

MANAGING MEDICAID

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ABSTRACT

In a steady but rapid march, managed care has come to Medicaid. Privatization has undoubtedly rebuilt the Medicaid landscape across America over the last three decades. Now, as managed care programs administer health care to three-in-four Medicaid beneficiaries nationwide, whether or not managed care is adequately managing America's largest public insurance program has become an increasingly important question.

Of particular note have been states' difficulties in constructing and organizing the bidding and selection processes of the private companies tasked with overseeing the administration of private Medicaid plans. Legal challenges to various states' bid procurement processes have been well documented. These conflicts, exacerbated by ballooning state budgets and sharply competitive carriers—and coupled with a dose of political tumult and palace intrigue—have raised the temperature of states' move to privatization. As a result, states' approaches to, and results from, privatization have not been uniform.

In short, this article summarizes the current landscape of Medicaid managed care. It provides background on the program and catalogs its costs, growth, evolution, and recent relevant regulatory changes. It provides vignettes of various states' experiences, including those that demonstrate the benefits of managed care, those that are hesitant to move fully towards privatization, and those that have run into legal challenges as they have tried to give the keys of their programs over to private actors. Finally, cost and access challenges are mentioned in an effort to highlight the ongoing dangers threatening privatization's widespread adoption into the future. Ultimately, this article seeks

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to highlight the importance of Medicaid managed care during a time of vexing uncertainty in American health care law and policy.

I. INTRODUCTION

Managed care is on the march. States across America are privatizing their Medicaid programs in efforts to gain predictability and cost control. In many of these states across the country, Medicaid managed care is considered a shining example of the power of the private market to save taxpayers millions of dollars.¹ As a result, millions of Medicaid enrollees now get their health care administered by private companies, continuing an accelerating trend that began a generation ago.

But there is another side to Medicaid managed care. In Iowa, the *Des Moines Register* calls the state's recent private plan adoption a "nightmare" for providers² and the "worst prank ever."³ In Florida, it has been referred to as a "mess" that is "costing money rather than saving money."⁴ And in Illinois, the rollout of the Medicaid managed care plan in the central part of the state has been alleged to be both "bungled" and "really bad for consumers."⁵

Medicaid managed care, hampered by its complexity and amplified by the pervasively uncertain future of the entire program of Medicaid itself,⁶ begs for

1. See Kristen Schorsch, *Big Savings. Painful Lessons. In Medicaid Revamp, Rauner Tries to Learn from Other States*, CRAIN'S CHI. BUS. (Mar. 7, 2017), <http://www.chicagobusiness.com/article/20170303/ISSUE01/170309924/big-savings-painful-lessons-in-medicaid-revamp-rauner-tries-to-learn-from-other-states> (last visited Sept. 11, 2017).

2. *Editorial: Providers' Medicaid Nightmare Becomes Reality*, DES MOINES REG. (July 16, 2016, 9:03 PM), <http://www.desmoinesregister.com/story/opinion/editorials/2016/07/16/editorial-providers-medicaid-nightmare-becomes-reality/87023948/> (last visited Sept. 11, 2017).

3. *Editorial: Privatized Medicaid is Worst Prank Ever*, DES MOINES REG. (Apr. 1, 2017, 5:02 PM), <http://www.desmoinesregister.com/story/opinion/editorials/2017/04/01/editorial-privatized-medicaid-worst-prank-ever/99733270/> (last visited Sept. 11, 2017).

4. *Editorial: Governor, Lawmakers Responsible for Florida's Health Care Mess*, TAMPA BAY TIMES (Sept. 21, 2015, 5:25 PM), <http://www.tampabay.com/opinion/editorials/editorial-governor-lawmakers-responsible-for-floridas-health-care-mess/2246508> (last visited Sept. 11, 2017).

5. Debra Pressey, *'The State Really Bungled This,'* THE NEWS-GAZETTE (Mar. 10, 2015, 7:00 AM), <http://www.news-gazette.com/news/local/2015-03-10/state-really-bungled.html> (last visited Sept. 11, 2017).

6. During the summer of 2017, the future of the size, scope, and viability of Medicaid nationwide was unclear. See Haeyoun Park & Wilson Andrews, *The C.B.O. Did the Math. These Are the Key Takeaways from the Senate Health Care Bill.*, N.Y. TIMES (June 26, 2017), <https://www.nytimes.com/interactive/2017/06/26/us/cbo-score-of-senate-health-care-bill.html> (last visited Sept. 11, 2017) (noting that by 2026, the Congressional Budget Office estimated that fifteen million fewer people would be enrolled in Medicaid under the proposed Senate plan). This uncertainty was largely due to the proposed cuts of nearly \$800 billion to the program brought about by the Better Care Reconciliation Act, which was being debated in the United States Senate. Amy Goldstein & Kelsey Snell, *Senate GOP Health-Care Bill Appears in Deeper Trouble Following New CBO Report*, WASH. POST (June 26, 2017), https://www.washingtonpost.com/national/health-science/imminent-cbo-report-could-prove-pivotal-for-senate-republicans-health-care-bill/2017/06/26/cb8d61e2-59f7-11e7-a9f6-7c3296387341_story.html?utm_term=.aae8c1c6e259 (last visited Sept. 11, 2017) ("[C]uts to the public insurance program for the poor still would account for by far the largest share of the reduction in federal spending under the Senate bill—\$772

legal and policy-based solutions to address its most salient challenges. Tension points—surrounding access, cost, and the ever-challenging environment of the bidding and procurement process—currently threaten its widespread success throughout the country.

This article summarizes and explores the current characteristics that define Medicaid managed care, specifically its growing popularity, its regulatory framework, and important details to consider when constructing states' bidding processes. It also seeks to present a number of illustrative narratives from the states that have experimented with Medicaid managed care: the good, the bad, and the ugly. Specifically, the stories of three states that have endured widely-covered litigation will be explored in an effort to paint the current landscape of Medicaid's move toward privatization, while also seeking to give state officials who are considering an expansion or evolution of their Medicaid programs a roadmap of both what to emulate and what to avoid.

This article proceeds in five parts. In Section II, the basics of Medicaid managed care—from its history, to its current enrollment and costs, to its current regulatory environment—will be summarized. In Section III, the ever-important topic of the state bidding process will be explored, focusing extensively on the most important considerations a state must address when building a fair and efficient application process. In Section IV, states' recent developments with Medicaid managed care—particularly those that have either moved away from or are substantially changing their managed care programs—will be reviewed. In Section V, the sagas of three states' bidding and selection processes—West Virginia, Iowa, and Missouri—will be presented in an effort to distill important lessons for states considering building fair and stable procurement processes. Lastly, in Section VI, the challenges of cost and access, two constant concerns within health law and policy literature, will be summarized as they relate to Medicaid managed care.

II. MEDICAID MANAGED CARE: THE BASICS

Over the last twenty-five years, managed care has come to Medicaid.⁷ Its expansion is no doubt owed to the promise of predictability and cost control of

billion over the coming decade.”). The uncertainty of Medicaid's future was also due to the \$834 billion in cuts applied by the American Health Care Act, which was passed by the U.S. House of Representatives in May of 2017. Danielle Kurtzleben, *GOP Health Plan Would Leave 23 Million More Uninsured, Budget Office Says*, NPR (May 24, 2017, 4:41 PM), <http://www.npr.org/2017/05/24/529902300/cbo-republicans-ahca-would-leave-23-million-more-uninsured> (last visited Sept. 11, 2017) (“By far the biggest savings would come from Medicaid, which serves low-income Americans. That program would face \$834 billion in cuts.”).

7. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO CONGRESS ON MEDICAID AND CHIP xvii (2016), <https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf> (“States use many techniques to control spending,

capitation⁸ that it provides to states' Medicaid programs.⁹ Its adoption has been steady and has continued into the era of recent reform. Even in the midst of uncertainty for the nation's largest public insurance program,¹⁰ states continue to explore, evolve, and expand privatization into Medicaid. This has constituted an unmistakable policy shift, one that increased rapidly through the 1990s and into the 2000s.

In an effort to better understand the impact of this dramatic policy shift, the following subjects are explored: (1) the total enrollment of Medicaid managed care, (2) the cost of Medicaid managed care, (3) the types of managed care plans that have proliferated, and (4) the recent changes that seek to standardize and clarify managed care regulations.

A. Enrollment Numbers

For the expansive program of Medicaid,¹¹ states have increasingly turned to private actors—particularly Medicaid managed care organizations (MCOs)—to administer their Medicaid programs to beneficiaries. As of spring 2017, thirty-eight states and the District of Columbia were working with MCOs to administer

including selective use of eligibility pathways, widespread use of managed care, imposition of tight limits over provider payment, and strict management of coverage and utilization.”).

8. In Medicaid managed care, capitation stands for the monthly premium that is paid “for each enrolled beneficiary.” Sidney D. Watson, *Medicaid, Marketplaces, and Premium Assistance: What Is at Stake in Arkansas? The Perils and Pitfalls of Medicaid Expansion Through Marketplace Premium Assistance*, 102 KY. L.J. 471, 473, 483 (2013–14). These are a “fixed amount for a defined bundle of services, with some practitioner risk factors for costs in excess of the capitation amount.” Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing Our Health Care Appetite*, 13 NEV. L.J. 822, 861 (2013); see also Susan Fendell, *The Unintended Results of Payment Reform and Electronic Medical Records*, 10 J. HEALTH & BIOMEDICAL L. 173, 177–78 (2014).

9. See MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 7, at 32 (“States contract with private health plans on a fixed (capitated) payment basis to provide Medicaid benefits to defined groups of enrollees. This approach can moderate cost growth through two mechanisms. First, federal rules allow managed care plans to use certain tools to limit the growth of per-person spending, including selective provider contracting, the use of drug formularies, and the option to offer alternative services in lieu of covered Medicaid services if the alternative services are more cost-effective. Second, by transferring insurance risk to private plans, states can gain greater predictability in their costs, limiting the state's own risk to costs associated with increases in enrollment (within the limits of the actuarial soundness rules). In these ways, state Medicaid programs can not only achieve greater cost predictability, but can also require and enforce full adherence to standards for access and improvements in the quality of care, goals that are difficult to achieve under fee for service.”)

10. See *supra* note 6 and accompanying text.

11. As of January 1, 2017, Medicaid paid for approximately half of all births, sixty-four percent of all nursing home residents, and thirty-nine percent of all children. Margot Sanger-Katz, *G.O.P. Health Plan Is Really a Rollback of Medicaid*, N.Y. TIMES (June 21, 2017), <https://www.nytimes.com/2017/06/21/upshot/gop-health-plan-is-really-a-rollback-of-medicaid.html> (last visited Sept. 11, 2017) (“Medicaid is the country's largest government health care program, covering more Americans than its better-known sibling, Medicare.”).

Medicaid to their beneficiaries.¹² By the end of 2014, 265 MCOs provided comprehensive services to these thirty-nine Medicaid programs.¹³ Nationwide, more than ninety percent of Medicaid beneficiaries lived in these states.¹⁴ By the end of 2016, the overall number of managed care enrollees seemed poised to grow.¹⁵

Medicaid managed care growth has been rapid but constant. Only 750,000 Medicaid beneficiaries were enrolled in a managed care plan just thirty-four years ago, which accounted for about three percent of all Medicaid beneficiaries.¹⁶ By 1994, nearly eight million beneficiaries had been enrolled in managed care, which constituted twenty-three percent of all Medicaid beneficiaries.¹⁷ Startlingly, just six years later, in 2000, more than fifty percent of Medicaid beneficiaries were enrolled in a managed care plan.¹⁸ And by 2008, that percentage exceeded seventy percent, before rising to seventy-five percent in 2012.¹⁹

Although the numbers are not exact,²⁰ based on most recent data in July 2014, of the roughly seventy-two million Medicaid beneficiaries (including

12. *Total Medicaid MCO Enrollment*, KAISER FAM. FOUND., <http://www.kff.org/other/state-indicator/total-medicare-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Aug. 25, 2017) (listing Medicaid MCO enrollment by state, and noting that Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, New York, Ohio, Pennsylvania, Tennessee, Texas, and Washington are states with more than one million Medicaid beneficiaries enrolled in a Medicaid MCO).

