

LEAP OF FAITH: MANAGED CARE AND THE PRIVATIZATION OF MEDICAID LONG-TERM CARE SERVICES

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The United States is aging. By 2030 there will be an estimated three million more 85-and-older residents than there were in 2012.¹ But we are doing little to prepare for an age wave characterized as a “silver tsunami.” Instead, our elderly population with acute medical needs is largely subject to the vagaries of state Medicaid funding, and state legislators have little political incentive to look ahead beyond their current budget cycle.

Following the passage of the Affordable Care Act, with its expansion of Medicaid in those states willing to embrace it, insurance companies became more interested in the Medicaid market. That interest has extended into administering what are called Long-Term Services and Supports. As the National Association of States United for Aging and Disabilities (“NASUAD”) has written, “Since 2010, states’ interest in a managed care delivery system for their LTSS has exploded. Between 2011 and 2016, the number of states operating a managed long-term services and supports (“MLTSS”) program mushroomed from 12 to 22.”²

This phenomenon is only likely to grow, given that Seema Verma, the administrator for the Centers for Medicare and Medi-

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¹ See, e.g., Jennifer M. Ortman et al., *An Aging Nation: The Older Population in The United States*, U.S. CENSUS BUREAU (2014), <https://www.census.gov/prod/2014pubs/p25-1140.pdf>.

² *Managed Long-Term Care Services and Supports*, NAT’L ASS’N. FOR STATES UNITED FOR AGING & DISABILITIES, <http://www.nasuad.org/initiatives/managed-long-term-services-and-supports> (last visited Mar. 11, 2018).

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caid Services (“CMS”) in the Trump Administration, was an architect of Medicaid privatization in Iowa prior to her federal appointment.³

NASUAD, although comprised of aging program directors from states that have largely not yet implemented MLTSS, has also actively advocated for managed care, even creating a “MLTSS Institute” in partnership with major insurance companies. As of March 5, 2018, the 11 advisory board members for the Institute included six insurance company executives.⁴

In 2017, NASUAD put out a report entitled “Demonstrating the Value of Medicaid MLTSS Programs.”⁵ It identified four major aims for MLTSS:

- Rebalancing Medicaid LTSS Spending.
- Improving Member Experience, Quality of Life, and Health Outcomes.
- Reducing Waiver Waiting Lists and Increasing Access to Services.
- Increasing Budget Predictability and Managing Costs.⁶

To its credit, NASUAD does not claim these goals have been definitively achieved. The same could not be said of a conclusory March 2018 report from the New Hampshire Department of Health and Human Services, that effectively parrots these aims as facts: “States who [sic] have implemented more comprehensive Medicaid managed long-term services and supports (MLTSS) experience better managed care for members, increased access to community-based care, improved member satisfaction and health

³ See David Steen Martin, *In Iowa, financial pain follows Trump-style Medicaid reforms*, STAT NEWS (Jan. 24, 2017), <https://www.statnews.com/2017/01/24/medicaid-iowa-trump-verma/>.

⁴ See *MLTSS Institute*, NAT’L ASS’N. FOR STATES UNITED FOR AGING & DISABILITIES, <http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-institute> (last visited Mar. 11, 2018).

⁵ Camille Dobson et al., *Demonstrating the value of Medicaid MLTSS programs*, NAT’L ASS’N. FOR STATES UNITED FOR AGING & DISABILITIES (2017), <http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>.

⁶ See *id.* at 3.

outcomes, and improved budget predictability.”⁷ Where is the evidence to support such a statement? Too often, when it comes to MLTSS, states seem to operate on faith, not facts.

The factors identified by NASUAD are a useful framework; however, the report did not share metrics for proving their achievement. Each can be examined in turn based upon the actual experience of states.

I. REBALANCING MEDICAID LTSS SPENDING

“Rebalancing” LTSS has often been cited as a motivator for managed care. The idea is to shift residents away from unnecessary nursing home utilization and into home-and-community-based services (“HCBS”). Such services are provided in states with what are known as 1915(c) waivers under the Social Security Act,⁸ as the only Medicaid long-term care entitlement would otherwise be a nursing home.

Certainly, HCBS has been the direction public demand has gone. According to a 2018 General Accounting Office report, “Expenditures on HCBS provided under managed care have grown from about \$8 billion in fiscal year 2012 to more than \$19 billion in fiscal year 2015.”⁹ A 2017 report from Truven Health Analytics

⁷ N.H. DEP’T OF HEALTH AND HUM. SERVICES, IMPLEMENTATION PLAN FOR MEDICAID CARE MANAGEMENT – NURSING FACILITY/CHOICES FOR INDEPENDENCE SERVICES 4 (2018).

⁸ Under federal law:

The Secretary may by waiver provide that a State plan approved under this title may include as ‘medical assistance’ under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that *but for the provision of such services* the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded. (Emphasis added).

⁴² U.S.C. § 1396n(c)(1) (2012).

⁹ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-18-179, MEDICAID ASSISTED

noted that “HCBS have accounted for all Medicaid LTSS growth in recent years while institutional service expenditures have been flat.”¹⁰

Yet in looking at those states spending the highest proportion of their long-term care budget on HCBS, there is no indication that the costly intercession of managed care companies was required. According to Truven’s 2015 data, Oregon invested more long-term care funding in HBCS, at 82% of its overall budget, than any other state, without MLTSS.¹¹ Oregon’s figure was better than that of Arizona (70%), which has only ever had MLTSS since the state, in 1982, became the last to enter the Medicaid program.¹²

Without MLTSS, the state of Washington in June 2017 had 1,451 fewer Medicaid clients in nursing homes than it did in July 2009 – a 13% reduction.¹³ Over that same period, the number of HCBS clients increased by 11,414 – a 26% increase.¹⁴ This suggests “rebalancing” can occur organically. In 2015, Washington was slightly-ahead of MLTSS-state Massachusetts in HCBS investment (69% vs. 65%).¹⁵ Massachusetts, in turn, was tied with two states – Colorado and Wisconsin – without statewide MLTSS, and slightly behind Vermont (69%), which doesn’t utilize MLTSS.¹⁶

New Hampshire is among those states that have, organically, seen long-term care populations rebalance. In December 2017 it had its lowest Medicaid census in nursing homes (4,005 residents), and had achieved its highest number of Medicaid home

LIVING SERVICES: IMPROVED OVERSIGHT OF BENEFICIARY HEALTH AND WELFARE IS NEEDED 11 n.22 (2018).

