now. It becomes essential under federal funding constraints.

Risks, Trade-Offs, and Unintended Consequences

The political economy of this reform is more favorable than it might initially appear. Plans that have invested most heavily in care management stand to gain from a system that rewards those capabilities. Provider organizations whose value lies in clinical coordination and care management would find those roles expanded. Safety-net providers, consumer advocates, and counties share an interest in infrastructure that supports continuity and coordination. The stakeholder engagement strategy should lead with these shared goals.

As described above, a key challenge is rate setting, which shifts to the state as a direct consequence of the ASO. The political discipline required to sustain transparent, evidence-based rate methodology should not be underestimated. Medi-Cal Dental operates as a single, statewide program with one administrator, yet provider participation remains low because reimbursement rates are inadequate. If the unified network inherits Medi-Cal's current rate structure without reform, administrative simplification alone will not resolve access problems driven by insufficient payment. Providers who believe state-set rates undervalue their services may challenge the rate-setting authority, which has happened in other Medicaid contexts. Rate adequacy is beyond this paper's scope, but the infrastructure proposed makes the consequences of rate decisions more visible and correctable than in the current system, where rates are negotiated plan by plan with limited transparency.

The transition will also produce short-term care costs before long-term savings. Removing access barriers will increase utilization, at least initially. If the current administrative friction suppresses appropriate care, as the evidence on prior authorization delays and directory inaccuracies suggests, a well-functioning system should produce more visits, more completed referrals, and more behavioral health connections. This is the reform working as intended, and the cost should

be weighed against the emergency department visits, hospitalizations, and complications that result from delayed or forgone care. Simultaneously, providers navigating both old and new systems during the transition will face temporary administrative burden and start-up costs. The phased implementation pathway would expose such challenges in a pilot before state-wide rollout, giving the state evidence to calibrate the pace of expansion.

Vertically integrated systems are a special case. A handful of organizations, most notably Kaiser Permanente and several county-operated systems such as the one in Contra Costa, use models in which the plan and delivery system share governance, data, and financial incentives. This reform should define an exception for systems with demonstrated quality and access performance at or above program benchmarks, and internal data transparency sufficient for state oversight and program-wide quality reporting. These systems have already solved the fragmentation problem this paper seeks to address through other means.

Conclusion

Imagine a Medi-Cal that works for patients and providers: A patient's card is accepted at any credentialed provider, and stable care relationships survive plan changes. One system for providers, one set of rules, and a reason to participate. Real-time data for the state, visibility into spending, and fiscal resilience. Competition among care management entities on clinical outcomes rather than administrative gatekeeping.

This reform is administratively radical. It eliminates plan networks, consolidates claims and credentialing, and strips away layers of delegation that add cost without demonstrating benefit. It is structurally conservative. It builds on existing infrastructure and follows a consolidation trajectory California is already on.

Three forces create urgency. Federal fiscal reductions enacted in 2025 make California's duplicative

administrative infrastructure unsustainable. CalAIM's promise of whole-person care cannot be delivered on plumbing built for network competition. And the current commercial managed care contracts will likely be renegotiated in the coming years. That process is a natural vehicle for foundational change. But the window to shape the next round of contracts requires groundwork that must begin now.

This paper does not address rate adequacy, behavioral health and other carve-outs, or whether managed care plans add sufficient value to justify their continued role. These are important questions, but the foundation matters more. The new structure would make them easier to answer with evidence, and leaves room for more transformative reform if the evidence warrants it.

Actions can begin now. First, DHCS should require managed care plans to disclose administrative cost breakdowns, including delegation and subcontracting costs, as a condition of contract renewal. The state cannot plan a transition it cannot cost. Second, DHCS should incorporate unified network participation and ASO-compatible administrative standards into the next managed care procurement cycle. Contractual requirements need no legislation and establish the expectation that the current fragmented model is not permanent. Third, the Future of Medi-Cal Commission should recommend that DHCS design and issue a request for proposals to pilot consolidated administrative functions.

The next governor will inherit a choice to continue layering initiatives on fragmented infrastructure or build the foundation for the next decade. Fourteen million Californians are waiting for a better card.

Endnotes

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