13. JULIA PARADISE, KAISER FAMILY FOUND., KEY FINDINGS ON MEDICAID MANAGED CARE: HIGHLIGHTS FROM THE MEDICAID MANAGED CARE MARKET TRACKER 1 (2014), <http://files.kff.org/attachment/key-findings-on-medicare-managed-care-highlights-from-the-medicare-managed-care-market-tracker-report>.

14. *Id.*

15. See, e.g., Mike Cason, *Alabama Medicaid Change to Managed Care Postponed till October*, AL.COM (Nov. 25, 2016, 5:05 PM), http://www.al.com/news/birmingham/index.ssf/2016/11/alabama_medicare_change_to_managed_care.html (last visited Aug. 26, 2017) (noting that “Alabama since 2013 has been working on a plan to shift some of the state’s 1 million Medicaid patients to managed care” but also noting a delay due to the “uncertainty about funding and what changes the Trump administration” may be bringing to Medicaid).

16. *Medicaid and Managed Care—Policy Brief (June 1995)*, KAISER FAM. FOUND., <http://www.kff.org/medicare/issue-brief/medicare-and-managed-care-policy-brief/> (last visited Aug. 26, 2017).

17. *Id.*

18. *Medicaid Managed Care: Trends and Snapshots 2000-2013*, CTRS. FOR MEDICARE & MEDICAID SERVS. 5 fig.1, <https://www.medicare.gov/medicare-chip-program-information/by-topics/data-and-systems/medicare-managed-care/downloads/2013-medicare-managed-care-trends-and-snapshots-2000-2013.pdf>.

19. *Id.*

20. See Caroline F. Pearson, *Avalere Analysis: Medicaid Managed Care Enrollment Set to Grow by 13.5 Million*, AVALERE HEALTH (Oct. 23, 2014), <http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicare-managed-care-enrollment-set-to-grow-by-13.5-million> (last

dually-eligible beneficiaries),²¹ about fifty-five million, or about seventy-seven percent, were enrolled in some kind of Medicaid managed care plan.²² Of those fifty-five million enrolled in a Medicaid managed care plan in 2014, about forty-three million, or about seventy-nine percent, were enrolled in a comprehensive managed care plan.²³ This accounted for about sixty percent of all Medicaid beneficiaries nationwide.²⁴ Nonetheless, it is not clear whether or not these mid-2014 numbers incorporate the full impact of the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA), which bolstered enrollment in managed care plans upon its enactment.

B. Types of Plans

Generally, there are three types of Medicaid managed care plans: (1) primary care case management plans (PCCMs), (2) prepaid health plans (PHPs), and (3) fully capitated, comprehensive full-risk plans.²⁵ PCCMs are plans that employ a

visited Sept. 11, 2017) (noting a fairly smaller nationwide managed care enrollment at sixty-seven percent in 2013); *see also* Virgil Dickson & Bob Herman, *85% Medical-Loss Ratio in Final Managed Medicaid Rule*, MOD. HEALTHCARE (Apr. 25, 2016), <http://www.modernhealthcare.com/article/20160425/NEWS/160429951> (last visited Sept. 11, 2017) (noting the enrollment of low-income people on Medicaid in 2015 amounted to forty-six million).

21. The moniker of “dual eligible” beneficiaries refers to individuals who are eligible for both Medicare and Medicaid. Eliminating the “dual eligible” from the enrollment count provides a Medicaid (and CHIP) enrollment in July 2014 of 67.2 million Americans. *See Total Monthly Medicaid and CHIP Enrollment*, KAISER FAM. FOUND., <http://www.kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/?activeTab=graph¤tTimeframe=1&startTimeframe=40&selectedDistributions=total-monthly-medicare-and-chip-enrollment&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Aug. 26, 2017) (“This number includes only those individuals who are eligible for comprehensive benefits (e.g., emergency Medicaid, family planning-only coverage and limited benefit dual eligible individuals are excluded).”).

22. *Total Medicaid Managed Care Enrollment*, KAISER FAM. FOUND., <http://www.kff.org/medicaid/state-indicator/total-medicare-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 11, 2017) (finding that California had the most individual beneficiaries enrolled in a Medicaid managed care plan, with nearly eight million beneficiary enrollees); *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, CTRS. FOR MEDICARE & MEDICAID SERVS. 17–18 (Spring 2016), <https://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicare-managed-care-enrollment-report.pdf>.

23. *Medicaid Enrollment in Comprehensive Risk-Based Managed Care*, KAISER FAM. FOUND., <http://www.kff.org/medicaid/state-indicator/medicaid-enrollment-in-comprehensive-risk-based-managed-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 11, 2017); *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, *supra* note 22, at 8 (noting that beneficiaries enrolled in comprehensive MCOs jumped from thirty-five million in 2013 to over forty-three million in 2014).

24. *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, *supra* note 22, at 23 tbl. 4.

25. *Medicaid and Managed Care—Policy Brief (June 1995)*, *supra* note 16.

primary care provider to act as a “gatekeeper” who is paid “a per-patient monthly case management fee to compensate for the provider’s expanded administrative responsibilities” even though the provider “do[es] not assume financial risk for the provision of these services.”²⁶ PHPs are prepaid plans that provide a particular type of service; they are paid a “fixed monthly capitation payment[] for each eligible enrollee.”²⁷ Finally, a risk-based comprehensive plan is administered by a private company that “assumes the financial risk of providing all of the medically necessary services under the contract.”²⁸

Comprehensive managed care plans are defined as plans that “provide[] comprehensive benefits,” including “acute, primary care, specialty, and any other,” with some comprehensive plans providing long-term care and behavioral health coverage.²⁹ Of those beneficiaries not enrolled in comprehensive managed care plans in 2014, millions were enrolled in “limited benefit managed care programs” and PHPs, including more than 12.1 million who had behavioral health organization coverage (which included prepaid inpatient and ambulatory services), about 5.5 million who had dental coverage, and more than 7.2 million who were enrolled in a PCCM plan.³⁰

State enrollment in different plans varies across the country. Some states, like Alabama, only enroll beneficiaries in a PCCM.³¹ Others, like Hawaii, enroll the vast majority of their total Medicaid beneficiaries in a comprehensive managed care plan.³² Still others, like Louisiana and Massachusetts, enroll their Medicaid beneficiaries in a mix of comprehensive plans, PCCMs, and various PHPs for behavioral health and dental services.³³

C. Costs

Mirroring the reality of health care pricing and financing, Medicaid managed care expenditures are growing. According to a report by the Centers for Medicare and Medicaid Services (CMS), payments and premiums under

26. *Id.* In these programs, services are still paid on a fee-for-service reimbursement scheme. See MEDICAID & CHIP PAYMENT & ACCESS COMM’N, REPORT TO THE CONGRESS: THE EVOLUTION OF MANAGED CARE IN MEDICAID 64 (June 2011), https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_June2011_web.pdf. States have also established “enhanced PCCM[s],” where “states may provide incentive payments to promote quality, increased care coordination, and management of complex chronic conditions.” *Id.* Indeed, states pay bonuses for performance measures or withhold a portion of reimbursement based upon a failure to meet benchmarks. See *id.* at 65.

27. *Medicaid and Managed Care—Policy Brief (June 1995)*, *supra* note 16.

28. *Id.*

29. *Medicaid Enrollment in Comprehensive Risk-Based Managed Care*, *supra* note 23.

30. *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, *supra* note 22, at 19–20 tbl. 2.

31. *Id.* at 19.

32. *Id.*

33. *Id.*

managed care programs are projected to grow at an average of eleven percent between 2014 and 2023, which is much faster than long-term care fee-for-service and acute care fee-for-service.³⁴ According to this projection, expenditures for Medicaid managed care plans are likely to reach \$400 billion by 2023.³⁵

However, those estimates may be low. In 2016, Medicaid managed care expenditures increased more than 13% from 2015.³⁶ Nonetheless, this growth was much slower than the growth seen in 2014 and 2015, which saw year-over-year expenditure gains of 27.8% and 31.2%, perhaps “due to the deceleration of states expanding Medicaid after two years of significant activity.”³⁷

In real dollars, Medicaid managed care expenditures reached \$269 billion in 2016, up from \$238 billion in 2015.³⁸ More noteworthy, however, was that Medicaid managed care’s expenditures as a percentage of total Medicaid expenditures reached 49.1% in 2016.³⁹ This was a major increase, up from 38.9% in 2014, 29.4% in 2012, and just 19.5% in 2007.⁴⁰ As of 2017, more than fifty cents of every Medicaid dollar spent in the United States is a Medicaid managed care expenditure, which is 2.5 times the percentage of Medicaid expenditures spent on managed care just ten years before.⁴¹

D. 2016 Regulatory Changes

In spring 2016, CMS published final rules that updated the regulation of Medicaid managed care plans nationwide.⁴² According to CMS, the final rule “aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections.”⁴³ Specifically, it links

34. *Medicaid Managed Care: Trends and Snapshots 2000-2013*, *supra* note 18, at 21.

35. *Id.* at 18 fig. 11.

36. HEALTH MGMT. ASSOCS., *Medicaid Managed Care Spending in 2016*, HEALTH MGMT. ASSOCIATES: BLOG (Jan. 26, 2017), <https://www.healthmanagement.com/blog/medicaid-managed-care-spending-2016/> (last visited Sept. 11, 2017).

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.* (noting that during the period between 2007 and 2016, Medicaid managed care grew at about 18% per year, while Medicaid expenditures grew on average of 6.5% annually). The expenditures per beneficiary vary substantially by plan type and service category. *See id.*

41. HEALTH MGMT. ASSOCS., *supra* note 36.

42. *See* Medicaid and CHIP Managed Care Final Rule, 81 Fed. Reg. 27,498, 27,498 (May 6, 2016) (to be codified at 42 C.F.R. pts. 431, 433, 438, 440, 457, and 495); CTRS. FOR MEDICARE & MEDICAID SERVS., *Medicaid and CHIP Managed Care Final Rule*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html> (last visited Sept. 11, 2017) (noting that the “final rule [was] the first major update to Medicaid and CHIP managed care regulations in more than a decade”).

43. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 42.

the regulation of Medicaid managed care to regulations that govern Medicare Advantage plans and Qualified Health Plans (QHPs) that are sold on the ACA individual exchange markets.⁴⁴

Substantively, the final CMS rule constitutes a grab bag of regulations intended to bolster beneficiary protections and improve the functionality of the marketplace. It imposes network adequacy requirements⁴⁵ (including continuity of care requirements for transitions and for long-term support service adequacy requirements), requires written quality strategies, encourages quality ratings, and mandates improvement projects for Medicaid managed care plans.⁴⁶ It also requires states to address problems of over- and under-utilization within their managed care programs.⁴⁷

Additionally, the final rule: (1) requires internal and external review (in addition to new notice requirements) for adverse coverage determinations; (2) encourages states to force managed care plans to implement new value-based payment models (as it has for Medicare in a mandated fashion);⁴⁸ (3) provides beneficiaries with support, counseling, and enrollment protections; and (4) inserts new program integrity requirements, including screening for certain providers before admitting them to a network.⁴⁹

The new rule imposes specific actuarial value metrics on Medicaid managed care plans. Specifically, it mandates a medical-loss ratio (MLR) requirement on Medicaid managed plans,⁵⁰ mandating that they set an MLR of eighty-five

44. See Timothy Jost, *Medicaid Managed Care Final Rule: Examining the Alignment with Qualified Health Plan Requirements (Updated)*, HEALTH AFF. BLOG (Apr. 29, 2016), <http://healthaffairs.org/blog/2016/04/29/medicaid-managed-care-final-rule-examining-the-alignment-with-qualified-health-plan-requirements/> (last visited Sept. 11, 2017) (comparing managed care plan regulation and the rules that govern QHPs and noting, “[This] is the first major update of the Medicaid managed care (MMC) rules since 2002 and comprehensively overhauls MMC requirements and oversight”).

45. See Dickson & Herman, *supra* note 20 (“HHS’ Office of the Inspector General found a clear need for better provider networks in Medicaid programs, saying in a harsh 2014 report that states were not ensuring Medicaid patients had enough hospitals and doctors to care for them.”).