¹⁰ Steve Eiken et al., *Medicaid expenditures for Long Term Services and Supports (LTSS) in FY 2015*, TRUVEN ANALYTICS 3 (2017), <https://www.medicicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf>.

¹¹ *See id.* at 11.

¹² *See id.*

¹³ *See* WASH. CASELOAD FORECAST COUNCIL, LONG TERM CARE, NURSING HOMES, http://www.cfc.wa.gov/HumanServices_LTC_HCS_NH.htm (open Excel spreadsheet).

¹⁴ *See* WASH. CASELOAD FORECAST COUNCIL, LONG TERM CARE, HOME & COMMUNITY SERVICES, http://www.cfc.wa.gov/HumanServices_LTC_HCS_Total.htm (open Excel spreadsheet).

¹⁵ *See* Eiken et al., *supra* note 10, at 11.

¹⁶ *See id.*

health clients (2,920) in just the prior month.¹⁷ Compared to December 2007 data, this represented an 11% drop in nursing home clients, and a 14% increase in home care clients over a decade's time.¹⁸ These trends are notable given that the state has the nation's second-oldest population.¹⁹

Indeed, the Truven data shows some of the worst states for HCBS spending were MLTSS states – with Florida, spending just 33% of its long-term care funding on HCBSS, second-worst in the country.²⁰ Tennessee, often celebrated by managed care advocates as a MLTSS pioneer, was spending just 48% of its long-term care budget on HCBS, as compared to the national average of 55 percent.²¹ It only slightly trailed Kansas, at 49%, another MLTSS showcase.²²

How have states without MLTSS succeeded in building more robust HCBS systems? Simply by doing what policymakers in any state could do – spending more money. In Oregon, for example, the 2015-19 contract between the state and the union representing home care workers provides hourly wages of \$14.50 an hour.²³ Under the union contract in the state of Washington, each home care worker will make no less than \$15 an hour by January 1, 2019.²⁴

¹⁷ See N.H. DEP'T OF HEALTH AND HUM. SERVICES, HEALTH & HUM. SERVICES DASHBOARD SFY2018 (Jan. 29, 2018), <https://www.dhhs.nh.gov/ocom/documents/2018-jan-30-fiscal-syf-2018.pdf>.

¹⁸ N.H. DEP'T OF HEALTH AND HUM. SERVICES, FISCAL CONDITION – JUNE 2010, <https://www.dhhs.nh.gov/ocom/documents/2010-sep-21-fiscal-jun-2010.pdf>.

¹⁹ See Gretchen Grosky, *The changing face of N.H.: What it means to have the 2nd oldest population in the nation*, UNION LEADER (Apr. 13, 2016), <http://www.unionleader.com/The-changing-face-of-NH:-What-it-means-to-have-the-2nd-oldest-population-in-the-nation>.

²⁰ See Eiken et al., *supra* note 10, at 11.

²¹ See *id.*

²² See *id.*

²³ See SERV. EMPLOYEES INT'L UNION 503 2015-2019 COLLECTIVE BARGAINING AGREEMENT, http://seiu503.org/wp-content/uploads/2017/09/2015-19-HCC-CBA_FINAL.pdf.

²⁴ See SERV. EMPLOYEES INT'L UNION 775 2017-2019 COLLECTIVE BARGAINING AGREEMENT, http://seiu775.org/files/2017/09/Homecare17_19WebReady-signature-page-w-mou.pdf.

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In Massachusetts, a MLTSS state, greater HCBS investment was also driven by union advocacy – not MCOs. The 2015-19 union contract for personal care attendants provides they will receive \$15 an hour effective July 1, 2018.²⁵

Such wages are a very significant influx of federally-matched Medicaid funding into the HCBS sector. According to a 2016 report from the Paraprofessional Health Institute, the median home care workers' wage was \$10.11 an hour nationally.²⁶

There is no evidence that one must rob Peter to pay Paul, in properly funding HCBS, as some have argued. Oregon, for example, also pays the nation's highest nursing home rate at \$301.70 per patient, per day.²⁷

It may be that HCBS settings, particularly in-home care, can actually be disadvantaged under MLTSS. A single home care client or worker does not have the voice that a disaffected nursing home provider would to bring attention to payment delays or denials.

As MLTSS was rolled out in Pennsylvania in 2018, a newspaper reported on “a paid caregiver in Beaver Falls since 2009 for her 28-year-old daughter, who has multiple disabilities” who saw paychecks, to which she was entitled since January 1, “delayed until Feb. 16, which put her several thousand dollars behind.”²⁸ Fearing retribution, “home care agencies have been reluctant to go on

²⁵ See COLLECTIVE BARGAINING AGREEMENT BETWEEN THE PERSONAL CARE ATTENDANT (PCA) QUALITY WORKFORCE COUNCIL & 1199 SERV. EMPLOYEES INT'L UNION UNITED HEALTH CARE WORKERS EAST (July 1, 2016-June 30, 2019), <https://www.mass.gov/files/documents/2017/08/baf/pca-fully-executed-cba-2016.pdf>.

