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Managed Care: Is it Working?

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I. Introduction

Leading causes of death from the pre-colonial era throughout much of the 19th and early 20th centuries resulted from preventable yet deadly diseases such as smallpox, typhoid, influenza, and cholera, as well as numerous wars with high soldier mortality rates, all of which had a significant weighting effect on the average lifespan during this time.[1] Luckily, modern medicine morphed from rudimentary battlefield procedures conducted without sound sanitation and wound care practices to state-of-the-art experimental surgeries transplanting the heart of a pig into a terminally-ill patient.[2] Today, chronic and sustained illnesses like heart disease and cancer followed by unintentional injuries arising from modern lifestyles (i.e., automobile accidents, poisoning, drowning, and workplace injuries) are the deadly drivers of the day.[3] Consequently, the average life expectancy has grown exponentially from 39 years in 1860 to 77.5 years in 2024,[4] with the oldest living person currently 116 years-old.[5] And the infant mortality rate has declined at a similar speed from 399 deaths per 1000 live births to an impressive 7 per 1000 over this same period.[6] While this progress should give comfort to one seeking a long life it is also well documented that those living to advanced age may do so with chronic or other disabling conditions requiring the need for long-term services and supports (LTSS) to assist with one or more activities of daily living (ADLs), such as eating, bathing, toileting, or ambulating, whether at home or in some other setting.[7]

This steady march towards longer life supported by emerging medical technology, sophisticated healthcare procedures, and mass inoculation of vaccines, coupled with a reliance on

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[1] Sarah Morin, *Disease in Colonial New England,* https://libguides.ctstatelibrary.org/archives/uncoveringnewhaven/blog/Disease-in-Colonial-New-England (last updated October 12, 2021).

[2] Lauran Neergaard, *Surgeons Perform Second Pig Heart Transplant,* https://apnews.com/article/pig-heart-transplant-d894f6ce27b7db71ecb0ec393cac3e86 (last updated September 22, 2023).

[3] Centers for Disease Control, *Leading Causes of Death,* https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm (last updated May 2, 2024).

[4] Centers for Disease Control, *Life Expectancy,* https://www.cdc.gov/nchs/fastats/life-expectancy.htm (last updated May 2, 2024).

[5] Guiness Book of World Records, *Oldest Living Person,* https://www.guinnessworldrecords.com/world-records/84549-oldest-person-living (last accessed September 2024).

[6] Aaron O'Neill, *Child Mortality Rate in the United States,* https://www.statista.com/statistics/1041693/united-states-all-time-child-mortality-rate/ (last updated August 9, 2024).

[7] Halli Heimbuch, *Prevalence and Trends of Basic Activities of Daily Living Limitations in Middle-Aged and Older Adults in the United States* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10660458/ (last updated November 9, 2023).

these advanced healthcare services to do so, comes at a very steep cost. Underlying this data is the accelerated rise in healthcare-related spending borne by both the patient and the nation writ large. Currently, the United States expends over $4 trillion dollars on healthcare representing almost 20% of the Gross Domestic Product (GDP), compared to just 2.2% of the GDP in the 1850s or 5% in the 1960s.[8] Yet, despite leading all nations in healthcare spending the U.S. reportedly wastes one-quarter of this spending and lags behind the top ten wealthiest nations both in health outcomes and public health services.[9]

This significant growth in healthcare spending has been crippling to the average U.S. consumer as well. Medical expenses are currently cited as the leading cause of household bankruptcies in the United States notwithstanding the number of Americans with some form of healthcare coverage rose from less than 10% pre-World War II to an astonishing 92% in 2023.[10] In colonial America, paying for an at-home birth with a midwife would take the form of bartering with readily available (often agricultural) resources. Now, one can expect a routine pregnancy to cost over $20,000 throughout the pregnancy, delivery, and postpartum care of the child, most of which is conducted in a medical setting.[11] At the other bookend, aging Americans in the 19th century would convalesce at home with support from immediate family, whereas, as of 2022 $467 billion was allocated to long-term care in the U.S. with out-of-pocket consumer costs on long-term care exceeding $63 billion.[12]

Considerations as to how much a patient pays for healthcare services, the amount a healthcare provider should charge for those services, who is responsible for payment once services are rendered, and the method or delivery of such service or payment has added an even further layer of complexity for our society to address and from which the U.S. health insurance

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[8] Centers for Medicare and Medicaid Services, *Historical,* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.3%20percent (last updated September 10, 2024).

[9] Niharika Namburi, *Managed Care Economics,* https://www.ncbi.nlm.nih.gov/books/NBK556053/ (last updated January 30, 2023).

[10] Katherine Keisler-Starkey, *Health Insurance Coverage in the United States: 2022,* https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf (last updated September 2023).

[11] Elizabeth Rivelli, *How Much Does It Cost to have a Baby? 2024 Averages,* https://www.forbes.com/advisor/health-insurance/how-much-does-it-cost-to-have-a-baby/ (last updated January 3, 2024).

[12] Congressional Research Service, *Who Pays for Long-Term Services and Supports?* https://crsreports.congress.gov/product/pdf/IF/IF10343 (last updated September 19, 2023).

market was born.[13] From our nation's inception methods of satisfying the costs of healthcare services have evolved from a simple, direct payment between patient and provider to an intricate web supporting today's infrastructure that is responsible for moving over $3 trillion dollars between patients and providers year-over-year.[14] Much of this spending over the past half century derives from Medicare, Medicaid, and employer-sponsored health insurance plans, none of which provide direct healthcare services to its enrollees but collectively satisfy some or all of the costs of healthcare to the overwhelming majority of Americans.[15]

To support a growing population reliant on immediately available healthcare that is as administratively efficient as possible and available to as many as possible; keep costs affordable while embracing the rapid emergence of medical breakthroughs and the provision of holistic care; and, ensure credentialed healthcare providers remain in the U.S. healthcare system; Medicare, Medicaid, and the myriad private health insurance companies have all gravitated toward "managed care" to help buoy this delicate healthcare ecosystem. A managed care model, as will be further defined below, is simply a healthcare delivery system that links payment for covered healthcare services from the insurer to the providers of those services often through the use of a third-party entity and at an agreed-upon rate per enrollee.[16] Although managed care has been a viable solution (albeit with various setbacks) for more than a century it is now the predominant healthcare delivery system in the nation. In fact, most insured Americans receive healthcare coverage through some form of managed care.[17] While originating in the private sector, both Medicare and Medicaid have embraced the perceived efficiencies of managed care and have incorporated its use throughout both programs. The remaining focus of this presentation, though, will be on Medicaid's application of managed care.