46. Julia Paradise & MaryBeth Musumeci, *CMS’s Final Rule on Medicaid Managed Care: A Summary of Major Provisions*, KAISER FAM. FOUND. 1, 3 (June 2016), <http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care>.

47. *Id.*

48. See Dickson & Herman, *supra* note 20 (“The federal government has made explicit goals to move Medicare toward alternative payment models and away from fee-for-service medical claims, and the final rule will incentivize states and health plans to do the same for Medicaid.”).

49. See Paradise & Musumeci, *supra* note 46, at 1.

50. This direct regulation of actuarial value matches the direct regulation of MLRs of individual plans sold on the ACA exchanges. See Jost, *supra* note 44; Dickson & Herman, *supra* note 20 (“[A]ll insurers must spend at least 85% of their Medicaid revenue on medical care and other activities that improve quality. The remaining 15% can be spent on employee salaries, marketing, profits and other administrative tasks.”).

percent for rate periods starting on July 1, 2017.⁵¹ The regulation provides that plans failing to meet the eighty-five percent MLR threshold could be subject to penalties and likely “will have their state rates lowered in the future.”⁵² Nonetheless, studies have found that about seventy-five percent of managed care plans in 2015 had an MLR at or above eighty-five percent.⁵³

Finally, in a part of the rule that was finalized at the beginning of 2017, CMS sought to redirect payments for Medicaid managed care plans that reportedly total \$3.3 billion annually.⁵⁴ These payments, “paid to Medicaid managed care plans on top of the base capitation rate,” require the plans to “pass these payments to contracted providers that treat a disproportionate share of Medicaid or uninsured patients.”⁵⁵ In the rule that was finalized in January 2017, “CMS told states to stop making such payments” but gave them a handful of years to do so.⁵⁶ Further, the rule changes the payments to link them to the quality of care provided instead of a straight pass through as it existed,⁵⁷ which was reportedly “not actuarially sound.”⁵⁸ This has impacted states’ plans to privatize their Medicaid programs, as these payments can make up a large percentage of payments for providers who see patients enrolled in a Medicaid managed care plan.⁵⁹ The American Hospital Association was “disappointed” in the rule.⁶⁰

III. THE BIDDING PROCESS: TRENDS AND DETAILS

Much of the press related to Medicaid managed care has been generated by its bidding process—the process by which states award contracts to private carriers to administer their Medicaid programs.⁶¹ The process has been subject to political allegations of favoritism, which resulted in a number of lawsuits,

51. Jost, *supra* note 44.

52. Dickson & Herman, *supra* note 20.

53. Jill Brostowitz et al., *Medical Loss Ratio (MLR) in the “Mega Reg,”* MILLIMAN 7 (June 24, 2016), <http://www.milliman.com/uploadedFiles/insight/2016/mlr-mega-reg-webinar-materials.pdf>.

54. Virgil Dickson, *Final Pass-Through Pay Rule Would Cost Hospitals More Than \$3 Billion a Year*, MOD. HEALTHCARE (Jan. 17, 2017), <http://www.modernhealthcare.com/article/20170117/NEWS/170119909> (last visited Sept. 12, 2017).

55. *Id.*

56. *Id.*

57. ADVISORY BD., *CMS Finalizes Rule to Block New ‘Pass-Through’ Payments for Medicaid Providers*, DAILY BRIEFING (Jan. 19, 2017, 8:20 AM), <https://www.advisory.com/daily-briefing/2017/01/19/cms-medicare-pass-through> (last visited Sept. 12, 2017).

58. *See* Dickson, *supra* note 54.

59. *See, e.g., infra* Section III.B.

60. Morgan Haefner, *CMS Finalizes Rule on Medicaid Managed Care Pass-Through Payments: 5 Things to Know*, BECKER’S HOSP. REV. (Jan. 18, 2017), <http://www.beckershospitalreview.com/payer-issues/cms-finalizes-rule-on-medicare-managed-care-pass-through-payments-5-things-to-know.html> (last visited Sept. 12, 2017).

61. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 60.

often between competing bidders. A summary of the typical bidding process—and a quick summary of some of its trends—follows below.

Within Medicaid managed care, states have latitude in determining the type of rate-setting and bidding processes they establish. In setting the rates for its Medicaid managed care contract, a state can elect to establish its own capitation rate (often referred to as fixed offer or “administered pricing” plans), can establish a range of acceptable rates and allow plans to bid on specific rates (often relying on a request for proposals (RFP)), or can elect to construct a hybrid method of the established rate process and the competitive bid process by establishing a fixed range of rates.⁶² The state’s proposed rates must be “actuarially sound.”⁶³ Further, with exceptions, states that mandate that Medicaid beneficiaries must enroll in a managed care plan “must give those beneficiaries a choice of at least two [plans]” from which to choose.⁶⁴ Rural residents are exempt from the choice requirements.⁶⁵ States must explore different factors in setting the rates, determining the risk adjustment and risk sharing arrangements, and designing other plan guidelines and limitations.

A. *Determining the Rate*

States examine a number of factors in setting capitation rates using “data and adjustment factors to predict enrollees’ use of health care services and the expected cost of these services.”⁶⁶ In determining these rates, states consider baseline data,⁶⁷ trends (in an effort to “establish an expected per member per

62. *Id.* at 59–60. Under the established rate, “[t]he managed care plan may accept or reject the offered capitation rate—or, in some cases, may have an opportunity to negotiate the rate.” Robert Damler et al., *Fixed Offer or Competitive Bid? Choosing the Right Medicaid Managed Care Contracting Methodology for Your State’s Needs*, MILLIMAN 1 (Mar. 2015), <http://www.milliman.com/uploadedFiles/insight/2015/fixed-offer-competitive-bid.pdf>. Under the competitive bid process, the range will be established and may be shared, after which the “managed care plans will then provide a bid rate,” which “will ultimately need to fall within the state’s actuary’s certified rate range.” *Id.*

63. Damler et al., *supra* note 62, at 3. Further, “[t]he capitation rates that are paid to a managed care health plan must fall within the capitation rate range certified by the state’s actuary.” *Id.*

64. 42 C.F.R. § 438.52(a) (2016).

65. *Id.* § 438.52(b).

66. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 60.

67. *Id.* (“Depending on the type of contracting method that a state chooses, states or plans typically set rates based on either FFS or managed care services and utilization data . . . if available, or both.”).

month amount”),⁶⁸ the fiscal health of the state,⁶⁹ carve outs,⁷⁰ additional payments (these include so-called “kick payments” that may be used for maternity services or transplant coverage, for example),⁷¹ and other incentives that may be built into the contract.⁷²

B. Risk Adjustment and Risk Sharing

Importantly, insurance plans must appropriately assume risk so that they can make a profit from Medicaid managed care contracts with states,⁷³ but states must also seek to “prevent MCOs from ‘cream-skimming’ by finding ways to disproportionately attract healthy enrollees.”⁷⁴ According to the Medicaid and CHIP Payment and Access Commission (MACPAC), in the past, “states have adjusted plan payment rates for demographic factors” like “paying higher rates for older enrollees.”⁷⁵ Recently, states are setting rates based on the health status of beneficiaries.⁷⁶ They may also charge different rates for different home zip codes “based on regional variation in costs.”⁷⁷

Risk adjustment is vital, as it can “affect plans’ willingness to participate in Medicaid managed care, particularly for more complex populations . . . or those with disabilities” in the first place.⁷⁸ It is also an important tool states can use to try to prevent insurance companies from engaging in “adverse selection” or “cherry picking” so as to enroll healthier individuals.⁷⁹ Risk adjustment

68. *Id.* at 61. Also, according to MACPAC, “states also adjust rates to account for efficiency factors,” including “reductions in emergency department (ED) services, unnecessary inpatient admissions, or the use of brand name drugs when a generic substitute is available.” *Id.*

69. *Id.* (“[S]tates may set managed care rates assuming reductions in profit margins, marketing costs, and other factors.”). *See also, e.g., infra* Section III.B.

70. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 61. These include any services that are excluded, like “behavioral health, transportation, [or] oral health,” *Id.* Importantly, “Medicaid managed care enrollees may still be able to access these services through FFS Medicaid or through a limited-benefit plan that is contracted to provide these services.” *Id.*

71. *Id.*

72. *Id.* These often include bonuses (“3 percent of per member per month” plans, for instance) for stellar performance. *Id.*

73. *See id.* at 62 (“Risk adjustment helps assure that health plans receive payment sufficient to cover the costs of delivering and arranging care efficiently without compromising quality and access.”).

74. Robert Book, *Benefits and Challenges of Medicaid Managed Care*, FORBES (Oct. 18, 2012, 10:09 PM), <https://www.forbes.com/sites/aroy/2012/10/18/benefits-and-challenges-of-medi-caid-managed-care/#692b3306720f> (last visited Sept. 12, 2017).

75. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 62.

76. *Id.*

77. Book, *supra* note 74.

78. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 62.

79. *Id.*

techniques include assessing demographics, health status, and pharmacy histories.⁸⁰

Finally, to alleviate some of the risk taken on by insurance carriers,⁸¹ states can build in processes that help protect the insurance company from major losses in the insurance marketplace, “includ[ing] risk corridors, [or] stop-loss or reinsurance provisions.”⁸²

A risk corridor helps to stabilize the risk that is taken by the MCO. For instance, in a risk corridor:

In the event that actual utilization exceeds the expected level by more than a specified percentage, the MCO would receive additional payments to make up for part or all of the difference. Conversely, if actual utilization is below the expected level by more than a specified percentage, the MCO would have to provide a partial refund to the Medicaid program.⁸³

Stop-loss or reinsurance programs are similar: They are insurance plans that shelter organizations “against those ultra-expensive ‘shock’ claims that can wreak years’ worth of financial havoc with just a few days of hospital charges.”⁸⁴ Stop-loss provisions often set a particular threshold of charges, beyond which “states will assume some or all of the enrollee’s cost of care.”⁸⁵ Indeed, when thresholds are set that protect insurance companies, states may lower the capitation rates for the managed care plan.⁸⁶

Alleviating risk often also includes giving insurance companies notice of the makeup of the insurance risk pool. In an effort to limit costs, the managed care company would want to ensure that its Medicaid pool is relatively healthy.⁸⁷ To

80. *Id.*

81. See Book, *supra* note 74. (“Setting specific per-patient monthly rates transfers the risk of statistical variation in health care needs from the state and the federal governments to the MCOs,” and “this is a benefit for the governments,” but “a downside for the MCOs.”).

82. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 62.

83. Book, *supra* note 74.

84. Peter Wehrwein, *Reinsurance and Stop-Loss Coverage: Are You on a Firm Footing?*, MANAGED CARE (Feb. 1998), <https://www.managedcaremag.com/archives/1998/2/reinsurance-and-stop-loss-coverage-are-you-firm-footing> (last visited Sept. 12, 2017); see also, e.g., *Stop Loss Program*, N.Y. STATE DEP’T. OF HEALTH, (Oct. 2016), <https://www.health.ny.gov/facilities/hospital/reimbursement/stoploss/> (last visited Sept. 12, 2017) (“Stop Loss is a type of reinsurance, or risk protection, offered by NYS to Medicaid managed care plans, which is intended to limit the plan’s liability for individual enrollees.”).

85. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 63.