²⁶ See U.S. HOME CARE WORKERS: KEY FACTS, PARAPROFESSIONAL HEALTH INSTITUTE 5 (2016), <https://phinational.org/resource/home-care-workers-key-facts/>.

²⁷ See PROVIDER ALERT, OR. DEP'T OF HUM. SERVICES (July 11, 2017), <http://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/AdminAlerts/APD%20Rate%20Schedule%20Effective%20July%201,%202017.pdf>.

²⁸ Gary Rotstein, *What's New in Aging: State officials, but not everyone, praise Community HealthChoices rollout*, PITTSBURGH POST-GAZETTE (Feb. 16, 2018), <http://www.post-gazette.com/aging-edge/gary-rotstein-s-what-s-new-in-aging/2018/02/16/Community-HealthChoices-launch-Pennsylvania-Medicaid-long-term-care-success-payment-problems/stories/201802160180>. Similar

the record with their complaints[.]”²⁹

Under MLTSS, the *Des Moines Register* noted in 2016 that “Iowans who provide in-home care for disabled people have gone without pay for weeks or months, according to a state workers’ union. These are individuals who change bedpans, bathe and feed patients while earning \$9 to \$12 per hour.”³⁰

Matters were much the same in 2018, as the *Register* reported in a special investigation headlined “Care denied: How Iowa’s Medicaid maze is trapping sick and elderly patients in endless appeals.”³¹ The newspaper noted that “Medicaid expenses for in-home care that had been routinely approved when the state ran the program are now being rejected by managed-care providers as unnecessary and outside the scope of what the program authorizes.”³² Among those whose care had suffered under MLTSS was a 32-year-old whose in-home visits were reduced from twice-daily to five times a week. As the *Register* related:

“AmeriHealth’s Dr. Brian Morley testified that it wasn’t necessary for McDonald to receive daily assistance to clean himself after bowel movements. ‘People have bowel movements every day where they don’t completely clean themselves, and we don’t fuss over (them) too much. ... You know, I would allow him to be a little dirty for a couple of days.’”³³

sad stories arose in Virginia, another new 2018 entrant into MLTSS. See e.g., Cathy Dyson, *Smith family gives Adelynn dream vacation in the midst of Medicaid nightmare*, LANCE FREE-STAR (Jan. 27, 2018), http://www.fredericksburg.com/news/healthy_living/smith-family-gives-adelynn-dream-vacation-in-the-midst-of/article_a0bf08e5-f813-5b71-a867-7c91077d9c88.html.

²⁹ *Id.*

³⁰ Editorial, *Providers Medicaid nightmare becomes reality*, DES MOINES REG. (July 16, 2016), <https://www.desmoinesregister.com/story/opinion/editorials/2016/07/16/editorial-providers-medicare-nightmare-becomes-reality/87023948/>.

³¹ Jason Clayworth, *Care Denied: How Iowa’s Medicaid maze is trapping sick and elderly patients in endless appeals*, DES MOINES REG., <http://features.desmoinesregister.com/news/medicaid-denials/> (last visited Mar. 11, 2018).

³² *Id.*

³³ *Id.*

Disability Rights Iowa filed a 2017 federal class action lawsuit against the state for in-home care denials by managed care organizations.³⁴

The *Kansas City Star* has reported on the lack of transparency home care clients have faced under privatized Medicaid. Caregivers were routinely asked by MCOs to sign off on care plans without seeing them, unwittingly reducing care hours and forcing legal appeals to recover them.³⁵

In New York, another major MLTSS state, *Bloomberg* reported in 2018 that:

“The State Department of Health pays a flat per-patient rate to a ‘managed-care’ insurance company, which in turn contracts with home-care agencies, which in turn employ aides. The rate, once set for a particular insurer, doesn’t vary, regardless of how much help a patient needs, so the actuarial math for the most seriously ill—elders who are bed-bound or have advanced Alzheimer’s—is punishing.”³⁶

As *Bloomberg* noted, “New York’s reimbursement scheme thus discourages managed-care companies and home-care agencies from accepting high-hours cases and masks the true level of demand.”³⁷

The *New York Times*, in 2014, found similar problems in Tennessee, noting “hidden pitfalls as the system of caring for the frail comes under the twin pressures of cost containment and profit motive. In many cases, care was denied after needs grew costlier—

³⁴ See Tony Leys & Jason Clayworth, *Disabled Iowans, fed up with cuts under privatized Medicaid, sue Gov. Reynolds*, DES MOINES REG. (June 13, 2017), <https://www.desmoinesregister.com/story/news/investigations/2017/06/13/disabled-iowans-medicaid-privatization-lawsuit/370484001/>.

³⁵ See Andy Marso, *Caregivers of disabled left in dark under Kansas’ private healthcare system*, KAN. CITY STAR (Nov. 16, 2017), <http://www.kansas-city.com/news/politics-government/article184167411.html>.

³⁶ E Tammy Kim, *Americans Will Struggle to Grow Old at Home*, BLOOMBERG (Feb. 9, 2018), <https://www.bloomberg.com/news/features/2018-02-09/americans-will-struggle-to-grow-old-at-home>.

³⁷ *Id.*

including care that people would have received under the old system.”³⁸

With the threshold raised for admission into nursing homes, Tennesseans could fall between the cracks. When a home care recipient “developed dementia and his health fell apart in the fall of 2012, the state and the insurer denied his application for nursing home placement and told him he would lose his home care, too.”³⁹ Then “the day after an official letter scored his need for care at zero, he fell from his short-stay convalescent bed, gashing his face and breaking his nose.”⁴⁰

One way of safeguarding against unnecessary nursing home utilization is to maintain certificate of need or bed moratorium laws. Such limitations do not apply in the HCBS sphere.