Although most states have long used managed care models as a Medicaid delivery method for one or more Medicaid covered services, not every state employs this approach

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[13] Peter D. Fox, *A History of Managed Health Care and Health Insurance in the United States,* https://samples.jbpub.com/9781284043259/Chapter1.pdf (last updated September 3, 2015).
[14] Centers for Medicare and Medicaid Services, *National Health Expenditure Fact Sheet,* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (last updated September 10, 2024).
[15] *Id*.
[16] Fox, *supra* n. 13.
[17] L.E. Block, *Evolution, Growth, and Status of Managed Care in the United States,* https://pubmed.ncbi.nlm.nih.gov/9553445/#:~:text=Currently%2C%20three%2Dquarters%20of%20Americans,Americans%20enrolled%20in%20such%20plans (last accessed September 2024).

specifically for the delivery of long-term services or supports.[18] The increasing number of states that are providing Medicaid-funded LTSS through managed care systems, however, are doing so, in part, to control costs while increasing utilization rates among the population of current or prospective Medicaid enrollees. But is this model working?

A brief history of managed care as a Medicaid delivery system will be explored below, followed by a discussion of the impact that the competing goals of cost containment and increased health services utilization has on the long-term viability of the managed care model. This topic will also provide a synopsis of the various states' approach to the provision of LTSS through this delivery system, and then conclude with a survey of the challenges and successes that states and Medicaid enrollees may experience as managed care continues to evolve.

II. The Historical Development of Managed Care

Prior to the 20th century, healthcare services in the United States were primarily paid directly by the patient to the provider in the form of cash, goods, or labor (the original fee-for-service model).[19] Although there is documented evidence that as early as the colonial period well-regarded physicians would contract with wealthy clients to provide on-demand medicine at a fixed annual rate,[20] such arrangements were a concierge service rather than an insurance product to hedge against financial disruption.[21] And while sporadic employer-sponsored health benefits began to emerge in the first half of the 19th century by the railroad, mining, and lumber industries treating sick or injured tradespeople and laborers through the provision of doctors and/or hospitals at or near the jobsite, it was not until much later that traditional health insurance took shape to include indemnity insurance in which another party (i.e., an insurer, employer, or government agency) was responsible for the payment of a patient's healthcare services.[22]

Historians frequently point to the wage control laws and favorable tax treatment of healthcare benefits of the WWII era as the powder keg that caused the stratospheric rise of

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[18] Elizabeth Hinton, *10 Things to Know about Medicaid Managed Care,* https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ (last updated May 1, 2024).
[19] Erin Allen, *Paying the Doctor in 18th-Century Philadelphia,* https://blogs.loc.gov/loc/2016/04/paying-the-doctor-in-18th-century-philadelphia/ (last accessed September 2024).
[20] *Id.*
[21] Fox, *supra* n. 13.
[22] Fox, *supra* n. 13.

citizens with some form of healthcare coverage.[23] In a twenty-year period from 1940 to 1960 the number of individuals with healthcare coverage grew seven-fold from 20 million to an astounding 140 million.[24] In two decades, society went from an uninsured rate of over 90% to less than 10%.[25] Because of the high demand for maximum domestic factory output to support the war effort and the concurrent strained labor market due to the draft, wage controls were implemented limiting the amount of wages certain industries could pay its workers.[26] To remain competitive in the labor market and through the efforts of strong labor unions, employers would offer health insurance coverage as an in-kind benefit to offset those wage ceilings. Moreover, Congress exempted such employer-sponsored health coverage from federal income tax in 1954 thereby weaving the deep importance of healthcare coverage into the United States fabric.[27] By 1965, an already expansive insurance market grew markedly larger with the government's entrance via the passage of Medicare and Medicaid extending healthcare coverage to those not in the labor market due to age or ability, as well as those living in poverty.[28] Together these programs provided healthcare coverage to an additional 20 million Americans in just the first few years of inception.[29] Today, over 300 million Americans receive healthcare coverage from employer-sponsored health insurance, Medicare, and/or Medicaid collectively.[30]

During the last half of the 20th century as traditional indemnity insurance was growing in prevalence the primary delivery system between the patient, provider, and insurer was the "fee-for-service" model. Under this model, which still permeates throughout today's insurance market, physicians, hospitals, and other healthcare providers are paid by the insurer *per service* performed.[31] Critics of this model argue that it supports a volume-over-value proposition devoid of any coordinated care for the patient allowing providers to drive pricing to unsustainable

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[23] Fox, *supra* n. 13.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] The author assumes the reader is familiar with the Medicare (42 U.S.C. § 1395 et seq.) and Medicaid (42 U.S.C. § 1396 et seq.) programs, the population of enrollees both programs cover, and the respective eligibility requirements.
[29] Fox, *supra* n. 13.
[30] Starkey, *supra* n. 10.
[31] Centers for Medicare and Medicaid Services, *Fee for Service Definition,* https://www.healthcare.gov/glossary/fee-for-service/#:~:text=A%20method%20in%20which%20doctors,include%20tests%20and%20office%20visits (last accessed September 2024).