86. *Id.*

87. See *Medicaid Best Buys: Critical Strategies to Focus on High-Need, High-Cost Beneficiaries*, CTR. FOR HEALTH CARE STRATEGIES, INC. (Apr. 2010), https://www.chcs.org/media/Medicaid_Best_Buys_2010.pdf (“[T]he majority of those currently [in 2010] enrolled in managed care are relatively healthy.”).

accomplish this, these plans may seek to exclude higher-cost beneficiaries, who then are covered by the state, often in a fee-for-service program.⁸⁸

This category of beneficiaries, referred to as “Beneficiaries with Complex Care Needs and High Costs,” includes “super-utilizers.”⁸⁹ Super-utilizers are “an extremely heterogeneous group with varying medical, behavioral, and psycho-social needs.”⁹⁰ Interestingly, like in private insurance, the most expensive one percent of Medicaid beneficiaries make up one-fourth of overall Medicaid expenditures, and the top five percent account for fifty-four percent of all Medicaid expenditures.⁹¹ Nonetheless, “states increasingly are looking to expand their Medicaid managed care programs to cover more . . . high-cost populations and services,” largely due to the budget predictability of managed care.⁹² In transitioning high-cost beneficiaries to managed care, critics have concerns over health care access and quality for these populations.⁹³

C. Other Characteristics

Finally, other considerations that must be undertaken by the state involve details surrounding the bidding and contract award process. Indeed, as has been mentioned, “Protests of contract awards are a fact of life in public procurement, making protest mitigation strategies a necessity—especially in critical and high-cost areas such as Medicaid managed care.”⁹⁴ To simplify the contractual options, the state “can limit the number of slots available for winning bids.”⁹⁵ Finally, the state needs to prioritize values other than just cost savings, such as

88. See MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 26, at 4; see also CTR. FOR HEALTH CARE STRATEGIES, INC., *supra* note 87, at 2 (“[T]he bulk of beneficiaries with the most challenging health care needs are in the fragmented and uncoordinated fee-for-service delivery system.”).

89. CTRS. FOR MEDICARE & MEDICAID SERVS., *Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs*, MEDICAID.GOV, <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html> (last visited Sept. 12, 2017).

90. *Id.*

91. *Id.*

92. Michael Sparer, *Medicaid Managed Care: Costs, Access, and Quality of Care*, ROBERT WOOD JOHNSON FOUND. 1 (Sept. 2012), <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106>.

93. *Id.* at 2.

94. See Damler et al., *supra* note 62, at 2. Damler et al. notes that both the competitive bidding and state-set capitation rate bidding bring challenges of their own:

Competitive bidding adds complexity to the procurement process, thus creating more avenues for protest. On the other hand, state-set capitation rates eliminate the quantitative cost element of scoring and thus increase the likelihood of attempts by protesting parties to question the details underlying the subjective evaluation process. States should clearly understand what benefits they hope to achieve with the selection of either state set capitation rates or competitive bidding. *Id.*

95. *Id.*

seamlessness, quality, and access for the beneficiaries on a Medicaid managed care plan.⁹⁶

IV. RECENT NOTEWORTHY DEVELOPMENTS

Even though most states have moved toward expanding managed care offerings within their Medicaid programs and a number have trumpeted their savings,⁹⁷ at least two states, Connecticut and Oklahoma, have recently moved away from managed care.⁹⁸ A third state, Illinois, is revamping its managed care offerings in the state, which may ultimately lead to an expanding enrollment.⁹⁹ Quick summaries of these three states' forays into—and away from—managed care are explored immediately below.

A. *Moving Away: Connecticut*

In one of the more widely publicized moves of the last decade, Connecticut largely abandoned its Medicaid managed care effort in late 2011¹⁰⁰ after being called a “cautionary tale” of inadequate networks and chaotic enrollment.¹⁰¹ Claiming that the state had “diminishing confidence in the value of what [MCOs

96. See ANTHEM PUB. POLICY INST., MEDICAID MANAGED CARE FOR MEMBERS WITH MENTAL HEALTH CONDITIONS AND/OR SUBSTANCE USE DISORDERS: INTEGRATING BENEFITS AND CARE 2 (Dec. 2016), https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjg2/~edisp/pw_g286050.pdf (an insurance carrier within Medicaid managed care programs noting the importance of “integrated, person-centered care” focused on “access, quality of care, health out-comes, and spending,” as well as “seamless care”).

97. See, e.g., Schorsch, *supra* note 1 (“In Arizona, Medicaid officials estimate they saved nearly \$29.5 billion over the last five years by outsourcing the bulk of their enrollees’ health care to private insurers. Ohio did the same thing, and the results are promising. From 2009 to 2013, it slowed the growth of costs in its \$25 billion Medicaid program from 9 percent to 3 percent. Annual spending has remained relatively flat ever since.”).

98. See, e.g., Phil Galewitz, *Connecticut Drops Insurers from Medicaid*, KAISER HEALTH NEWS (Dec. 29, 2011), <http://khn.org/news/connecticut-drops-insurers-from-medicaid/> (last visited Sept. 12, 2017) (“Connecticut’s decision stands out at a time when a growing number of states are requiring more people in Medicaid to join managed care plans—Florida, Texas, and California are among nearly two dozen states planning expansions in 2012.”).

99. See *infra* Section III.C. Governor Rauner seeks to shrink the number of managed care plans in the state, but expand the enrollment of Medicaid beneficiaries in managed care, especially south of Chicago. Schorsch, *supra* note 1.

100. Galewitz, *supra* note 98 (“In the past decade, most states have turned Medicaid over to private [insurance] plans with the hopes they could control costs and improve care. Nearly half of the 60 million people in the government program for the poor are now in managed care plans run by insurance giants such as UnitedHealthcare and Aetna. But Connecticut, the ‘insurance capital of the world,’ is bucking the trend.”).

101. *A Cautionary Tale from CT on Medicaid Managed Care Plans*, HEALTH CARE FOR ALL (May 13, 2008) (citing Jane Zhang, HMO Pullouts Upend Connecticut Medicaid, WALL ST. J., May 13, 2008, at A4), <http://www.hcfama.org/blog/cautionary-tale-ct-medicaid-managed-care-plans> (last visited Sept. 12, 2017) (“[T]he small number of managed care plans in the Connecticut Medicaid program are heading for the door or have already left.”).

were] providing,” Connecticut moved its Medicaid population of nearly a half-million beneficiaries back under state control.¹⁰²

The state moved back to a fee-for-service reimbursement scheme, so-called “managed fee-for-service,”¹⁰³ and in early 2016, reportedly saved money (particularly on administrative costs) and improved care after making the move.¹⁰⁴ Per-person Medicaid costs in Connecticut have dropped in recent years—reportedly decreasing nearly six percent year over year in 2016¹⁰⁵—and at least part of the cost savings could be due to Connecticut’s decision to move away from managed care.¹⁰⁶ As other states’ Medicaid privatization efforts have been criticized, the story of Connecticut has been used to galvanize support toward a traditional publicly-funded and administered state Medicaid program.¹⁰⁷

102. Galewitz, *supra* note 98.

103. Melinda Beck, *Connecticut Moves Away from Private Insurers to Administer Medicaid Program*, WALL ST. J. (Mar. 18, 2016, 6:24 PM), <https://www.wsj.com/articles/connecticut-moves-away-from-private-insurers-to-administer-medicaid-program-1458325696> (last visited Sept. 12, 2017).

104. *Id.* (“At a time when most states are paying private insurers to provide health care for their Medicaid recipients, Connecticut says it has saved money and improved care by going the opposite way.”); Katherine Moody, *Connecticut Touts Success of Its ‘Managed Fee-for-Service’ Medicaid Model*, FIERCEHEALTHCARE (Mar. 21, 2016, 10:52 AM), <http://www.fiercehealthcare.com/payer/connecticut-touts-success-its-managed-fee-for-service-medicaid-model> (last visited Sept. 12, 2017) (“This, state officials tell the *WSJ*, has cut administrative costs to 5 percent of total costs, compared with 12 percent on average at Medicaid managed-care plans.”).

105. Arielle Levin Becker, *Medicaid Costs in Connecticut Have a Silver Lining*, HARTFORD COURANT (Jan. 19, 2016, 5:51 AM), <http://www.courant.com/health/hc-ctm-medicaid-spending-down-20160119-story.html> (last visited Sept. 12, 2017). State officials also noted that other changes and healthier beneficiaries may have contributed to the decline. *See id.*; Beck, *supra* note 103 (“Average cost per patient, per month, is down from \$718 in mid-2012 [when Connecticut made the switch] to \$670 [in 2015], according to state data. The number of doctors willing to treat Medicaid patients is up 7% and as a result fewer patients are using emergency rooms for routine care.”).

106. *See* Becker, *supra* note 105 (noting that now one company administers the Medicaid program and the state is “responsible for claims costs”).

107. *See, e.g., Editorial: Connecticut Abandoned Privatized Medicaid*, DES MOINES REG. (Mar. 22, 2016, 9:23 PM), <http://www.desmoinesregister.com/story/opinion/editorials/2016/03/22/editorial-connecticut-abandoned-privatized-medicaid/82081130/> (last visited Sept. 12, 2017) (detailing Connecticut’s move and noting: “The irony of all this should not be lost on a single Iowan. While [Governor] Branstad has dragged the people of this state into privatization, Connecticut is finding savings and success pursuing [sic] the model of state-managed Medicaid our state is now abandoning. That’s the model in which public dollars compensate doctors, not stockholders. The questions before us now: How much damage will be done to Iowa before state officials have the epiphany that Connecticut had about privatization? How much damage will be done before Iowans vote for changes in leadership?”).

B. Moving Away (and Then Back?): Oklahoma

In 2004, Oklahoma became the first state to move away from Medicaid managed care following rapid rate increases and a conclusion that the state could administer Medicaid coverage at a fraction of the cost of its private SoonerCare Plus program.¹⁰⁸ The program “struggled from the start” due to “the weakness of Oklahoma’s HMO market,” and following rate increases that approached twenty percent, the Oklahoma Health Care Authority ended the program on January 1, 2004.¹⁰⁹

Nonetheless, in 2015, the Oklahoma legislature passed House Bill 1566, “which require[d] the Oklahoma Health Care Authority (OHCA) to solicit requests for proposals for care coordination models for Oklahomans on Medicaid who [were] aged, blind, or [had] a disability.”¹¹⁰ This proposal would cover a population that made up only about fifteen percent of Oklahoma’s Medicaid beneficiaries but that constituted more than forty-six percent of Oklahoma’s annual Medicaid expenditures.¹¹¹

The managed care RFP was released by the state on November 30, 2016, seeking “care coordination models” for aged, blind, and disabled (ABD) beneficiaries.¹¹² The new program, SoonerHealth+, sought to establish a capitated payment for health services for the ABD population on a “per member per month” basis.¹¹³ The request sought between two to four contracts in two different regions of the state (East and West) and intended to award the contracts by the summer of 2017 for the plans to commence administering care on April 1, 2018.¹¹⁴

However, by spring of 2017, with Oklahoma moving forward with the new program, concerns arose over funding, particularly over the new federal supplemental payment rules involving pass-through payments.¹¹⁵ Due to

108. See David Blatt, *Lessons Unlearned?*, OKLA. POL’Y INST. (Mar. 20, 2013), <http://okpolicy.org/lessons-unlearned/> (last visited Sept. 12, 2017).

109. *Id.*

110. Carly Putnam, *Back on the Road to Medicaid Managed Care*, OKLA. POL’Y INST. (Oct. 7, 2015), <http://okpolicy.org/back-on-the-road-to-medicaid-managed-care/> (last visited Sept. 12, 2017).

111. *Id.* (“Legislators who supported HB 1566 believe that there are potential cost savings to be found by instituting a managed care system.”).

112. *SoonerHealth+ Managed Care RFP Released*, OKLA. HOSP. ASS’N. (Dec. 7, 2016), http://www.okoha.com/OHA/Hotline/2016/Dec_16/SoonerHealth+%20managed%20care%20RFP%20released.aspx (last visited Sept. 12, 2017) (“Other SoonerCare members [the non-ABD population] will remain in the fee-for-service Medicaid program.”).