II. IMPROVING MEMBER EXPERIENCE, QUALITY OF LIFE, AND HEALTH OUTCOMES

NASUAD speculates that “improvement of health outcomes may be more likely when a program includes all services—physical health, behavioral health, and LTSS—under one MCO. All of the states surveyed indicated that improving consumer health, as well as consumers’ satisfaction and/or quality of life was a primary goal for MLTSS implementation.”⁴¹

Assuming such a motivating benevolence to be true, this is a challenging area for measurement. Against what benchmark would better quality of life be measured? Some metrics seem intuitive, such as the general consumer preference for less-restrictive settings: “In Texas, consumers receiving MLTSS services reported that having HCBS gave them a sense of independence and personal space that was important for their quality of life.” However, as mentioned before, HCBS can be funded absent diverting Medicaid funds to MCOs.

³⁸ Nina Bernstein, *Pitfalls Seen in a Turn to Privately Run Long-Term Care*, N.Y. TIMES (Mar. 6, 2014), <https://www.nytimes.com/2014/03/07/nyregion/pitfalls-seen-in-tennessees-turn-to-privately-run-long-term-care.html>.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Dobson et al., *supra* note 5, at 10.

One empirical quality measure we have for long-term care is the number of health deficiencies cited in nursing homes, under exacting federal standards. According to the last federal data compendium, New Hampshire had the second-fewest deficiencies per facility in 2014, without MLTSS.⁴² Would MLTSS improve upon that? Neighboring Massachusetts, a MLTSS state, had over three times more deficiencies per facility.⁴³

Absent a control group (a similarly-situated population not in MLTSS), or a longitudinal study predating MLTSS, the quality and consumer satisfaction metric may remain nebulous. NASUAD acknowledges, “states do not often collect baseline measurements across several cost and quality indicators prior to an MLTSS program launch.”⁴⁴ Further, “States have limited capacity to conduct and oversee data collection efforts across the scope of questions needed to cover all aspects of the MLTSS program.”⁴⁵

As the *Kansas City Star* reported on a CMS investigation of KanCare, “The state’s failure to ensure effective oversight of the program put the lives of enrollees at risk and made it difficult for them to navigate their benefits, the investigators found. They cited concerns about the program’s transparency and effectiveness.”⁴⁶ One 2018 Republican gubernatorial candidate said, “about 90 percent of the constituent complaints he fielded while in the Kansas House from 2013 through 2016 were KanCare related.”⁴⁷

The opaqueness of MLTSS in the states is evident in a 2018 description by the General Accounting Office of a MLTSS demonstration project in Arizona:

“As part of its evaluation, the state was assessing

⁴² See U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES, NURSING HOME DATA COMPENDIUM 2015 EDITION 61, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.

⁴³ *Id.*

⁴⁴ Dobson et al., *supra* note 5, at 15.

⁴⁵ *Id.*

⁴⁶ Bryan Lowry & Hunter Woodall, *Criticizing Kansas, feds deny extension of KanCare privatized Medicaid program*, KAN. CITY STAR (Jan. 9, 2017), <http://www.kansascity.com/news/politics-government/article127424309.html>.

⁴⁷ Marso, *supra* note 35.

whether the quality of and access to care, as well as quality of life, would improve during the demonstration period for long-term care beneficiaries enrolled in MLTSS. However, evaluation results submitted in October 2016—the only results submitted for the state’s most recently completed demonstration cycle—lacked data on key measures of access, such as hospital readmission rates, and on quality of life, such as beneficiaries’ satisfaction with their health plan, provider, and case manager.”⁴⁸

GAO noted that MLTSS data limitations also thwarted a multi-state evaluation objective of CMS: “For states testing the delivery of long-term services and supports through managed care, examine the effects of these programs on spending, access, and quality of care.”⁴⁹ Even for CMS, the oversight agency providing federal funding for MLTSS, “Limitations in the available data, including the quality of managed care encounter data, *reduced the number of potential study states from 20 to 2—New York and Tennessee.*”⁵⁰ (Emphasis added). Furthermore, “Sufficient data on the costs of services and on access for New York were not available.”⁵¹

In a 2016 MLTSS presentation in New Hampshire, NASUAD admitted, “There have been no national studies assessing the efficacy of MLTSS programs; however, there are anecdotal indications of improvement.”⁵² One decidedly anecdotal indication was that New York MLTSS plans “increased

⁴⁸ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-18-220, MEDICAID DEMONSTRATIONS: EVALUATIONS YIELDED LIMITED RESULTS: UNDERSCORING NEED FOR CHANGES TO FEDERAL POLICIES AND PROCEDURES 15 (2018)

⁴⁹ *Id.* at 25.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Camille Dobson, Deputy Executive Director, NAT’S ASSOC. OF STATES UNITED FOR AGING & DISABILITIES, *MLTSS – The National Landscape, Presentation to the SB 553 Working Group 26* (Oct. 4, 2016), <https://www.dhhs.nh.gov/sb553/documents/mltsthenationallandscapeenasuad100416.pdf>.

administration of flu vaccines.”⁵³ According to the 2015 New York State Department of Health report NASUAD cited for this claim, “Seventy-seven percent of enrollees received the recommended annual influenza vaccination. Plan results ranged from 67 to 98 percent.”⁵⁴

This is a strange measure of “improvement,” to say the least, and not just because there was no baseline to compare it to. According to the Center for Disease Control, “Thirty-two states have flu vaccination provisions that expressly reference long-term care facilities or that apply to various healthcare facilities that are considered long-term care facilities.”⁵⁵ In New York, for example, the law requires that *all* patients in long-term care facilities be vaccinated.