rates.[32] Because insurers and providers operate independent of each other without incentivization under a fee-for-service approach, critics posit that consumer costs have ballooned and an "unrestrained delivery of services" have led to out-of-control insurance premiums and reduced health outcomes.[33]

Regardless of this criticism's validity, it was clear to President Nixon and Congress that an alternative healthcare delivery method should be explored to confront the soaring prices of (and spending on) healthcare services and the resulting inflationary pressures that both were having on the overall economy. By the early 1970s, most healthcare services were paid for by a third party rather than the patient directly, i.e., an employer-sponsored health plan, Medicare, and/or Medicaid. This new third-party payer system primarily delivered via fee-for-service effectively ended the payment relationship between the patient and provider, which had the net effect of increasing both price and utilization.[34] While the uninsured rate experienced a dramatic reduction by 45% in the 1960s, healthcare-related spending as a percentage of the GDP rose by 3 points during this same decade with healthcare costs outpacing the economy of the day.[35]

Many viewed managed care as a viable solution to a disjointed fee-for-service delivery approach which could concurrently control costs and expand the provision of coordinated, holistic medical care. As was loosely defined above, managed care is a healthcare delivery system that 1) integrates the patient, provider, and insurer; 2) designs cost control methods to, among other purposes, manage unnecessary healthcare utilization; 3) incentivizes competition among healthcare providers by rate and/or price-setting, and 4) provides administrative services and accountability.[36]

A Managed Care Organization (MCO) is the entity largely responsible for this integrated network. Depending on the geographic market and type of MCO, the consumer may have a range of restrictions placed upon their access to healthcare. Though there are a variety of hybrid MCOs, the three traditional MCOs under a managed care model are the 1) Health Maintenance Organization (HMO), 2) Preferred Provider Organization (PPO), and 3) a Point of Service (POS) plan. HMOs, often offered to enrollees for low or no deductibles, require enrollees to choose

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[32] Naoki Ikegami, *Fee-for-Service Payment – an evil practice that must be stamped out?* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4322626/ (last accessed September 2024).
[33] Namburi, *supra* n. 9.
[34] Fox, *supra* n. 13.
[35] *Id.*
[36] Namburi, *supra* n. 9.

providers and hospitals that are *in-network*, greatly reducing covered services to enrollees seeking care of their choosing that may be found outside of the HMO's network of providers absent an emergency (restrictive).[37] With an HMO, an enrollee is required to have a primary care physician (PCP) who is responsible for coordinating care and referring an enrollee to specialists. Alternatively, PPOs are on the less restrictive side of the MCO spectrum where a PPO will enter into discounted pricing arrangements with select healthcare providers and allow the enrollee to see specialists without a PCP referral and (somewhat) free of a network/referral system.[38] Enrollees in a PPO will usually see higher deductibles as a result of the flexibility afforded to the enrollee under this plan.[39] POS plans are essentially a hybrid HMO/PPO that require an enrollee to select a PCP but allows for out-of-network services.[40] By 2022, 49% of employer-sponsored health insurance was offered through a PPO, followed by 12% enrolled in an HMO, and 9% in a POS. The remaining population was in a High Deductible Health Plan (HDHP) within an HMO or PPO.[41]

MCOs are supported in large part by a payment model in which the MCO builds a network of healthcare providers who offer comprehensive care to enrollees at a fixed-fee per member, per month (known as "capitation").[42] Put simply, if an enrollee's cost-of-care is less than the capitated rate over a sustained period, the MCO should be profitable. The risk of financial loss, as well as the benefit of any financial gain, is shifted to the MCO.[43] This risk/reward model, in turn, requires the MCO to be hyper-focused on the price of services by the provider, utilization of those services by the consumer, and quality of care received to improve patient outcomes.[44]

Although managed care did not formally enter the national health insurance conversation until the passage of the Health Maintenance Organization Act of 1973,[45] the managed care

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[37] Namburi, *supra* n. 9.
[38] *Id*.
[39] University of Florida, *Choosing Your Health Insurance Plan,* https://news.hr.ufl.edu/benefits/choosing-your-health-insurance-plan-hmo-vs-ppo-vs-hdhp/ (last accessed September 2024).
[40] Namburi, *supra* n. 9.
[41] *Id*.
[42] Leona Rajaee, *What is Capitation in Healthcare?,* https://www.elationhealth.com/resources/independent-primary-care-practices-blog-elation-health-ehr/capitation (last updated April 10, 2024).
[43] *Id*.
[44] *Id*.
[45] *See* U.S. Gov. Accountability Office, *Implementation of the Health Maintenance Organization Act of 1973,* https://www.gao.gov/products/105122 (last accessed September 2024).

concept is credited for some of the first health insurance coverage offerings of the early 20th century with the advent of both the HMO and capitation concepts discussed above. [46] By way of example, in 1910 a clinic in Tacoma, Washington began offering mill owners and their employees' access to medical services for $.50 per month, effectively providing the consumer with a fixed cost and offering the clinic a revenue pipeline. [47] Not long after, by the late 1920s Blue Cross plans emerged when teachers in Texas were able to prepay for inpatient hospital care at Baylor Hospital (known as the "Baylor Plan"), which quickly expanded to other hospital associations and employers.[48] And then its twin, Blue Shield, entered a decade later when companies offered injured employees outpatient medical care offered by healthcare providers that the companies would contract with at a negotiated monthly fee, which would then be paid to the provider by a third-party.[49] Now, BlueCross and BlueShield – a longstanding provider of managed care plans – offers healthcare coverage to 1 in 3 Americans and has a network of almost 2 million healthcare providers and hospitals nationwide.[50]