113. *Id.*

114. *Id.*

115. See Dale Denwalt, *Experts Worry About Future of Oklahoma Medicaid Funding*, THE OKLAHOMAN (Apr. 7, 2017, 5:00 AM), <http://newsok.com/article/5544753> (noting challenges facing the transition to privatization) (last visited Sept. 12, 2017); see also *supra* notes 54–60 and accompanying text.

concerns over limitations on pass-through payments from the federal level and fresh concerns over state funding (including as much as \$100 million in state startup funds for the privatization effort), the Oklahoma Health Care Authority terminated the bidding process after being asked by Governor Mary Fallin to delay its implementation for one year.¹¹⁶ A number of Oklahoma's health care providers and hospitals were pleased by the cancellation.¹¹⁷

C. A Current "Reboot" in Illinois

Illinois is in the midst of a so-called "reboot," where newly-elected Governor Bruce Rauner is seeking to "limit the number of insurers that contract with the state, expand managed care statewide to fill gaps in care and focus on mental health and addiction."¹¹⁸ With uncertainty swirling around Medicaid policy, this could be a risky proposition and has been criticized,¹¹⁹ particularly given Illinois' recent budgetary crisis and the fact that the state added more than 600,000 people to its Medicaid enrollment following the Medicaid expansion under the ACA.¹²⁰ More than three million citizens are Medicaid beneficiaries in Illinois.¹²¹

Down from about thirty insurers,¹²² Illinois now relies on twelve insurers to administer Medicaid services to about two-thirds of its overall Medicaid

116. Dale Denwalt, *Asked to Delay Privatization, Oklahoma's Medicaid Agency Opts to Cancel*, THE OKLAHOMAN (June 18, 2017, 5:00 AM), <http://newsok.com/article/5553169> (last visited Sept. 12, 2017).

117. *See id.* ("Some people in the health care industry are relieved that privatization of an Oklahoma Medicaid program has ground to a halt for lack of funds."); *Nursing Home Advocates Praise Decision to Delay Managed Care Implementation*, EDMOND SUN (June 23, 2017), http://www.edmondsun.com/news/nursing-home-advocates-praise-decision-to-delay-managed-care-implementation/article_116120a8-5860-11e7-8ad1-330281387ff7.html (last visited Sept. 12, 2017) ("A diverse coalition of health care providers, including nursing homes, hospitals, mental health professionals, and both the Oklahoma State University and University of Oklahoma medical centers had expressed concerns about the plan. . . . The Oklahoma Association of Health Care Providers (OAHCP), which represents the state's nursing homes, praised the decision.").

118. Schorsch, *supra* note 1.

119. *See* Lisa Schencker, *4 Insurers Out of Running for Rauner's Medicaid Overhaul*, CHI. TRIB. (May 16, 2017, 4:53 PM), <http://www.chicagotribune.com/business/ct-medicare-managed-care-bids-0516-biz-2-20170515-story.html> (last visited Sept. 12, 2017) (quoting the state comptroller's criticism in which she questions the "monumental change" during "unprecedented upheaval," at a time when there is no working budget for the state).

120. Kenneth S. Polonsky, *Commentary: ACA Repeal Means Serious Risk for Illinois*, CHI. TRIB. (Feb. 16, 2017, 5:19 PM), <http://www.chicagotribune.com/news/opinion/commentary/ct-obamacare-repeal-effects-medicare-illinois-perspec-0217-md-20170216-story.html> (last visited Sept. 12, 2017) ("The decisions that will be made in Washington in the coming weeks will have a major impact on access to health care for many years to come. Illinois faces particular challenges.").

121. *Id.*

122. Kristen Schorsch, *Rauner Scraps Medicaid Managed Care, Outlines New Plan*, CRAIN'S CHI. BUS. (Feb. 27, 2017), <http://www.chicagobusiness.com/article/20170227/NEWS03/170229896/rauner-scraps-illinois-medicare-managed-care-program> (last visited Sept. 12, 2017).

population (about two million people) through its managed care program.¹²³ As of 2017, Governor Rauner wants to decrease that number to “between four and seven”¹²⁴ and wants to expand the number of beneficiaries on managed care to eighty percent.¹²⁵ Changes are underway, as the state has reportedly “confirmed it will competitively bid managed care contracts” starting in 2018; Illinois is studying other states’ plans.¹²⁶

In spring 2017, Governor Rauner’s plans resulted in a “major shake-up of the program, with several insurers . . . out of the running” to administer the Medicaid program.¹²⁷ Specifically, four of the twelve insurers that operated within the managed care program—insurers that administered Medicaid managed care services for more than 200,000 of the state’s Medicaid beneficiaries—did not submit a competitive bid in response to an RFP from the state.¹²⁸ By August, Governor Rauner’s administration had selected the six companies that would administer Illinois’ new managed care program, and in October, Rauner vetoed a bill that would have required future awarding of managed care contracts to be subject to a stricter state bid procurement process.¹²⁹

V. CONTROVERSY AND LITIGATION

Perhaps Medicaid managed care’s biggest media spotlight has come from its bidding processes. Multiple states have experienced protracted, contentious litigation over their bidding processes related to their Medicaid managed care programs. Sagas in three states—West Virginia, Iowa, and Missouri—are covered in depth below.

Frequently, courts have found that states’ bidding processes have been appropriate, dismissing lawsuits brought by insurance company competitors

123. Schorsch, *supra* note 1.

124. Schorsch, *supra* note 122.

125. Schorsch, *supra* note 1 (“In 2014, just 8 percent of [Illinois’s] Medicaid recipients were in managed care. Today, it’s 65 percent, and Rauner wants it closer to 80 percent.”); *see also* Schorsch, *supra* note 122 (Seeking to grow the program geographically as well as numerically, “Rauner wants to expand managed care services statewide and add another 15 percent of all Medicaid enrollees to the program. In Central Illinois, for example, Medicaid recipients have little access to managed care.”).

126. Schorsch, *supra* note 1 (noting that Illinois is looking at successful Medicaid managed care plans in Arizona and Ohio).

127. Schencker, *supra* note 119.

128. *Id.*

129. *See* Lisa Schencker, *Illinois Names 6 Insurers to Take Part in Overhauled Medicaid Managed Care*, CHI. TRIB. (Aug. 11, 2017, 5:56 PM), www.chicagotribune.com/business/ct-medi-caid-insurers-chosen-0813-biz-20170811-story.html (last visited Nov. 5, 2017); *Rauner Vetoes Medicaid Purchase Plan as Duplicative*, U.S. NEWS & WORLD REP. (Oct. 13, 2017, 6:04 PM), <https://www.usnews.com/news/best-states/illinois/articles/2017-10-13/rauner-vetoes-medi-caid-purchase-plan-as-duplicative> (last visited Nov. 5, 2017).

who lost out on winning the bid. For instance, last year in Nebraska, a court found against Aetna Better Health of Nebraska and Arbor Health Plan, finding no evidence that substantiated allegations that Nebraska's bidding process was unfair.¹³⁰

Ohio experienced a similar—but more unpredictable—Medicaid managed care bidding dispute in 2012. First, in the early summer of 2012, Aetna was granted a temporary injunction that ordered Ohio to “stop awarding new health insurance contracts . . . because of alleged flaws in a bidding process.”¹³¹ Specifically, Aetna successfully argued that Ohio Medicaid “officials ‘abused their discretion when they revoked their previous award to Aetna of the contract and refused Aetna the right of protest otherwise guaranteed to applicants’” for purposes of granting a temporary injunction.¹³² Further, another insurance company and fellow bidder, Amerigroup, filed a lawsuit based on “alleged unfairness in the evaluation of its Medicaid submission,” seeking a similar order to mandate the “rescoring of all bids or a new start to the entire bidding process.”¹³³

But just two months later, the same judge, the late Judge Richard Sheward, reversed course. Specifically, he “lifted an injunction on the state’s awarding of health insurance contracts under Medicaid and tossed Aetna Inc.’s lawsuit alleging flawed bidding procedures, saying company officials lacked credibility.”¹³⁴ Further, Judge Sheward “suggested Aetna intentionally misled

130. *Coventry Health Care of Nebraska, Inc. v. Nebraska Dep’t of Admin. Servs.*, No. 4:16CV3094, 2016 WL 4435197, at *10 (D. Neb. Aug. 19, 2016); see also Riley Johnson, *Aetna Ends Court Fight with State Over Medicaid Plan*, LINCOLN J. STAR (Aug. 26, 2016), http://journalstar.com/news/state-and-regional/govt-and-politics/aetna-ends-court-fight-with-state-over-medicare-plan/article_90ae2bed-7208-5e5e-8b52-eff4c0304a2d.html (last visited Sept. 13, 2017) (Aetna was “alleging the award process was not open and fair to all bidders as required by Nebraska law. But U.S. District Judge Robert Rossiter Jr. denied that request Aug. 19, saying Aetna’s legal claims failed to show the need for the injunction they sought, which he called [an] ‘extraordinary remedy.’”). Further, Aetna Better Health of Nebraska, United Healthcare, and Arbor Health are the companies providing Medicaid and CHIP managed care in the state, but “[a]lmost everyone on Medicaid or CHIP will be in Heritage Health,” a new plan that won the state bid. Molly McCleery, *What to Know About Big Changes to Medicaid in Nebraska*, NEB. APPLESEED (Sept. 8, 2016), <https://neappleseed.org/blog/21020> (last visited Sept. 12, 2017).

131. Jeff Overley, *Aetna Wins Halt of Ohio Medicaid Contracts*, LAW360 (Jun. 27, 2012, 5:31 PM), <https://www.law360.com/articles/354450/aetna-wins-halt-of-ohio-medicare-contracts> (last visited Sept. 13, 2017).

132. *Id.*

133. *Id.* (quoting the company as saying, “Amerigroup does not make the decision to pursue legal remedies against a state partner lightly, [but] given the facts and circumstances associated with the [bid] scoring, it has been deemed necessary to do so in this case”).

134. Jeff Overley, *Slamming Aetna Execs, Judge Tosses Medicaid Contract Suit*, LAW360 (Aug. 17, 2012, 1:57 PM), <https://www.law360.com/articles/370687/slamming-aetna-exec-judge-tosses-medicare-contract-suit> (last visited Sept. 13, 2017) (noting that the decision was a “striking turnaround”).

the state in its bid to land contracts, saying it was hard to fathom that high-ranking executives didn't understand basic Medicaid guidelines."¹³⁵ The judge was particularly harsh on the executives, saying that Aetna's leaders should have known "they didn't have a prayer" in their attempt to win the contract.¹³⁶ The stinging decision gave Ohio the right to implement the new contracts, and it did so in 2013.¹³⁷

Finally, in Kentucky in 2016, a settlement was reached between the state and Centene, a Medicaid managed care administrator, for claims arising out of its agreement to administer Kentucky's Medicaid managed care contract.¹³⁸ Specifically, it was Centene's subsidiary, Kentucky Spirit, that had been awarded the contract but had alleged that the state did not adequately disclose materially necessary information and provided inaccurate information related to the state's Medicaid managed care contract that covered 140,000 Kentuckians.¹³⁹

As a consequence, Kentucky Spirit canceled the contract a year early, after only one year of plan administration.¹⁴⁰ The state then alleged that the contract cancellation cost it between twenty-eight million and forty million dollars, and sued.¹⁴¹ After the trial and appellate courts found for the state,¹⁴² the two sides reached a settlement agreement in November of 2016 in which the state did not have to pay any money.¹⁴³ In the settlement, both the state and the company

135. *Id.*

136. *Id.* (noting that the judge accused the leader of the Aetna Medicaid unit of being untruthful, saying, "I don't believe the testimony of these witnesses for a second that they didn't know what full risk meant . . . I don't believe Tom Kelly for a second. He knows what full risk is.").

137. See Catherine Candisky, *Judge Dismisses Aetna's Lawsuit Challenging State Contracts for Medicaid Program*, COLUMBUS DISPATCH (Aug. 16, 2012, 9:58 PM), <http://www.dispatch.com/content/stories/local/2012/08/16/judge-upholds-state-contracts-Medicaid-Aetna-lawsuit.html> (last visited Sept. 13, 2017) (quoting the judge as saying, "I did not find that the state abused its discretion at all . . . Quite the contrary, I think Aetna came up with a new interpretation as to what full risk is and I definitely did not accept that . . . I thought it was unbelievable and frankly, I don't think half the Aetna people believed it but the higher ups felt if they didn't do something creative they had no chance . . . I think they knew better.").

138. See Erica Teichert, *Centene and Kentucky Settle Medicaid Managed-Care Contract Spat*, MOD. HEALTHCARE (Nov. 4, 2016), <http://www.modernhealthcare.com/article/20161104/NEWS/161109948> (last visited Sept. 13, 2017).