III. REDUCING WAIVER WAITING LISTS AND INCREASING ACCESS TO SERVICES

As NASUAD notes, “In 2015, there were over 600,000 individuals on HCBS waiver waiting lists in 35 states.”⁵⁶ Can MLTSS reduce these waiting lists?

In Florida, after Gov. Rick Scott claimed, in his 2016 State of the State Address, to have eliminated the “critical needs waiting list,” PolitiFact pointed out, “about 20,000 remain on a waiting list” – with 2014 data showing it to be the second-largest waiting list in the nation after Texas, another MLTSS state.⁵⁷

Such wait lists are most predominantly in the intellectual and developmental disabilities’ (“I/DD”) category, making this

⁵³ *Id.*

⁵⁴ N.Y. DEP’T OF HEALTH, 2015 MANAGED LONG-TERM CARE REPORT, http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2015.pdf.

⁵⁵ U.S. CTR. FOR DISEASE CONTROL, MENU OF STATE LONG-TERM CARE FACILITY VACCINATION LAWS, <https://www.cdc.gov/phlp/docs/menu-ltcinfluenza.pdf> (last accessed Mar. 11, 2018).

⁵⁶ Dobson et al., *supra* note 5, at 13.

⁵⁷ Amy Sherman, *Rick Scott: Florida completely funded the critical needs waiting list for first time*, POLITIFACT (Jan. 13, 2016), <http://www.politifact.com/florida/statements/2016/jan/13/rick-scott/rick-scott-florida-completely-funded-critical-need/>.

“waiting list” category misleading. According to 2016 data from the Kaiser Family Foundation, the 423,735 people on I/DD waiting lists nationally dwarfed other categories like aged/disabled (147,693).

As NASUAD notes, “Individuals with I/DD have typically been the last population to be enrolled in MLTSS programs; as state agencies and MCOs gain further experience with effectively coordinating care and gaining stakeholder support, this trend is expected to continue.”⁵⁸ To put it more bluntly, there is not the margin to be made for insurers with this population, making its inclusion in MLTSS an afterthought.

The Kaiser data showed Florida with a 2016 wait list of 46,412 in the aged/disabled category alone, trailing only Louisiana in that category.⁵⁹ New Hampshire, in contrast, had a 2016 wait list of 11 residents in the aged/disabled category, while most states (37) reported no waiting list at all in that category.⁶⁰ As noted before, access to HCBS services can be increased without managed care.

IV. INCREASING BUDGET PREDICTABILITY AND MANAGING COSTS

At last we come to the meatiest metric for MLTSS success, and arguably the true motivation for implementing it. Can it control Medicaid costs? Even NASUAD is not entirely sanguine: “Ensuring program sustainability and cost effectiveness are important MLTSS program goals; however, inadequate data have been a barrier to states’ ability to demonstrate these outcomes.”⁶¹ They admit states “do not often have solid cost projections for their fee-for-service programs against which they can compare their MLTSS programs. This makes it almost impossible to reliably make ‘pre—

⁵⁸ Dobson et al., *supra* note 5, at 7.

⁵⁹ See *Waiting List Enrollment for Medicaid Section 1915(c) Home and Community-Based Services Waivers*, KAISER FAMILY FOUNDATION, <https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Aged%2F%20Disabled%22,%22sort%22:%22asc%22%7D> (last visited Mar. 11, 2018).

⁶⁰ See *id.*

⁶¹ Dobson et al., *supra* note 5, at 15.

post' comparisons."⁶²

To believe MLTSS saves money requires a leap of faith. One must believe introducing an intermediary with its own profit motives between a state's (usually-inadequate) Medicaid payments and Medicaid care providers is efficient.

And yet, saving money is clearly the overriding goal. New Hampshire state law, for example, lists, as MLTSS goals, "value, quality, efficiency, innovation, and savings."⁶³ Yet, even prior to the planned July 1, 2019 implementation of MLTSS, the state's Medicaid reimbursement was among the nation's worst, with one analysis showing the second-largest reported gap between Medicaid payments and nursing home care costs.⁶⁴ A Catholic charity running eight nursing homes reported operating them at a loss in 2017 due to Medicaid underfunding.⁶⁵ What more "savings" could be extracted?

For purposes of this analysis, we will assume that the "delay-and-deny" claim practices that characterize many insurance companies should not cross into what the *Des Moines Register* editorially described in 2016: "Now perhaps it is becoming clear how the Medicaid belt will be tightened: *by not paying health care providers for services.*"⁶⁶ (Emphasis added).

A challenge in assessing the performance of managed care insurers is the sophistication of such companies. Many states will not possess the actuarial acumen to double-check the math of a Fortune 500 company. States may feel that privatizing Medicaid is a way of reducing their own responsibilities, when, in fact, such outsourcing should require investing considerable new resources in proper oversight. That oversight will have to come not only through the state agency charged with Medicaid, but the state's insurance regulators as well.

⁶² *Id.*

⁶³ N.H. REV. STAT. ANN. 204:2(II).

⁶⁴ AM. HEALTH CARE ASS'N, https://www.ahcancal.org/research_data/funding/Documents/2016%20Preliminary%20State%20Numbers.pdf.

⁶⁵ Thomas E. Blonski, Opinion, *A troubling future for New Hampshire's elderly?*, CONCORD MONITOR (Mar. 1, 2018), <http://www.concordmonitor.com/A-troubling-future-for-NH-elderly-15824078>.

⁶⁶ Editorial, *supra* note 30.