As the indemnity insurance market continued to develop and expand in the latter half of the 20th century, along with both the fee-for-service and managed care delivery systems underlying this market, healthcare-related inflation grew rampant causing Congress to embrace managed care more fully through the passage of the HMO Act of 1973.[51] The third-party payer system comprised of the triad – Medicare, Medicaid, and employer-sponsored health insurance - was viewed to have further enabled that which most found off-putting with fee-for-service, which is inflated pricing by providers. By leveraging a risk-shifting model focused on capitation and coordinated care organized by a MCO that has *insight* into the patient and *oversight* of the provider, it was presumed that reduced costs to the insured, employers, and state and federal government alike would follow. The HMO Act of 1973 bolstered managed care by 1) offering grants and loans to support the expansion of HMOs; 2) preempt contradictory state law that would impede an HMO; and most importantly 3) requiring employers with more than 25

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[46] Fox, *supra* n. 13.
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] BlueCross BlueShield, *The Blue Cross and Blue Shield System,* https://www.bcbs.com/about-us/blue-cross-blue-shield-system (last accessed September 2024).
[51] Fox, *supra* n. 13.

employees who offered healthcare coverage to provide at least one federally qualified HMO choice.[52]

The Employee Retirement Income Security Act (ERISA) of 1974 (protecting MCOs from malpractice), the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (shifting Medicare hospital reimbursement from fee-for-service to a "prospective payment system" and creating the precursor to Part C), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)(extending temporary healthcare coverage during unemployment), and the Affordable Care Act (ACA)(extending Medicaid enrollment, increasing the age of a dependent entitled to coverage, and requiring coverage for pre-existing conditions) all had meaningful, substantive impacts to the development of managed care well into the 21st century.[53]

Managed care grew steadily from the HMO Act's enactment until the late 1990s when there was a backlash toward this model insofar as this was the only part of the healthcare system that would micromanage a patient's care and even deny coverage in the guise of case management as will be further discussed.[54] Nonetheless, this backlash eventually subsided and managed care returned to the forefront now covering 160 million Americans and is the primary delivery system for the 80 million Americans receiving Medicaid – except for LTSS covered services which remains fragmented.[55]

III. The Intersection of Medicaid and Managed Care

Grabbing the baton from Presidents Harry Truman and John Kennedy's efforts to extend healthcare coverage in the United States, in particular to older and low-income Americans, President Lyndon Johnson is credited for achieving some of the most sweeping healthcare-related legislation in the nation's history with the establishment of Medicare and Medicaid in 1965.[56] Although the political support, purpose, financing, eligibility, and healthcare coverage

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[52] GAO, *supra* n. 45.
[53] Namburi, *supra* n. 9.
[54] *Id.*
[55] Centers for Medicare and Medicaid Services, *May 2024 Medicaid & CHIP Enrollment Data Highlights,* https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=80%2C855%2C947%20individuals%20were%20enrolled%20in,individuals%20were%20enrolled%20in%20CHIP (last accessed September 2024).
[56] National Archives, *Milestone Documents: Medicare and Medicaid Act (1965),* https://www.archives.gov/milestone-documents/medicare-and-medicaid-act#:~:text=On%20July%2030%2C%201965%2C%20President,for%20people%20with%20limited%20income. (last updated February 8, 2022).

for both programs are separate and distinct, both programs share a similarity inasmuch as each are undergirded by the fee-for-service and managed care delivery systems.

Managed care has been coupled with Medicare throughout Medicare's history. Original Medicare, comprised of Part A (Hospital Insurance) and Part B (Medical Insurance), is strikingly similar to the early Blue Cross and Blue Shield concepts which was attractive to members of Congress during this time and assisted in securing the votes necessary for the program's enactment. Furthermore, Medicare-recognized *HMO-type* plans were authorized for reimbursement at Medicare's inception eight years before HMOs were formally recognized in federal legislation.[57] With the 1972 amendments to the Social Security Act, Medicare managed care offered through HMO enrollment was introduced into the program, and the risk-based private plans associated with Medicare Part C (known as "Medicare Advantage") followed with the Tax Equity and Fiscal Responsibility Act of 1982 as enhanced by the Balanced Budget Act of 1997.[58] However, the effectiveness and usage rates of Medicare managed care has ebbed and flowed driven by vacillating legislation, fluctuating premiums, consumer-opposed cost control exercises, changing enrollee demographics (think Baby Boomers), and ever-changing provider payment methodologies.[59] Nonetheless, as of 2023 almost one-half of Medicare's 64 million recipients were enrolled in Medicare Part C – Medicare's primary managed care model. The remainder of Medicare's relationship with managed care is beyond the scope of this presentation and should be viewed separately from Medicaid's embrace of this delivery system.

Medicaid's foray into managed care and what led to managed care as the preferred delivery method among states' Medicaid programs took a more linear path likely resulting from the respective states mandated cost-share to fund the program that does not entirely exist within the Medicare framework.[60] Also, Medicaid, which offers a suite of healthcare coverage to low-income individuals, children, pregnant women, older Americans and those with special needs or disabilities, is a very unique healthcare structure serving a particular demographic that is different from the pools of plan participants found in employer-sponsored coverage and

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[57] Thomas Mcguire, *An Economic History of Medicare Part C,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/ (last accessed September 2024).
[58] *Id.*
[59] *Id.*
[60] Fox, *supra* n. 13.

Medicare.[61] And assuming a state remains consistent with federal law and its approved state Medicaid plan, states have significant agency in the administration of its respective Medicaid program (including the services covered and excluded) causing variability among states. For these and other reasons one should expect that Medicaid managed care follows a separate trajectory than the managed care models of the other two members of the triad. Nevertheless, by employing managed care as a Medicaid delivery system, states generally experience "budget predictability" and reduced administrative responsibilities while the enrollee receives coordinated care, which is not often found when states assume these functions under a fee-for-service approach.[62] With the stated goals of reducing Medicaid program costs to the state and federal government while concurrently increasing patient utilization and improved health outcomes,[63] Medicaid managed care is now at the forefront of most states' Medicaid programs.