139. *Id.*; Samantha Liss, *Centene Reaches Settlement with State of Kentucky*, ST. LOUIS POST-DISPATCH (Nov. 4, 2016), http://www.stltoday.com/business/local/centene-reaches-settlement-with-state-of-kentucky/article_9611ac17-f58c-51cf-8085-ac6284d4c415.html (last visited Sept. 13, 2017); see also Claire Galofaro, *Kentucky Spirit Loses Appeal in Medicaid Suit*, COURIER-JOURNAL (Feb. 6, 2015, 4:48 PM), <http://www.courier-journal.com/story/news/local/2015/02/06/kentucky-spirit-loses-appeal-medicaid-suit/23000931/> (last visited Sept. 13, 2017).

140. See Liss, *supra* note 139.

141. Teichert, *supra* note 138.

142. See Galofaro, *supra* note 139 (noting that the Kentucky Court of Appeals found "that the company breached its contract and ordered that the state is entitled to damages").

143. Teichert, *supra* note 138.

“agree[d] that neither party acted in bad faith, that they took reasonable positions in light of the applicable contractual language and that parties acted in good faith in attempting to address a difficult situation,” according to a company statement.¹⁴⁴

These recent occurrences—in Nebraska, Ohio, and Kentucky—highlight the often highly contentious bidding process that occurs within the Medicaid managed care program. Three additional states’ recent litigious pasts—those of West Virginia, Iowa, and Missouri—are summarized immediately below.

A. *West Virginia*

In West Virginia, five taxpaying citizens brought a lawsuit seeking to: (1) review the state Medicaid managed care contracts with four insurance companies from the summer of 2014 to the summer of 2015, and (2) enjoin the state from implementing and operating under new Medicaid managed care contracts in the summer of 2015.¹⁴⁵ The plaintiffs argued that the West Virginia Bureau for Medical Services violated the state procurement laws based upon legislation that was passed in 2013 and 2014 that clearly evinced the legislature’s intent to have these contracts bid out competitively.¹⁴⁶ The plaintiffs were sure to highlight that the failure to put the Medicaid managed care contracts to bid resulted in a “significant negative impact to [the state’s] budget,” creating “a substantial burden upon West Virginia taxpayers.”¹⁴⁷ According to the plaintiffs:

In order to deliver Medicaid services through this program to eligible Medicaid participants throughout West Virginia, the State enters into contracts with Managed Care Organizations (“MCOs”) that in turn contract with health care providers that treat the Medicaid beneficiaries. West Virginia law requires all State agencies to award government contracts exclusively through a competitive bidding process. In this case, Defendants have awarded large contracts under the

144. *Id.*

145. Complaint and Petition for Writ of Certiorari and Mandamus at 3, 10, 13, *Rucker v. W. Va. Dep’t. of Admin.*, No. 15-C-1192 (W. Va. Cir. Ct. June 12, 2015) (“Defendants awarded, and intend to award, managed care contracts to MCOs as part of West Virginia’s Medicaid program without subjecting those MCOs or their proposed contracts to a process of competitive bidding. Defendants awarded, and intend to award, those contracts, therefore, in violation of the West Virginia Code and related regulations, which require the use of the competitive bidding process.”).

146. Verified Petition for Injunctive Relief at 2, *Rucker v. W. Va. Dep’t. of Admin.*, No. 15-C-786 (W. Va. Cir. Ct. Apr. 24, 2015). Interestingly, the plaintiffs had standing to sue, claiming it under *State ex rel. E.D.S. Fed. Corp. v. Ginsburg. Id. Ginsburg* noted that when “an unsuccessful bidder or a taxpayer” is challenging the award of a public contract in West Virginia, he or she “must show fraud, collusion, or such an abuse of discretion that it is shocking to the conscience.” *State ex rel. E.D.S. Fed. Corp. v. Ginsburg*, 259 S.E.2d 618, 620 (W. Va. 1979).

147. Verified Petition for Injunctive Relief, *supra* note 146, at 5.

State Medicaid program to a small group of MCOs without subjecting those contracts to competitive bidding.¹⁴⁸

Further, the plaintiffs were not attempting to void the contracts but instead sought an order demanding that the state put the contracts to a competitive bid.¹⁴⁹ Specifically, the plaintiffs were seeking to “enjoin Defendants’ longstanding violation of West Virginia law in the awarding of the State’s managed care contracts, a practice that has dramatically harmed the taxpayers of West Virginia, failed to control healthcare costs, and netted profits for MCOs that vastly outpace those of nearly every other state.”¹⁵⁰ Indeed, the lead plaintiff was quoted as saying that “[t]he requirement for competitive bidding is common sense” and noting that “[j]ust as the average citizen would not buy a car without shopping around for the best deal, state government should not enter into contracts without ensuring that taxpayers get the best deal possible.”¹⁵¹

The West Virginia Department of Health and Human Resources, for its part, denied that its bidding processes violated any laws, and it also noted that under the contractual system in place, its rates could not be decreased without violating federal law.¹⁵² Specifically, West Virginia had “an MLR rebate model” in the contract that “would penalize the plans for not being able to maintain an MLR of 85 percent or more.”¹⁵³ Plans that missed the MLR benchmark were required to “rebate the state the difference,” leading the deputy secretary for public health and insurance to assert that “the idea that competitive bidding would save the state money ‘isn’t realistic’—plans would only submit capitation rates to the state and not a projected MLR,” resulting in the state paying more without any quality care guarantee.¹⁵⁴ Indeed, the state argued that because West Virginia was at an “actuarial floor,” opening the process to a competitive bid may have

148. Complaint and Petition for Writ of Certiorari and Mandamus, *supra* note 145, at 2.

149. *Id.*

150. *Id.*

151. *Taxpayers File for Injunction over No-Bid Contracts in West Virginia’s Medicaid Managed Care Program*, CISION PR NEWSWIRE (Apr. 26, 2015, 6:00 AM), <http://www.prnewswire.com/news-releases/taxpayers-file-for-injunction-over-no-bid-contracts-in-west-virginias-medicaid-managed-care-program-300072143.html> (last visited Sept. 13, 2017). Ms. Rucker, the lead plaintiff, was also quoted as saying the following: “Because Medicaid was not bidding out these contracts, we were losing up to \$100 million a year With this settlement, I think, taxpayers are going to be gaining because we’re going to be saving money, it’s going to be a more transparent system, and we’re going to be a lot more efficient.” Lydia Nuzum, *WV DHHR Medicaid Lawsuit Settlement Means HMO Contracts Must Be Bid Out*, CHARLESTON GAZETTE-MAIL (Nov. 20, 2015, 2:11 PM), http://wvgazette.com/chan-52375381/all_p59.html (last visited Oct. 17, 2017).

152. See Nuzum, *supra* note 151 (quoting the West Virginia Department of Health and Human Resources deputy secretary for public health and insurance as saying “DHHR stands by the position that its contracting practices for Medicaid managed care have complied with federal and state law”).

153. *Id.*

154. *Id.*

resulted in a higher rate for the state, particularly if all the bids that were submitted were higher than the state would have paid under the old regime.¹⁵⁵ Nonetheless, the circuit court judge noted that the West Virginia MCOs were raking in “excessive profits.”¹⁵⁶ According to the petition, the West Virginia Medicaid managed care companies were “realizing profits ranging from 8 percent to 13 percent, compared to a national average of 1.2 percent.”¹⁵⁷

Plaintiffs’ attorney Jesse Forbes quibbled with the state’s characterization that the lawsuit was unnecessary.¹⁵⁸ He cited the possibility that an insurance company could submit a bid that would be higher than the previous MLR requirement.¹⁵⁹ Consequently, the litigation resulted in the possibility that the state could save more money on its Medicaid managed care contracts.¹⁶⁰

Nonetheless, whether beneficial or not, by November of 2015, the targeted state agencies settled the lawsuit with the taxpayer plaintiffs.¹⁶¹ Under the settlement, the West Virginia Bureau for Medical Services agreed to competitively bid all Medicaid managed care contracts beginning in 2017.¹⁶² The settlement also required that the Medicaid program heed all transparency requirements and release annual performance summaries.¹⁶³ The eighty-five percent MLR requirement is still in place under the settlement.¹⁶⁴

155. *Id.* (quoting Jeremiah Samples, the Department of Health and Human Resources deputy secretary for public health and insurance as saying: “If a plan comes in and their proposed rate is well below what an actuary will sign off on, an actuary wouldn’t sign the letter we submit to [the Centers for Medicare & Medicaid Services], and conversely, if they come in at a level that is above the actuarial range, then the same situation would occur The risk in this entire process, and it’s something we’ve said several times, is that, because we’ve been at the actuarial floor, if the plans come in at a higher rate but are still within range, then we could see an increase in the cost of managed care. The notion that there is going to be money saved through this process is—I just don’t understand how people can come to that conclusion”).

156. Richard Stevens, *DHHR Must Bid MCO Contracts*, W. VA. PHARMACISTS ASS’N (Dec. 29, 2015), <http://wvpharmacy.org/2015/12/dhhr-must-bid-mco-contracts/> (last visited Sept. 13, 2017).

157. *Id.*

158. *See* Nuzum, *supra* note 151.

159. *Id.*

160. *See id.*

161. *See id.*

162. *Id.*

163. *See* Nuzum, *supra* note 151; *see also* Brooke Murphy, *West Virginia Medicaid Program Settles Lawsuit Over Managed Care Contracts*, BECKER’S HOSP. REV. (Nov. 23, 2015), <http://www.beckershospitalreview.com/legal-regulatory-issues/west-virginia-medicaid-program-settles-lawsuit-over-managed-care-contracts.html> (last visited Sept. 13, 2017).

164. Nuzum, *supra* note 151; Murphy, *supra* note 163.

B. Iowa

When it comes to the switch to Medicaid managed care, perhaps no state has been as politically volatile and legally salacious as has Iowa.¹⁶⁵ The most explosive allegations were lobbed—specifically that the entire bidding process was “riddled with errors and nepotism,” according to court allegations—during a lawsuit brought by Medicaid managed care providers Aetna, Meridian, and Iowa Total after they lost the Iowa bid.¹⁶⁶

Plaintiffs in the lawsuit alleged that WellCare—one of four companies that ultimately received the Iowa Medicaid managed care contracts (agreements that ultimately “manage the program that provides health care to 560,000 Iowans”)¹⁶⁷—made inappropriate inquiries of state officials. According to litigation reports, the plaintiffs alleged that WellCare “asked two former state lawmakers for assistance in determining who was on the committee that would be evaluating the bids and how it might influence their decisions,” and the lawmakers allegedly responded.¹⁶⁸ Further, the plaintiffs alleged that WellCare was in contact with members of Governor Terry Branstad’s staff during the bid “blackout” period.¹⁶⁹

The state “acknowledged” that the alleged communications of an insurance company official and former state lawmaker with a Department of Human Services consultant did take place “during a critical review period” and were improper, but maintained that the communications “had no bearing on Iowa’s selection of four companies that [were] in line to manage the state’s Medicaid

165. See *Editorial: Connecticut Abandoned Privatized Medicaid*, *supra* note 107; see also Jason Clayworth, *Did Politics Taint Iowa Medicaid Bid Process?*, DES MOINES REG. (Oct. 29, 2015, 8:51 PM), <http://www.desmoinesregister.com/story/news/investigations/2015/10/29/did-politics-taint-iowa-medicaid-bid-process/74799352/> (last visited Sept. 13, 2017) (“A private company that ultimately won a contract to help manage Iowa’s \$4.2 billion Medicaid program asked two former state lawmakers for assistance in determining who was on the committee that would be evaluating the bids and how it might influence their decisions, according to evidence presented in court on Thursday.”).

166. Clayworth, *supra* note 165 (“The evidence was submitted as part of a legal challenge from three companies—Aetna, Meridian and Iowa Total—who were not among those chosen to get the lucrative state contracts and who claim the public bid process behind the largest government privatization effort in state history was riddled with errors and nepotism.”); accord Sarah Boden, *Aetna, WellCare and DHS Spar Over Medicaid Implementation Progress*, IOWA PUB. RADIO (Jan. 14, 2016), <http://iowapublicradio.org/post/aetna-wellcare-and-dhs-spar-over-medicaid-implementation-progress#stream/0> (last visited Sept. 13, 2017) (“Aetna attorney Mark Weinhardt told the court the state’s evaluation process was ‘fatally flawed,’ due in part to the state’s rush to make a selection. He says the ‘irrationality of the scoring process’ was an abuse of discretion by the selection committee.”).