In Illinois, according to a January 2018 report of the Office of the Auditor General, “Auditors determined that the Department of Healthcare and Family Services (“HFS”) did not maintain the complete and accurate information needed to adequately monitor \$7.11 billion in payments made to and by the 12 MCOs during FY16.”⁶⁷ For four years the state had not even bothered to calculate the medical loss ratio for the MCOs, making overpayment a real risk.⁶⁸

Monitoring the MLR, generally required to be at 85%,⁶⁹ is going to be important in any state MCO contract. Medicaid providers are likely to be especially insistent upon it, as their own margins are so narrow. An annual report to Congress by the Medicare Payment Advisory Commission in March 2018 found nursing homes nationally, in 2016, were only at a .7% margin, down from 1.6% in 2015 – or actually in the negative (-2.3%) if Medicare payments were excluded.⁷⁰ Nationally, Medicaid spending on nursing home care only went up .9% in 2015 and .9% in 2016, according to federal data.⁷¹ As I wrote in *USA Today*, “It is impossible to understand how nursing home care, already operating at a negative mar-

⁶⁷ ILL. OFFICE OF THE AUDITOR GENERAL, PERFORMANCE AUDIT OF MEDICAID MANAGED CARE ORGS. (2018), http://www.auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Performance-Audits/2018_Releases/18-Medicaid-MCOs-Perf-Full.pdf (Similarly, in New York, a September 2017 report from the Office of the Inspector General for the U.S. Department of Health & Human Services found errant MLTSS payment practices by New York may have cost “\$1.4 billion (\$717 million Federal share) during our 1-year audit period.”); OFFICE OF THE INSPECTOR GENERAL, U.S. DEP’T OF HEALTH & HUM. SERVICES, NEW YORK STATE IMPROPERLY CLAIMED MEDICAID REIMBURSEMENT FOR SOME MANAGED LONG-TERM CARE PAYMENTS (2017), <https://oig.hhs.gov/oas/reports/region2/21501026.pdf>.

⁶⁸ *Id.*

⁶⁹ *See generally* 42 C.F.R. 438.4 (2017).

⁷⁰ REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, MEDICARE PAYMENT ADVISORY COMM’N 207 (2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0.

⁷¹ U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES, HISTORICAL, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (open NHE Tables zip file, then open Table 15).

gin for Medicaid, can survive a further diversion of Medicaid resources to managed care profits.”⁷²

Not only had Illinois failed to oversee MCOs, but the MCOs were being sued in federal court for taking too long to pay nursing homes. According to a December 2017 article, “The filing says Aetna Better Health Inc., Meridian Health Plan, Humana Inc., and Molina Healthcare of Illinois Inc. violated federal law because they didn't process and pay bills in a timely manner.”⁷³

Failed oversight is endemic to MLTSS. In Kansas, a CMS review of KanCare found in 2017 that “[t]he state’s oversight of KanCare has diminished over the four years of KanCare operation, as evidenced by its annual onsite reviews of the MCOs and subsequent reviews. The 2013 annual report was a comprehensive document. ... The 2014 and 2015 reports were each two pages long, with little content of substance.”⁷⁴

Provider groups commissioned Leavitt Partners to conduct a November 2016 report on KanCare. According to the report, “Interviewees consistently mentioned that seeking reimbursement from Medicaid and the MCOs is extremely resource intensive. The administrative burden of managing the claims billing and adjudication process has tripled for providers.”⁷⁵ That burden, shifted to providers already struggling to staff, should be considered as part of MLTSS cost.

⁷² Brendan Williams, *Medicaid cuts are the real ‘death panels’*: Column, USA TODAY (Apr. 28, 2017), <https://www.usatoday.com/story/opinion/2017/04/28/medicaid-cuts-real-death-panels-column/100939932/>.

⁷³ Kimberly Marselas, *Nursing homes seek overdue Medicaid managed care payments*, MCKNIGHT’S LONG-TERM CARE NEWS (Dec. 21, 2017), <https://www.mcknights.com/news/nursing-homes-seek-overdue-medicaid-managed-care-payments/article/720126/>.

⁷⁴ Letter from James G. Scott, Assoc. Regional Administrator, Centers for Medicare & Medicaid Services, to Susan Mosier, Sec’y, Kan. Dep’t of Health & Env’t (Jan. 13, 2017), https://issuu.com/tcj5/docs/01.13.17_kansas_pre-compliance_lett_.

⁷⁵ Leavitt Partners, *Understanding Kancare’s Challenges: Is the program living up to its original rationale and commitments as it approaches its five year waiver renewal with CMS?*, Presentation to the Kansas Hospital Association, Kansas Medical Society, and Kansas Association for Medically Underserved (Nov. 2016), http://www.khi.org/assets/uploads/news/14677/understanding_kancare_full_final_report_nov__2016.pdf.

In 2014, the *Kansas City Star* reported providers “have complained bitterly about having to delay paying bills and even making payroll while they’re waiting for reimbursements from the managed care companies.”⁷⁶ Matters had not improved by 2018, according to an article in *The Hays Daily News*:

“Haely Ordoyne, who represents the Kansas Adult Care Executives Association, which involves approximately 300 administrators at nonprofit and for-profit nursing homes, said the KanCare clearinghouse continued to struggle with determining eligibility for consumers and with payments to providers. ‘We estimate the nursing facilities led by our members are experiencing delays with as much as 90 percent of their Medicaid-dependent residents,’ Ordoyne said.”⁷⁷

Iowa’s 2016 Medicaid privatization scheme ended up costing more than anticipated, prompting insurers to renegotiate their rates in 2017. As the *Des Moines Register* reported, “The new rates will cost an estimated \$182.8 million more each year than the initial rates set when the program began.”⁷⁸ In response to legislative and public concern, an unusual bill was introduced in 2018:

“The Iowa Department of Human Services requested the filing of a bill last week in the Legislature that would reduce how often it must report performance

⁷⁶ Editorial, *Gov. Sam Brownback’s KanCare experiment has a spotty record*, KAN. CITY STAR (Sept. 20, 2014),

<http://www.kansascity.com/opinion/editorials/article2174129.html>.