Eleven years after Medicaid was signed into law and only three years following the passage of the HMO Act of 1973, Congress amended the HMO Act to permit states that offered Medicaid to contract with federally qualified HMOs to deliver Medicaid covered services so long as the respective HMO had no more than 50% of its enrollees enrolled in either Medicare or Medicaid.[64] This cap was increased to 75% with the Omnibus Budget Reconciliation Act of 1981 and then eliminated in its entirety with the Balanced Budget Act of 1997, at which point managed care grew exponentially within the Medicaid framework.[65] California first explored Medicaid managed care as early as 1971 at the behest of Governor Ronald Reagan to reduce Medicaid spending, by the 1980s Arizona sought to offer Medicaid managed care as the only Medicaid delivery system available in the state, and now 40 years later, the majority of states leverage a Medicaid managed care model to provide covered services to nearly two-thirds of Medicaid enrollees nationwide.[66]

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[61] *See* Centers for Medicare and Medicaid, *Medicaid,* https://www.medicaid.gov/medicaid/index.html (last accessed September 2024).
[62] Hannah Maniates, *Why did they do it that way? Understanding Managed Care,* https://medicaiddirectors.org/resource/understanding-managed-care/ (last updated January 22, 2024).
[63] *See* Centers for Medicare and Medicaid, *Managed Care,* https://www.medicaid.gov/medicaid/managed-care/index.html (last accessed September 2024).
[64] Maniates, *supra* n. 62.
[65] *Id.*
[66] *See* Kaiser Family Foundation, *Medicaid Managed Care Tracker,* https://www.kff.org/statedata/collection/medicaid-managed-care-tracker/#about-this-collection (last accessed September 2024).

Federal regulations recognize four MCO entities under the Medicaid managed care model – Managed Care Organizations (MCO), Primary Care Case Management (PCCM), Prepaid Inpatient Health Plan (PIHP), and the Prepaid Ambulatory Health Plan (PAHP).[67] The MCO offering provides the Medicaid enrollee a comprehensive benefits package (i.e., primary, acute, and specialty care) with payment based on capitation.[68] With a capitated Medicaid managed care program the state will pay an MCO a monthly rate per Medicaid enrollee for the MCO to manage a range of services, including, but not limited to, 1) establishing provider networks; 2) satisfying payment to providers for Medicaid-covered services; 3) implementing utilization management practices and other program administration responsibilities; and 4) providing care coordination for enrollees.[69] This model shifts the risks associated with the cost to administer Medicaid from the state to the MCO thus making this the preferred managed care program among the states. Alternatively, PCCMs provide for primary care case managers who contract with the state Medicaid agency to provide case management on a fee-for-service basis in addition to a monthly case management fee; whereas, PIHPs only offer limited benefits for inpatient hospital and other institutional settings at either a capitated rate or fee-for-service, and conversely, PAHP plans offer limited coverage that excludes inpatient hospital and other institutional settings.[70] Of the 90 million Medicaid enrollees in 2021, 77 million where enrolled in any one (or more) of the MCO options outlined above with a staggering 67 million enrolled in a comprehensive, risk-based (capitated) MCO.[71]

State Medicaid agencies are authorized to deliver Medicaid benefits to eligible residents within a managed care framework under several federal enabling authorities. The three primary authorities, however, are the State Plan Authority found in 42 U.S.C. § 1932(a) and the two

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[67] 42 CFR § 438 et seq.
[68] Centers for Medicare and Medicaid Services, *Managed Care Entities,* https://www.medicaid.gov/medicaid/managed-care/managed-care-entities/index.html (last accessed September 2024).
[69] *Id.*
[70] *Id.*
[71] *See* Centers for Medicare and Medicaid Services, *Managed Care Enrollment Summary,* https://data.medicaid.gov/dataset/52ed908b-0cb8-5dd2-846d-99d4af12b369/data?conditions[0][property]=year&conditions[0][value]=2021&conditions[0][operator]=%3D (last updated July 21, 2023).

Waiver Authorities found in 42 U.S.C. § 1915(a)-(b) and 42 U.S.C. § 1115.[72] These statutes effectively permit a state to deviate from otherwise required federal Medicaid law to implement a managed care delivery system which grants states broad discretion to 1) design a managed care delivery system targeting certain geographic areas of a state rather than offering a statewide plan; 2) provide different benefits to different people enrolled within the managed care system; and 3) only afford Medicaid enrollees a Medicaid managed care option.[73] A state's process to design, implement, and execute a Medicaid managed care delivery system will vary depending on the respective authority(ies) from which the state sought approval. Notwithstanding these authorities, all states are required to comply with federal law applicable to managed care.[74] This includes requiring state oversight of MCOs, notice obligations, appeals and grievance processes, provider network governance, access to providers, and enrollment support.[75] Because of the sheer monetary value of a managed care contract between a state and MCO, there are voluminous procedural requirements surrounding the procurement process, capitation/rate setting, utilization management, and monitoring and enforcement actions.[76] It is in the value of these contracts and resulting financial incentives that states are able to require MCOs to focus on increased access to quality healthcare services.