167. Clayworth, *supra* note 165.

168. *Id.*

169. *Id.*

program.”¹⁷⁰ During the litigation, evidence of a “more extensive network of communications between former lawmakers, sitting legislators, the governor’s staff and companies vying for lucrative contracts” to administer the Medicaid managed care contract was made public.¹⁷¹ Repeatedly, the insurance companies that had lost the bid with the state used state emails to allege improper communications.¹⁷²

Some of the allegations against WellCare led to the cancellation of the contract with the state but did not result in the losing bidders being awarded the contract. Indeed, in late 2015, an Iowa administrative judge suggested that “WellCare’s contract be tossed out, citing improper communications between WellCare and state employees” and a failure to disclose both details surrounding a corporate integrity agreement¹⁷³ and “information regarding \$137.5 million in fines to resolve false claims litigation.”¹⁷⁴ WellCare appealed the administrative judge’s decision in early 2016, noting that it had provided additional, clarifying information in response to questions from the state and arguing that state rules that prevented conversations during an RFP were unclear and vague.¹⁷⁵

However, the district court judge upheld the administrative judge’s decision, and WellCare dropped the appeal in mid-February 2016.¹⁷⁶ According to reports surrounding the case, the judge noted that there was “‘substantial evidence’ to support the assertion that WellCare failed to disclose information in its bid,

170. Jason Clayworth, *Iowa DHS: Medicaid Director’s Private Email ‘Improper.’* DES MOINES REG. (Oct. 26, 2015, 7:22 PM), <http://www.desmoinesregister.com/story/news/investigations/2015/10/26/iowa-dhs-medicaid-directors-private-email-improper/74640246/> (last visited Sept. 13, 2017) (“Schulte [the state lawmaker-turned consultant] posted a response to social media shortly after the state selected the winning companies stating that she helped WellCare with its bid, which raised questions about whether she provided the company unfair or insider information.”).

171. Jason Clayworth, *Medicaid Communications Frequent During “Blackout” Time*, DES MOINES REG. (Oct. 30, 2015, 9:30 PM), <http://www.desmoinesregister.com/story/news/investigations/2015/10/30/medicaid-communications-frequent-during-blackout-time/74898374/> (last visited Sept. 13, 2017) (“The emails presented as evidence show WellCare representatives floated specific questions about the work through Michael Bousselot, Branstad’s policy director for human services at the time of the communications with Rants. Bousselot was promoted on July 30 to be the governor’s chief of staff. Attorneys for the plaintiffs contend the communications with Bousselot—frequently referred to simply as MB in the emails—may have given the company a fraudulent edge to win one of the four coveted contracts.”).

172. *See id.*

173. Chelsea Keenan, *WellCare to Drop Appeals of Iowa Medicaid Contract After Judge’s Ruling*, CEDAR RAPIDS GAZETTE (Feb. 16, 2016, 10:00 AM), <http://www.thegazette.com/subject/news/health/district-judge-affirms-iowas-decision-to-toss-out-wellcare-medicaid-contract-20160215> (last visited Sept. 13, 2017).

174. Chelsea Keenan, *WellCare Appeals to District Judge to Keep Iowa Medicaid Contract*, CEDAR RAPIDS GAZETTE (Feb. 1, 2016, 6:59 PM), <http://www.thegazette.com/subject/life/health/health-care/medicaid/wellcare-appeals-to-district-judge-to-keep-iowa-medicaid-contract-20160201> (last visited Sept. 13, 2017).

175. *Id.*

176. Keenan, *supra* note 173.

including the ‘true extent’ of false claims litigations and details of a corporate integrity agreement.”¹⁷⁷ The litigation effectively ended WellCare’s challenge, and the company noted that it was time “to move forward,” according to the company’s senior vice president, chief legal and administrative officer.¹⁷⁸

But the companies that lost the original Medicaid managed care bid did not reap the benefits of WellCare’s exclusion. Meridian Health Plans had its challenge denied, with the judge finding the review “scoring and evaluation to be adequate and logical.”¹⁷⁹ Aetna, which sought to “throw out all . . . winning bids” and “freeze . . . future actions in the privatization plan,” ultimately did not have its delay request granted.¹⁸⁰

Nonetheless, this does not mean that the transition to Medicaid managed care has proceeded smoothly. The initial date of privatization, January 1, 2016, was delayed in December of 2015 by sixty days after CMS noted that it was concerned about a lack of high-quality care and a risk of serious disruptions for beneficiaries.¹⁸¹ According to critics of privatization, including the Iowa Hospital Association, the delay highlighted the haphazard and hasty shift by state administration officials.¹⁸² CMS delayed the move for a second time in late February, approving privatization on April 1, instead of March 1, noting that the new date “provide[d] additional time for Iowa to complete activities.”¹⁸³ Accordingly, on April 1, 2016, Iowa began its privatized Medicaid managed care program, with Amerigroup Iowa, AmeriHealth Caritas Iowa, and UnitedHealthcare of the River Valley serving as plan administrators.¹⁸⁴

But criticism has continued.¹⁸⁵ By the summer of 2016, providers and equipment companies reported that new Medicaid managed care administrators

177. *Id.*

178. *Id.*

179. *Id.*

180. Jason Clayworth, *Companies Challenge Iowa’s Medicaid Recommendation*, DES MOINES REG. (Dec. 2, 2015, 10:25 PM), <http://www.desmoinesregister.com/story/news/health/2015/12/02/companies-challenge-iowas-medicaid-recommendation/76687684/> (last visited Sept. 13, 2017).

181. Tony Leys, *Feds Tell Iowa: Delay Medicaid Privatization by 60 Days*, DES MOINES REG. (Dec. 17, 2015, 1:57 PM), <http://www.desmoinesregister.com/story/news/politics/2015/12/17/feds-tell-iowa-delay-medicaid-privatization-60-days/77495488/> (last visited Sept. 13, 2017).

182. *See id.*

183. Chelsea Keenan, *Feds Delay Start of Iowa Medicaid Changes to April 1*, SIOUX CITY J. (Feb. 23, 2016), http://siouxcityjournal.com/news/state-and-regional/iowa/feds-delay-start-of-iowa-medicaid-changes-to-april/article_4e5a058d-a2fe-51b2-a19e-3138656afabf.html (last visited Sept. 13, 2017) (noting also that the state had made progress since December of 2015).

184. *See* Chelsea Keenan, *Iowa Moves Medicaid over to Managed Care*, CEDAR RAPIDS GAZETTE (Apr. 3, 2016, 6:00 AM), <http://www.thegazette.com/subject/news/health/iowa-moves-medicaid-over-to-managed-care-20160403> (last visited Sept. 13, 2016) (noting the challenges facing the system with a new private administrator).

185. *See supra* notes 2–3 and accompanying text.

were not paying enough for needed services and products.¹⁸⁶ In a 2016 survey, the majority of survey respondents “said they have received lower reimbursement rates than what [was] stated in their contracts,” and “almost 80 percent said they [were] not getting paid on time.”¹⁸⁷ In August 2016, two of the state’s three Medicaid administrators claimed tens of millions of dollars in deficits.¹⁸⁸ By autumn of that year, the state was injecting tens of millions of dollars more into the program by increasing payment rates,¹⁸⁹ and newspapers still reported that the “payment shortages [were] ‘catastrophic’” and “not acceptable.”¹⁹⁰ By the end of 2016, Iowa’s Medicaid administrators had “lost hundreds of millions of dollars on the project”—with the three companies claiming a combined loss of more than \$500 million.¹⁹¹ The companies also criticized a “lack of transparency” in the process, claiming that the state’s Medicaid managed care “rate development process [was] not actuarially sound.”¹⁹²

In early 2017, modifications to the program continued. In March 2017, it was reported that the Iowa Department of Human Services was establishing a

186. See Chelsea Keenan, *Medicaid Payment Challenges Still Plaguing Iowa Health Care Providers*, CEDAR RAPIDS GAZETTE (Aug. 7, 2016, 1:00 AM), <http://www.thegazette.com/subject/news/health/medicaid-payment-challenges-still-plaguing-iowa-health-care-providers-20160807> (last visited Sept. 13, 2017) (“Under the fee-for-service system, Iowa Medicaid reimbursed the company for 85 percent of the suggested retail price on a wheelchair But under managed care, the MCOs are only paying for 10 percent to 50 percent of the retail price.”).

187. *Id.*

188. Sarah McCarthy, *Millions Owed to Iowa Medicaid Providers, According to State Reports*, KCRG-TV9 (Aug. 23, 2016, 6:31 PM), <http://www.kcrg.com/content/news/Millions-owed-to-Iowa-Medicaid-providers-according-to-state-reports-391085411.html> (last visited Sept. 13, 2017) (AmeriHealth Caritas Iowa reported a deficit of more than \$42.6 million, with Amerigroup Iowa reporting a \$66.7 million deficit).

189. William Petroski & Tony Leys, *Branstad Pumps \$33 Million More into Medicaid Privatization*, DES MOINES REG. (Oct. 31, 2016, 4:52 PM), <http://www.desmoinesregister.com/story/news/politics/2016/10/31/branstad-pumps-33-million-more-into-medicare-privatization/93052804/> (last visited Sept. 13, 2017) (reporting the governor said that the program was “more efficient than expected so the state will still meet its goal of \$110 million annually in projected Medicaid cost savings”).

190. Tony Leys, *Iowa Medicaid Payment Shortages are ‘Catastrophic,’ Private Managers Tell State*, DES MOINES REG. (Dec. 21, 2016, 6:27 PM), <http://www.desmoinesregister.com/story/news/health/2016/12/21/iowa-medicare-payment-shortages-catastrophic-private-managers-tell-state/95697880/> (last visited Sept. 13, 2017) (“The for-profit companies running Iowa’s Medicaid program have been complaining to state administrators that the controversial project is ‘drastically underfunded’ and that the situation has been a ‘catastrophic experience,’ newly released documents show.”).

191. *Id.*; accord Chelsea Keenan, *Iowa Offers Medicaid Insurers a Hand When It Comes to Losses*, CEDAR RAPIDS GAZETTE (Mar. 24, 2017, 8:04 PM), <http://www.thegazette.com/subject/news/health/iowa-offers-medicare-insurers-a-hand-when-it-comes-to-losses-20170324> (last visited Sept. 13, 2017).

192. Leys, *supra* note 190.

risk corridor to protect the administrators of the Medicaid private plans from debilitating losses.¹⁹³ The risk corridor program was priced at about \$10 million to the state, but the federal government's share—set to be paid in fiscal year 2019—could be more than \$200 million.¹⁹⁴ The move to managed care continues to be characterized as “highly contentious,”¹⁹⁵ with former Iowa Governor Terry Branstad claiming that the Medicaid privatization has saved the state \$110 million.¹⁹⁶

C. Missouri

In 2012, Missouri had its own contentious litigation. Molina Healthcare, one of the bidders for Missouri's Medicaid managed care contract, alleged that the state “changed the rules in the midst of a competitive bidding process” and also alleged political favoritism, which violated the state competitive bidding law.¹⁹⁷ In the bidding process, Missouri had limited the number of contracts it was awarding from five to three (in an effort to achieve increased leverage with more members per plan).¹⁹⁸ Molina had been in the Missouri market since 2007, but the state awarded the new contract to newcomer Centene, in addition to others.¹⁹⁹

After Molina Healthcare began raising questions, the Missouri Office of Administration responded that there was a “competitive bid process for the managed care contract” and that “[p]oints were awarded for each bid based on quality; the method of performance; organizational experience; and most

193. See Keenan, *supra* note 191.

194. Tony Leys, *Exclusive: Feds' Tab Could Hit \$225 Million to Help Medicaid Firms Cover Iowa Losses*, DES MOINES REG. (Mar. 29, 2017, 10:47 AM), <http://www.desmoinesregister.com/story/news/health/2017/03/29/exclusive-feds-tab-could-hit-225-million-help-medicaid-firms-cover-iowa-losses/99756352/> (last visited Aug. 20, 2017).