⁷⁷ Tim Carpenter, *Kansas prepares to impose hefty fine on Medicaid contractor for fumbling applications*, HAYS DAILY NEWS (Feb. 18, 2018), <http://www.hdnews.net/news/20180218/kansas-prepares-to-impose-hefty-fine-on-medicare-contractor-for-fumbling-applications>.

⁷⁸ Jason Clayworth & Brianne Pfannenstiel, *Reynolds says Medicaid appeals will be reviewed after Register investigation reveals 'systemic' denial of care*, DES MOINES REG. (Jan. 16, 2018), <https://www.desmoinesregister.com/story/news/investigations/2018/01/16/reynolds-says-medicare-appeals-reviewed-after-register-investigation-reveals-systemic-denial-care/1037551001/>.

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data on the health care program for the poor and disabled. The legislation would also remove some consumer protection metrics and *eliminate a requirement that the agency report its expected savings under the privatized system.*⁷⁹ (Emphasis added).

Why the secrecy? In Florida, nursing home providers brought suit in federal court against seven MCOs in 2017, claiming, as *McKnight's Long-Term Care News* describes the suit, that “the insurance companies fabricated reasons to reject providers' proper claims, forcing them to ‘jump through unnecessary, nonsensical hoops,’ and purposely delayed payments to generate larger profits.”⁸⁰

Driving Medicaid managed care is a belief that fee-for-service is inefficient. A similar belief has driven the proliferation of the Medicare Advantage insurance option. Yet, according to the Medicare Payment Advisory Commission, average payments for Advantage plans for 2017 were 4% higher than fee-for-service, due to “quality bonuses” and sophisticated Advantage insurers coding their enrollees with risk scores 10% higher than fee-for-service patients.⁸¹

The Medicare Advantage example accentuates the need for rigorous state oversight of MLTSS. As a 2016 report put out by the Center for Health Care Strategies notes:

“Risk measurement may be subject to manipulation by managed care plans or assessors if they have a financial incentive to increase beneficiaries’ functional status scores (e.g., record greater need for assistance

⁷⁹ Barbara Rodriguez, *Iowa Agency Reduces Medicaid Oversight Requirements in Bill*, U.S. NEWS (Feb. 11, 2018), <https://www.usnews.com/news/best-states/iowa/articles/2018-02-11/iowa-agency-reduces-medicaid-oversight-requirements-in-bill>.

⁸⁰ Emily Mongan, *Florida SNFs suing managed care groups over delayed Medicaid payments*, MCKNIGHT'S LONG-TERM CARE NEWS (Aug. 4, 2017), <https://www.mcknights.com/news/florida-snfs-suing-managed-care-groups-over-delayed-medicaid-payments/article/679798/>

⁸¹ See REPORT TO THE CONGRESS, *supra* note 70, at 347-48, 360.

with ADLs to receive a higher capitation rate). To reduce the opportunity to profit from this type of gaming, states should ensure that functional status assessments are conducted by conflict-free parties such as state-employed staff or independent contractors, or states should perform regular audits and validation of managed care plan-conducted assessments.”⁸²

Enormous money is at stake. Facing a revenue shortfall in Rhode Island, Governor Raimondo proposed two budget cuts for 2018 to reduce MCO margins – “a reduction of the administrative component of the MCO rates by 2.5%” (saving \$1,892,496) and “elimination of the guaranteed profit margin component of MCO rates” (saving \$6,912,796).⁸³ To put those proposed cuts (and MCO margins) into perspective, Gov. Raimondo’s proposed 1% rate increase for nursing home care would cost only \$2,574,599.⁸⁴ Imagine how much more Rhode Island care funding would be available absent MCOs.

With its acquisition of rival Health Net, Missouri-based Centene became the biggest insurance company in the Medicaid managed care space. According to its 2016 annual report, it had \$40.6 billion in annual revenues.⁸⁵ Its CEO earned \$25.3 million in salary in 2017.⁸⁶ In 2017, Centene’s revenue increased to \$48.4 bil-

⁸² Debra Lipson et al., *Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations*, CTR. FOR HEALTH CARE STRATEGIES (Jan. 2016), https://www.chcs.org/media/MLTSS-Rate-Setting_Final-2.pdf.

⁸³ R.I. EXEC. SUMMARY, FY 2019, HEALTH & HUM. SERVICES 73, http://www.omb.ri.gov/documents/Prior%20Year%20Budgets/Operating%20Budget%202019/ExecutiveSummary/3_Health%20and%20Human%20Services.pdf.

⁸⁴ *Id.*

⁸⁵ See 2016 Annual Review, Centene Corp. <https://www.centene.com/content/dam/corporate/investors/pdfs/CenteneAnnualReport2016.pdf>.

⁸⁶ See David Nicklaus, *Centene’s CEO’s pay rises to \$25.3 million*, ST. LOUIS POST-DISPATCH (Mar. 20, 2018), http://www.stltoday.com/business/columns/david-nicklaus/centene-ceo-s-pay-rises-to-million/article_408e28ce-fdc4-5c38-a726-054a7b63ed60.html.

lion, and its 87.3% medical loss ratio allowed for enormous administrative costs and profits.⁸⁷ Properly overseeing a behemoth like Centene is arguably a more difficult task than a state administering a Medicaid fee-for-service LTSS program itself.