However, the flexibility offered to states in the Medicaid managed care space is a leading contributor of the variation among state Medicaid programs as it relates to the type and volume of Medicaid managed care plans, the number of enrollees, and the healthcare services covered (or excluded).[77] This is readily apparent when a Medicaid enrollee attempts to move out-of-state and then reestablish coverage in their new state. Despite the negative consequences that may arise from these disparities the fiscal savings and program administration support experienced by a state utilizing a Medicaid managed care model will continue to make this model the preeminent delivery system for Medicaid benefits nationally. In particular, the risk-based, capitated MCO plan is the most attractive form of Medicaid managed care as evidenced by the 41 states who

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[72] *See* Centers for Medicare and Medicaid Services, *Managed Care Authorities,* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html (last accessed September 2024).
[73] CMS, *supra* n. 72.
[74] Maniates, *supra* n. 62.
[75] CMS, *supra* n. 72.
[76] Maniates, *supra* n. 62.
[77] *Id.*

employ this particular delivery system.[78] In fact, payments to MCOs comprised over 50% of state and federal Medicaid spending compared to 39% of spending delivered through a fee-for-service structure.[79]

While managed care is now firmly rooted in the delivery of Medicaid benefits nationally, ever-changing state and federal political landscapes, market pressures, and a complex regulatory framework dictate that Medicaid managed care will continue to evolve.[80] Where states were previously using the flexibility afforded by managed care as a sword to exclude coverage for a number of healthcare services, like LTSS, mental or behavioral health, and prescription drug coverage, the tide is changing and such programs are now being scoped into MCO contracts.[81] This is particularly true for LTSS benefits where spending grew from $6 billion in 2008 to $47 billion in 2019. Unfortunately, though, enrollment in MCOs for adults over 65 or those with a disability who require LTSS continues to trail the enrollment figures for children and adults receiving other Medicaid covered services.[82] For instance, the penetration rate for adults over 65 or those with a disability remains at or below 50% in a majority of the 41 states offering Medicaid managed care.

IV. Delivery of LTSS through a Medicaid Managed Care Model

As outlined in the Introduction, the advent and advancement of modern medicine and other therapies have allowed Americans to live longer, as well as live more independently with a disability or special need.[83] But these breakthroughs come with challenges, especially related to receiving and paying for the long-term services and supports necessary to support one's aging process. These challenges become transparent when coupled with the "gray tsunami" of seventy-three million baby boomers graduating into retirement who will soon comprise 20% of the U.S. population thereby placing increased demand on the LTSS infrastructure. Moreover, almost 30% of adults in the United States reported having a disabling or chronic condition in 2022; of those

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[78] Elizabeth Hinton, *10 Things to Know About Medicaid Managed Care,* https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ (last updated May 1, 2024).
[79] Hinton, *supra* n. 78
[80] Maniates, *supra* n. 62.
[81] Hinton, *supra* n. 78.
[82] *Id.*
[83] Erica Reaves, *Medicaid and Long-term Services and Supports: A Primer,* https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/ (last accessed September 2024).

ages 18 to 44 within this population, 1 in 4 often did not have access to a healthcare provider or annual check-up leading to an unmet healthcare need.[84] Added to this population are the 70% of adults who will live to age 65 and develop a need for assistance with one or more ADLs at home or in an institutional setting but may not have adequate finances to satisfy the attendant costs for a sustained period.[85] For these reasons, both the access to and affordability of LTSS-related healthcare services will be a growing topic of concern over the next several decades.

Because Medicare only offers limited coverage for LTSS, if at all, and there are not often viable commercial or employer-related insurance products readily available to this segment of society, Medicaid has become the primary payer of long-term care in the United States.[86] As of 2020, over 30% of the $597 billion in Medicaid spending was related to long-term care services even though the number of Medicaid enrollees receiving LTSS coverage was disproportionately small compared to the overall population of Medicaid recipients.[87] This fiscal disparity, along with the accelerated demand for complex healthcare and increased spending on long-term care within the Medicaid program, has caused states and the federal government to increasingly look toward creative solutions to deliver holistic long-term care services in a cost-efficient way, and once again, managed care is under consideration as a viable solution.[88]

People commonly conflate long-term care with institutional care provided in a skilled care facility. While there are over 1.6 million licensed nursing home beds in the United States,[89] LTSS are much more expansive than simply the provision of institutional care. In order to "facilitate optimal functioning" to the millions of Americans requiring long-term care, LTSS offers a range of healthcare and social services in the person's home, community, or facility, to

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[84] Centers for Disease Control, *Disability and Health Promotion,* https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html (last updated July 2024).
[85] Richard Johnson, *What is the Lifetime Risk of Needing and Receiving Long-term Services and Supports?* https://aspe.hhs.gov/reports/what-lifetime-risk-needing-receiving-long-term-services-supports-0 (last updated April 3, 2019).
[86] Reaves, *supra* n. 83.
[87] Centers for Medicare and Medicaid Services, *Long Term Services and Supports,* https://www.medicaid.gov/medicaid/long-term-services-supports/index.html (last accessed September 2024).
[88] Medicaid and CHIP Payment and Access Commission, *Managed Long-term Services and Supports,* https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/ (last updated March 22, 2022).
[89] Centers for Disease Control, *Nursing Home Care,* https://www.cdc.gov/nchs/fastats/nursing-home-care.htm (last updated November 5, 2023).

assist a person with limitations arising from a physical or mental condition or disability.[90] Such services may include skilled care, day programs, home health aides, personal care services, transportation, supported employment, caregiver support, and much more.[91] Medicaid offers broad coverage of LTSS, but this coverage and the underlying delivery method is inconsistent among the states.[92]

Historically, there has been a bias in the Medicaid program toward prioritizing institutional level-of-care by way of a fee-for-service model insofar as states are mandated to provide such coverage whereas home and community-based LTSS benefits are optional.[93] This bias has led to paradoxically disproportionate Medicaid expenditures allocated to the highest level of institutional care and a lack of care coordination for a population of Medicaid enrollees with incredibly complex health and social needs that could likely be met in the person's preferred residential setting.[94] Over time, however, there has been a recognition that institutional level-of-care is expensive, the traditional fee-for-service delivery system may not lead to a positive health outcome absent coordinated care, and most people prefer to remain in the residential setting of their choosing with proper supports to be able to do so. Medicaid-managed LTSS is designed to address these concerns.