195. Mary Caffrey, *GAO Reports on the Benefits of Being a Medicaid Managed Care Official*, AJMC (May 1, 2017), <http://www.ajmc.com/focus-of-the-week/0517/medicaid-managed-care-officials-earn-more-than-medicaid-directors-but-have-easier-jobs-gao-finds> (last visited Sept. 13, 2017) (stating that Iowa “has seen a highly contentious transition to Medicaid managed care”).

196. Chelsea Keenan, *Managed Care Year One: The Iowa Medicaid Program Sees Successes, and Continued Challenges*, CEDAR RAPIDS GAZETTE (Apr. 1, 2017, 11:27 AM), <http://www.thegazette.com/subject/news/health/managed-care-year-one-the-medicaid-program-sees-successes-and-continued-challenges-04012017> (last visited Aug. 20, 2017).

197. Elana Gordon, *Lawsuit Challenges Medicaid Managed Care Decision in Missouri*, KAISER HEALTH NEWS (May 9, 2012), <http://khn.org/news/missouri-medicaid-managed-care-lawsuit/> (last visited Aug. 20, 2017); see also Jason Hancock, *Missouri Medicaid Faces Lawsuit from Molina Healthcare*, KAN. CITY STAR (Apr. 10, 2012, 5:00 AM), <http://www.kansas.com/news/local/article302261/Missouri-Medicaid-faces-lawsuit-from-Molina-Health-care.html> (last visited Aug. 20, 2017).

198. Gordon, *supra* note 197.

199. See *id.*

importantly, access to care.”²⁰⁰ But the *Kansas City Star* reported that Centene was a “major donor” to Governor Jay Nixon, and the House Government Oversight and Accountability Committee said there were “serious questions about the [contract bidding] process.”²⁰¹ According to the report, Centene allegedly made a number of political donations to those in power, including Governor Nixon and his campaign.²⁰²

By May 2012, however, Molina’s lawsuit had been dismissed.²⁰³ Judge B.C. Drumm Jr. of the Cole County Circuit Court found that Molina did not object until it found it was not rewarded with the contract and that it was not the highest-rated company for quality metrics when it was reviewed in 2006 and 2009.²⁰⁴ As a result, coupled with challenges in other states, Molina saw its stock drop precipitously.²⁰⁵

VI. LOOKING FORWARD: COST AND ACCESS

After all of the stories featuring challenges and opportunities for Medicaid managed care, health policy analyses often come down to cost and access. A quick glance at the scorecard and challenges for Medicaid managed care on these points follows immediately follow.

First, on the cost front, conclusions on whether Medicaid managed care saves money for states have been “mixed.”²⁰⁶ For instance, in Florida, moving from traditional Medicaid to managed care has reportedly reduced hospital costs between seven and twelve percent.²⁰⁷ Additionally, Ohio and Arizona have

200. *Id.*; accord Jason Hancock, *Missouri Medicaid Faces Lawsuit from Molina Healthcare*, KAN. CITY STAR (Apr. 10, 2012, 5:00 AM), <http://www.kansascity.com/news/local/article302261/Missouri-Medicaid-faces-lawsuit-from-Molina-Healthcare.html> (last visited Aug. 20, 2017) (“Molina . . . questioned how they scored so poorly in relation to access to care, yet were beat out for the contract by Centene—which currently has no network of doctors and hospitals in the state. ‘More shocking than the results (of the bidding process) was the fact that Molina’s existing network and proud record of quality and performance had been adjudged inferior to plans with no network and no relevant Missouri experience,’ Molina said . . . ‘Such results, so completely out of step with history and present practice, are necessarily suspect and merit a close review.’”).

201. Hancock, *supra* note 200.

202. *Id.* (noting that Centene donated to the Democratic Governors’ Association, Governor Nixon’s campaign, the state attorney general, and the state auditor).

203. See Jim Doyle, *Judge Dismisses Missouri Medicaid Lawsuit*, ST. LOUIS POST-DISPATCH (May 11, 2012), http://www.stltoday.com/business/local/judge-dismisses-missouri-medicaid-law-suit/article_2ce3424a-9bb7-11e1-bb60-001a4bcf6878.html (last visited Aug. 20, 2017).

204. *Id.*

205. Esha Dey & Balaji Sridharan, *Molina Shares Drop on Margin Squeeze in Texas*, REUTERS (June 7, 2012, 8:46 AM), <http://www.reuters.com/article/us-molina-shares-idUSBRE8560QM20120607> (last visited Aug. 20, 2017).

206. R. Cauchi, *Medicaid and Managed Care*, NAT’L CONF. OF STATE LEG. (Oct. 12, 2015), <http://www.ncsl.org/research/health/medicaid-and-managed-care.aspx> (last visited Aug. 20, 2017).

207. Jessica Van Parys, *How Do Managed Care Plans Reduce Healthcare Costs?* 3 (Columbia Univ., Working Paper, 2014), <http://www.columbia.edu/~jnv2106/jvanparys.jmp.pdf>.

reportedly been successful in saving money in the switch to privatization.²⁰⁸ According to reporting:

In Arizona, Medicaid officials estimate they saved nearly \$29.5 billion over the last five years by outsourcing the bulk of their enrollees' health care to private insurers.

Ohio did the same thing, and the results are promising. From 2009 to 2013, it slowed the growth of costs in its \$25 billion Medicaid program from 9 percent to 3 percent. Annual spending has remained relatively flat ever since.²⁰⁹

Health insurance trade groups are also quick to trumpet the savings; according to another study, managed care capitation rates were about ten percent lower than traditional fee-for-service payments in Ohio (according to the health insurance industry)²¹⁰ and will save Texas about four billion dollars in six years (also according to the health insurance industry).²¹¹

Nonetheless, other studies seem to echo the findings that on cost savings, managed care has been mixed. According to key findings from a 2012 Robert Wood Johnson Foundation study: "There is little evidence of national savings from Medicaid managed care, but a few states have had some success. The states that did realize cost savings were more likely to be states with relatively high reimbursement rates under fee-for-service."²¹² Thus, whether or not Medicaid managed care is saving taxpayers substantial money remains a somewhat open question, one that will likely be informed with more data as an increasing number of beneficiaries enroll in Medicaid managed care.

Second, following the release of the new Medicaid managed care regulations in 2016, Professor Sara Rosenbaum identified challenges that continue to face the program.²¹³ These included challenges surrounding access, eligibility and enrollment, payment incentives for reimbursement, alignment with other social supports, and information technology.²¹⁴ Indeed, even given a number of robust

208. See Schorsch, *supra* note 1.

209. *Id.*

210. OHIO ASS'N OF HEALTH PLANS, THE IMPACT OF PRIVATE INDUSTRY ON PUBLIC HEALTH CARE: HOW MANAGED CARE IS RESHAPING MEDICAID IN OHIO 7 (2017), <https://oahp.org/wp-content/uploads/2017/02/The-Impact-of-Private-Industry-on-Public-Health-Care.pdf>.

211. *Study Reveals Cost-Saving Benefits of Medicaid Managed Care*, TEX. ASS'N OF HEALTH PLANS (Feb. 17, 2015), <http://tahp.org/study-reveals-cost-saving-benefits-of-medicaid-managed-care/> (last visited Sept. 13, 2017).

212. M. Sparer, *Medicaid Managed Care*, ROBERT WOOD JOHNSON FOUND. (Sept. 2012), <http://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html> (last visited Sept. 13, 2017).

213. See Sara Rosenbaum, *The Medicaid Managed Care Rule: The Major Challenges States Face*, COMMONWEALTH FUND (May 6, 2016), <http://www.commonwealthfund.org/publications/blog/2016/may/the-medicaid-managed-care-rule> (last visited Aug. 26, 2017).

214. See *id.*

access standards at the state level,²¹⁵ access to quality care remains a potent policy challenge facing Medicaid managed care. The challenge of access is often particularly dire in underserved and rural areas, where hospitals are less likely to join a managed care market because of less competitive marketplaces.²¹⁶

Further, oversight challenges also impact access to care.²¹⁷ Often complicated by a lack of information or incomplete information, Medicaid managed care beneficiaries can often have a difficult time accessing care, even when it is offered and available. According to a recent study by the U.S. Department of Health and Human Services Office of the Inspector General (OIG):

Fifty-one percent of providers could not offer appointments because they were not participating at the listed location . . . or were not accepting new patients enrolled in the plan. This means that Medicaid managed care enrollees may not be able to make appointments with as many as half of the providers listed by their plans.²¹⁸

Finally, as aforementioned, some states' access to care standards are robust, but they are tremendously varied.²¹⁹ This has led the OIG to recommend that

215. See *Medicaid MCO Access Standards: Primary Care*, KAISER FAM. FOUND. (2013), <http://www.kff.org/other/state-indicator/medicaid-mco-access-standards-primary-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Aug. 27, 2017).

216. See, e.g., Virgil Dickson, *Central Illinois Facing Medicaid Network Adequacy 'Crisis,'* MOD. HEALTHCARE (Feb. 14, 2017), <http://www.modernhealthcare.com/article/20170214/NEWS/170219955> (last visited Aug. 26, 2017) (noting that “in more urban areas, the competition is so stiff that hospitals risk losing out on patients if they don't join a managed care network”).

217. See Phil Galewitz, *5 Challenges Facing Medicaid at 50*, U.S. NEWS & WORLD REP. (July 30, 2015, 12:01 AM), <http://www.usnews.com/news/articles/2015/07/30/5-challenges-facing-medicaid-at-50> (last visited Aug. 26, 2017) (noting a 2014 report that “found widespread inaccuracies in Medicaid managed care plans' provider directories,” and that “[h]alf of the doctors listed in the directories were unavailable because providers were not at that location, were not in the plan's network or were no longer taking new patients”); see also DEP'T. OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., ACCESS TO CARE: PROVIDER AVAILABILITY IN MEDICAID MANAGED CARE 13 (Dec. 2014), <https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

218. DEP'T. OF HEALTH & HUMAN SERVS., *supra* note 217, at 8; accord Simon Basseyn & Karin Rhodes, *Ongoing Challenges in Access to Care in Medicaid Managed Care*, PA. UNIV., LEONARD DAVIS INST. OF HEALTH ECONS., (Dec. 12, 2014) <https://ldi.upenn.edu/ongoing-challenges-access-care-medicoid-managed-care> (last visited Aug. 26, 2017) (noting that the report and previous studies seem to indicate “the lower willingness of some providers to see new Medicaid patients in order to maintain a desired payer-mix, even among providers who participate in MMC plans”).

219. DEP'T. OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE 8–12 (2014), <https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf> (noting that the majority of states “limit the distance or time enrollees should have to travel to see a provider,” that “appointments be provided within a certain timeframe,” and that “[t]wenty [s]tates require a minimum number of providers based on the number of enrollees”). Still, as noted, “these standards vary considerably—from 1 primary care provider for every 100

CMS “strengthen its oversight” of states’ access standards.²²⁰ Needless to say, access remains a chief challenge for Medicaid managed care going into the future.

VII. CONCLUSION

In a time of pervasive uncertainty and high anxiety surrounding the American health care system, Medicaid managed care continues its expansion and evolution, championed by states that have seen costs drop and access rise. But challenges remain. Chief among them, states must successfully navigate the often complicated and politically sensitive procurement process in awarding Medicaid bids and successfully tackle access problems. Indeed, Medicaid managed care may not be a panacea to what ails state budgets, but its continued adoption nationwide seems unrelenting. Whether its expanded implementation will ultimately pay off remains complicated in the midst of a uniquely unpredictable era in American health care.

enrollees to 1 for every 2,500 enrollees.” *Id.* at 10. Still other states limit in-office wait time, provide access to multilingual care, provide telephonic access to providers, and “incorporate[] . . . performance measures into its access standards,” like, for example, “requir[ing] that 83 percent of enrollees 1 to 19 years old have had a primary care visit within the previous year.” *Id.* at 12.

220. *Id.* at 19.