The political power of the MLTSS industry is evident in this startling excerpt from a 2018 *Crain's Detroit Business* article: "In a tersely worded proposal in the 2017-2018 state budget, Section 1857 states: 'By July 1 of (2018), the department (Health and Human Services) shall explore the implementation of a managed care long-term support service.' Dom Pallone, director of the Michigan Association of Health Plans, *took credit for the language* in the current year's budget."⁸⁸ (Emphasis added). Is this how public policy involving the most vulnerable should be made?

There is also a question of what exactly there is to pay to manage with long-term nursing home residents. Care for the rest of that resident's life will be managed by the nursing home, without the need for an MCO's cost. In 2017 a bill was introduced in the Florida Senate to take such residents, who would not be eligible for HCBS, out from under managed care. Providers maintained Senate Bill 682 would save the state \$67.8 million annually in MCO case management and administrative costs, while the MCO-friendly governor's administration asserted it would cost the state \$200 million annually in avoidable care.⁸⁹ Of the state's calculations, Senate Appropriations Committee staff wrote, "It is believed these estimates are significantly overstated, however."⁹⁰ Committee members apparently thought so too – voting 18-0 to pass the bill on

⁸⁷ See Press Release, Centene Corp., Centene Corporation Reports 2017 Results and Increases 2018 Guidance (Feb. 6, 2018), <https://centene.gcs-web.com/news-releases/news-release-details/centene-corporation-reports-2017-results-and-increases-2018>.

⁸⁸ Jay Greene, *Plan would move Medicaid long-term care into managed care*, CRAIN'S DETROIT BUS. (Feb. 23, 2018), <http://www.crainsdetroit.com/article/20180218/news/653216/plan-would-move-medicaid-long-term-care-into-managed-care>.

⁸⁹ See FLA. SENATE COMM. ON APPROPRIATIONS, SB 682 BILL ANALYSIS AND FISCAL IMPACT STATEMENT 14 (Apr. 22, 2017), <http://www.flsenate.gov/Session/Bill/2017/682/Analyses/2017s00682.ap.PDF>.

⁹⁰ *Id.*

to the Senate floor.⁹¹

A 2017 Florida State University study of the state's MLTSS experience in 2014-15 found significant savings had not materialized from MLTSS. "The average monthly nominal LTC program cost was estimated at \$3,517.12 versus \$3,516.23 in the Pre-LTC period. This represents an increase of \$0.89. After adjusting for inflation, the average monthly LTC program cost decrease or savings comes down to \$0.03 per individual per month."⁹² Given the pending federal lawsuit against MCOs by Florida nursing home providers, it remains to be seen whether even this modest savings trend holds up.

A 2018 effort by the Florida Senate to cut payments for Medicaid managed care organizations "by as much as \$230 million in state and federal funds" was rebuffed by the House.⁹³

Another confounding factor on cost is the so-called "woodwork effect" as HCBS services become available to those who would not normally have gone into a nursing home. The evidence on cost savings from HCBS is inconclusive, according to a literature review summarized in a 2017 Kaiser Family Foundation issue brief.⁹⁴

That brief also notes that a cross-state evaluation of the federal Money Follows the Person Rebalancing Demonstration Grant found that "[d]espite large investments in resources over several years, however, relatively few people have been transitioned to the community; from January 2008 to December 2015, approximately 63,000 Medicaid beneficiaries in institutions had been transitioned

⁹¹ See FLA. SENATE, SB 682 VOTE HISTORY, <http://www.flsenate.gov/Session/Bill/2017/682/?Tab=VoteHistory> (last visited Mar. 11, 2018).

⁹² FLA. ST. U., INDEPENDENT ASSESSMENT OF THE FLORIDA STATEWIDE MEDICAID MANAGED CARE PROGRAM: FINAL INTERIM REPORT (FY2014-15) 5 (June 30, 2017).

⁹³ Christine Sexton, *HMO rate cuts dropped in budget talks*, NEWS SERV. OF FLA. (Mar. 1, 2018), <https://newsserviceflorida.com/app/post.cfm?postID=28292>.

⁹⁴ Joshua M. Weiner et al., *Issue Brief: Strategies to Reduce Medicaid Spending: Findings From A Literature Review*, KAISER FAMILY FOUNDATION 19 (June 2017), <http://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review>.

to the community.”⁹⁵ They compare that 63,000 over seven years to the “about 1,000,000 Medicaid beneficiaries each year in nursing homes.”⁹⁶ This evidence suggests peril in overselling savings from MLTSS with the expectation of significant cost savings from shifting Medicaid beneficiaries toward HCBS. Settings such as in-home care and assisted living facilities deserve to be promoted on their own merits, not through false apples to oranges cost comparisons.

In conclusion, much more work is needed to measure the performance of MLTSS. No conclusive evidence exists that it has achieved its aims. As the Kaiser Family Foundation notes, “despite the popularity of these initiatives, there is a marked paucity of evaluations of their effectiveness in lowering unnecessary utilization and expenditures and improving quality of care.” Kaiser warns, “managed care always carries risks because of the financial incentives to provide less care and to contract only with only low-cost providers.”⁹⁷

While MLTSS success has not been clearly established, its problems are manifest, and its failure, given the vulnerability of those receiving services, can be measured in human lives. The critical policy decision for a state to enter into MLTSS should not be made upon faith alone.

⁹⁵ *Id.*

⁹⁶ *Id.* Furthermore, a 2017 report to Congress shows that only “about” 71% of those transitioning were in nursing homes. *See* U.S. DEP’T OF HEALTH & HUM. SERVICES, REPORT TO THE PRESIDENT & CONGRESS: THE MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION 4 (June 2017), <https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf>.

⁹⁷ Weiner et al., *supra* note 94, at 22.