Medicaid-managed LTSS is the delivery of the above-referenced services through a risk-based capitated managed care program where a state Medicaid agency contracts with an MCO to deliver LTSS benefits to eligible persons.[95] The eligible beneficiaries of this healthcare coverage tend to be individuals over age 65 or those ages 18 to 65 with a physical disability, although some states are starting to expand coverage to those with intellectual or developmental disabilities.[96] A case manager is often employed given the range of needs that these beneficiaries may encounter.[97] By utilizing a Medicaid managed LTSS model, care coordination, access to

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[90] Nga Thach, *An Overview of Long-term Services and Supports and Medicaid: Final Report* https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0 (last accessed September 2024).
[91] Reaves, *supra* n. 83.
[92] Thach, *supra* n. 90.
[93] Reaves, *supra* n. 83.
[94] MACPAC, *supra* n. 88.
[95] *Id.*
[96] Elizabeth Lewis, *The Growth of Managed Long-term Services and Supports Programs: 2017 Update,* https://www.medicaid.gov/medicaid/downloads/mltssp-inventory-update-2017.pdf (last accessed September 2024).
[97] MACPAC, *supra* n. 88.

home and community-based services, and improved health outcomes may be expanded for this vulnerable population while also allowing the state to achieve cost-savings, enhanced program administration efficiencies, and a competitive market with increased plan offerings.[98]

With approval of the Centers for Medicare and Medicaid Services, states may develop a managed LTSS program as part of its Medicaid plan by using one or more of the three federal authorities outlined above.[99] Currently, 46% of managed LTSS programs were authorized under § 11115(a) Demonstration Waivers, 27% through §1915(b) Waivers, 15% by §1915(a) Waivers, and the remaining 12% through amendment to the states' respective state Medicaid plan.[100] Depending on the federal enabling statute, states have the ability to require mandatory enrollment in a managed LTSS plan as well as test new programs, services, and covered populations.[101] In a majority of the states with managed LTSS plans, both older adults and those with a mental or physical disability are covered with the remaining states offering coverage to only one group (either aged or disabled).[102] As of 2017, there were over 20 programs designed for enrollees with intellectual or developmental disabilities.[103] Regarding program exclusions, Arizona, Kansas and Wisconsin are currently the only states with managed LTSS programs in which all Medicaid-covered services are provided for within the MCO capitation rate, whereas the remaining states will carve out benefits from the capitation rate such as institutional care, home and community-based services, behavioral health, prescription drugs, and others.[104]

Even though Arizona was a pioneer that sought to leverage managed care in the delivery of LTSS in the early 1980s, much of this growth has occurred in recent years.[105] There are currently twenty-four states operating over forty-one managed LTSS programs, which is a three-fold increase from 2008.[106] This has caused both the enrollment in managed LTSS programs and the number of available managed LTSS plans to double from 800,000 to 1.8 million in the five-

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[98] Reaves, *supra* n. 83.
[99] Centers for Medicare and Medicaid Services, *Managed Long-term Services and Supports, https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html (last accessed September 2024).*
[100] Lewis, *supra* 96 at pg. 11.
[101] Lewis, *supra* 96 at pg. 14.
[102] *Id.*
[103] Lewis, *supra* 96 at pg. 15.
[104] Lewis, *supra* 96 at pg. 19.
[105] Reaves, *supra* n. 83.
[106] MACPAC, *supra* n. 88.

year period from 2012 to 2017.[107] This delivery approach is similar to other Medicaid managed care products; however, the health needs of the enrollees receiving managed LTSS benefits are incredibly diverse which adds a layer of complexity as it relates to care coordination (utilization) and rate setting (capitation).[108] There are a variety of managed LTSS models offered by states ranging from the delivery of only LTSS covered services to comprehensive and fully-integrated LTSS programs that cover all Medicaid (and Medicare) services for the enrollee.[109] States with Medicaid managed LTSS may choose to target different participants with separate LTSS plans, such as those dual eligible for Medicare and Medicaid or individuals with intellectual or developmental disabilities, which why the number of available managed LTSS plans nationwide exceed the number of states offering managed LTSS coverage.[110]

Although there is a measurable movement toward states developing managed LTSS programs within their existing Medicaid managed care framework, Medicaid managed LTSS remains fragmented nationally. While there are several states considering the development of a managed LTSS program, Washington state retired its only managed LTSS plan.[111] In addition, given the different paths a state may follow driven by the respective federal enabling statute authorizing its managed LTSS program, there remains substantial variability among the managed LTSS programs throughout the country which is likely to be exacerbated as more states continue to implement managed LTSS. By way of example, the Florida Statewide Medicaid Managed Long-Term Care Plan was implemented in 2013 serving both older Floridians and those with physical disabilities.[112] Authorized under the § 1915(b) and § 1915(c) Waiver Authorities, over 93,000 Floridians are enrolled in a program that has the stated purpose of increasing the number of enrollees receiving care in the home or community rather than in an institutional setting while also limiting preventable hospitalizations and re-hospitalizations.[113] Florida's managed LTSS plan specifically excludes behavioral health, prescriptions, inpatient hospitalizations, and certain benefits for those with intellectual or developmental disabilities.[114] Conversely, the Kansas

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[107] Lewis, *supra* 96.
[108] MACPAC, *supra* n. 88.
[109] Lewis, *supra* 96 at pg. 5.
[110] Lewis, *supra* 96 at pg. 19.
[111] Lewis, *supra* 96 at pg. 25.
[112] *Id*.
[113] *Id*.
[114] Lewis, *supra* 96 at pg. 34.

KanCare MLTSS Plan was established in the very same year under the § 1115(a) Waiver Authority, and its 33,000+ LTSS enrollee population is much more expansive (older adults, adults with disabilities, adults with intellectual or developmental disabilities, and children with disabilities) and does not carve out coverage from its capitation rate.[115]

As more states continue to adopt a Medicaid managed LTSS model it will be imperative that CMS play a central role in measuring and monitoring program and healthcare outcomes across the states, as well as develop a comprehensive and standardized framework for states to follow as it relates to program eligibility, access, and funding.[116] States will also play a key role in the expansion of LTSS benefits and should continue to explore innovative solutions through a managed LTSS system to offer comprehensive coverage with the goals of further reducing the reliance on institutional care and the resulting disproportionate Medicaid expenditures on such care.

V. Past is Prologue - The Future of Managed Care

Does managed care work for the triad? It depends, but managed care is the preferred healthcare delivery method driving the U.S. healthcare system currently and was created, in part, to carry the extreme weight of the healthcare delivery chassis. To the extent managed care was designed to increase utilization of necessary healthcare services, equitably distribute the costs and risks among providers and patients, and operate at appropriate aggregate expenditure levels, the results are mixed.[117] Studies have shown that managed care has effectively improved healthcare access and quality, yet there is debate as to whether MCOs are best able to provide the extensive care coordination necessary to simultaneously achieve utilization and cost-containment.[118] Additionally, market participants, related tax laws, provider practices, and patient needs continue to change, and with these changes the expectations and incentives for

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[115] Lewis, *supra* 96 at pg. 41.
[116] *See* Centers for Medicare and Medicaid Services, *Measures for Medicaid Managed Long-term Services and Supports Plans: FAQ,* https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss-measures-faq.pdf (last accessed September 2024).
[117] Stanley Wallack, *Managed Care: Practice, Pitfalls, and Potential,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195142/ (last accessed September 2024).
[118] Maniates, *supra* n. 62.

MCOs to achieve real cost containment has declined as evidenced by the continued rapid spending on healthcare as a percent of GDP.[119]

As the managed care market continued to evolve in the last two decades of the 20th century with the rise in consolidation of MCOs and healthcare systems, changing regulatory expectations, and the emergence of for-profit managed care entities, a focus on utilization management increased which led to significant consumer backlash.[120] Consumers, in particular those with employer-sponsored health coverage, felt seemingly "pushed" into managed care by employers and were not accustomed to the requirement of prior authorization by a PCP as a prerequisite to obtain specialty care.[121] Being told "no" for treatment of a family member or loved one was off putting to the general public who had not previously experienced this effect under a traditional insurance structure; yet, this type of utilization oversight was necessary for MCOs to handle the significant growth experienced in the managed care market during this time. And while this backlash subsided early into the 21st century, there is no guarantee that this will not be a recurring complaint in the years ahead.

As it relates to Medicaid managed care and the delivery of LTSS services, there is a clear growth among states to prioritize healthcare quality for the aging and disability communities in order to reduce the need for expensive institutional care. But Medicaid managed LTSS models are not immune from the same challenges confronting managed care globally. Although capitated managed care is the primary delivery of Medicaid services for 75% of Medicaid enrollees, less than half of the states offer LTSS through this system and those that do often have extensive wait lists for those services.[122] Developing competitive capitation rates and other incentives for MCOs to scope in LTSS services will be integral to the long-term viability of LTSS within Medicaid. This will be challenging, however, due to the limited number of market participants as only five publicly traded companies account for over one-half of all MCO enrollment thus making the negotiation process between the state and provider(s) that much more arduous.[123] Lastly, there will continue to be inconsistencies in the delivery of managed

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[119] Alain Enthoven, *Why Managed Care has Failed to Contain Costs,* https://www.healthaffairs.org/doi/10.1377/hlthaff.12.3.27#:~:text=One%20explanation%20is%20that%20the,to%20cut%20cost%20and%20price (last accessed September 2024).
[120] Fox, *supra* n. 13 at pg. 15.
[121] Fox, *supra* n. 13 at pg. 16.
[122] Hinton, *supra* n. 78.
[123] *Id.*

LTSS coverage insofar as states operate their Medicaid programs independent of each other and are able to deviate from federal law using a plethora of state and federal law and regulation, as well as enjoy immense flexibility in monitoring MCOs and defining provider network adequacy standards.

Fortunately, the federal government has taken notice of both the risks associated with the fragmentation of Medicaid managed care as well as the benefits that a successful Medicaid managed care approach can have on state and federal funding and improved patient care.[124] To this end, CMS promulgated the *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule*[125] in 2024, which resulted from Executive Order 14070 directing agencies to seek out ways to expand the availability of affordable healthcare coverage. This rule was issued to 1) strengthen standards for timely access to routine primary care; 2) enhance the fiscal integrity for state directed payments; 3) better define "in lieu of services" to address health-related social concerns; and 4) implement a quality rating system for Medicaid managed care plans.[126] This Rule along with the federal government's continued efforts to condition federal spending on sound managed care practices, in addition to the re-balancing incentives between states and MCOs linking financial incentives to increased quality performance areas in MCO contracts (like LTSS delivery), will have a meaningful, long-term impact which cannot be overstated.[127]

It is fitting that the National Archives, which includes in its catalogue the original Medicare and Medicaid Act, at the entrance of its building has as an inscription Shakespeare's famous admonition that what is past may be indicative of what is next.[128] If managed care can efficiently deliver a plethora of Medicaid covered services to tens of millions of enrollees, long-

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[124] *See* Centers for Medicare and Medicaid Services, *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS – 2439 – F)*. https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule (last updated April 19, 2024).

[125] 89 Fed. Reg. 40542 (2024).

[126] CMS, *supra* n. 124.

[127] Sara Rosenbaum, *The Medicaid Managed Care Rule is a Blockbuster,* https://www.healthaffairs.org/content/forefront/medicaid-managed-care-rule-blockbuster (last updated May 13, 2024).

[128] Jessie Kratz, *A Prologue to Prologue,* https://www.archives.gov/publications/prologue/2017/winter/historian-winter-2017#:~:text=The%20title%20Prologue%20was%20appropriate,presses%20on%20June%206%2C%201969 (last accessed September 2024).

term services and supports should be included as a covered service under this model nationwide to best accommodate the unique needs of the next generation of Medicaid enrollees.