

Mismanaged Care

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Managed care dominates America's health care system. The prevailing theory is that private insurers can manage health care delivery and financing with better outcomes and for less cost than Medicare and Medicaid. But actual results have not lived up to the high aspirations and enthusiastic predictions of managed care advocates. Arguably Medicare Advantage (MA) and Medicaid managed care (MMC) created more new problems than they solved. Policymakers should reassess the marketplace managed care has created. A good place to start a review is with Medicaid managed long-term care (MMLTC). LTC users consume a disproportionate share of Medicaid expenditures and the services they use are vital, especially for America's most vulnerable aged, blind and disabled citizens. This essay explains what is at stake and proposes a solution.

Managed Health Care

Managed health care has swept the country. A few decades ago state and federal officials concluded government was paying too much for medical care. Physicians, hospitals and other providers charged steadily higher fees for their services. Yet care quality did not improve commensurate with the greater costs. So, the powers-that-be concluded that something had to be done to control costs and improve outcomes. They decided to turn over care delivery to private insurers and pay them a set monthly fee covering all needed services for each patient these managed care organizations (MCOs) enrolled.

This new managed care approach became an option called Medicare Advantage that beneficiaries could choose voluntarily. Most did. Today MA covers [over half](#) of all people receiving Medicare benefits. Managed care for Medicaid recipients operates differently. State Medicaid agencies opt to use managed care or a traditional fee-for-service system or a combination of both. Managed care is even more prevalent in Medicaid than Medicare. [Four of five](#) Medicaid recipients are covered, mostly involuntarily, by MMC.

Medicaid Managed Care

Understanding MMC is important because of Medicaid's outsized role in the U.S. health care system. Program [enrollment spans](#) 9.5 percent of the population in Utah to as high as 33.1 percent in California with a national average of 21.7 percent. Medicaid accounted for [18 percent](#) of U.S. health care spending in 2022, reaching \$900.3 billion in FY2023, of which \$619.9 billion was federal (68.9 percent) and \$280.4 billion was state spending (31.1 percent). With more than one in five Americans receiving Medicaid and 80 percent of them relying on MMC, it behooves policy makers to assess the benefits and disadvantages of managed care conscientiously.

A special case that starkly illuminates the pros and cons of managed care is Medicaid LTC, also known as long-term services and supports (LTSS). Medicaid managed care permeates LTC service delivery and financing with [24 states](#) having adopted it. LTC is special because its

principal users, the aged, blind and disabled (ABD), are only [19 percent of Medicaid enrollees, but they consume over 51 percent of total program expenditures](#). Likewise, while Medicaid LTC users are [only six percent of enrollees, they use up 37 percent of spending](#). Whether managed care is a boon or bane is crucial to consider as it affects quality and cost in vital Medicaid LTC services and financing.

Benefits and Disadvantages of Managed LTC

Benefits

Advocates make [elaborate claims](#) for managed LTC's advantages. They highlight better than expected health outcomes, higher cost efficiency, and improved access to home and community-based services (HCBS). They attribute these benefits to managed care's superior care coordination and emphasis on preventive care. Presumably, compared to fee-for-service systems, private MMLTC plans apply improved quality standards, minimize unnecessary hospitalizations, expand services to more supportive, less institutional environments, manage complex health needs more effectively and apply rigorous oversight, ensuring that care meets quality benchmarks more often.

Unfortunately, rigorous multi-state evaluations show that objective, empirical evidence supporting these claims is mixed, inconclusive, or absent. See [here](#) and [here](#). MMLTC programs rarely produce uniform savings or superior clinical outcomes compared to fee for service (FFS). Some states show modest shifts toward HCBS, but results vary widely. MMLTC transfers administrative burdens to home care agencies and long-term care providers leading to increased billing friction, delayed service authorizations, and operational disruptions. Independent researchers repeatedly note that a primary obstacle to proving MMLTC's superiority is a [lack of standardized, high-quality data across MCOs](#) to track quality metrics, hospitalization rates, and true state net savings rigorously over time.

Disadvantages

By inserting MCOs between patients and providers, MMLTC introduces an extra layer of management, creates potential pre-authorization obstacles, and complicates billing procedures that can interfere with access to care. Nursing homes, assisted living facilities, home health agencies and direct-care workers may encounter inconsistent credentialing requirements across multiple MCO plans, delayed claims processing, and reduced reimbursement margins. Because MCOs bear financial risk, they are prone to aggressive utilization controls intended to preserve or maximize their profits. They may avoid high-need, high-cost enrollees likely to require intensive long-term services. Studies frequently point to [gaps in MCO network adequacy](#), particularly in rural or underserved areas. MCO encounter data can be incomplete, inconsistent, or difficult for state regulators and independent researchers to audit, because it is not based on individual claims data as in FFS systems. Enforcement of network adequacy, quality standards, and beneficiary appeals varies widely among states, leading to inconsistent beneficiary protections. Despite MMLTCs objective to rebalance care from nursing homes to home care, research shows that budget limits and workforce shortages frequently lead to cutting home care hours or delays in service.

Managed Care Theory's Flaw

Clearly, Medicaid managed care and Medicaid managed LTC have not performed at the high success levels their advocates predicted. The theory that converting from FFS to capitated care would save money, increase HCBS significantly, and improve efficiency disappointed in practice. While policymakers and program administrators work assiduously to make managed health care perform as well as possible in the face of these challenges, they should also consider whether the basic approach is defective and a completely different strategy is needed.

Managed health care's essential problem is that it addressed **symptoms, not causes**. High costs and increasing overruns were never intrinsic to fee-for-service reimbursement. In fact, exactly the opposite is true. In a market where most transactions occur between individual voluntary buyers and sellers, competition for customers tends to keep prices down and quality up. But such a market is exactly what managed health care counteracts. Instead, big private insurers with strong incentives to maximize the system's structural advantages stand in between patients who need care and the providers who deliver it.

Under managed care, transactions take place between giant corporate and government entities. Individuals have no way to vote with their health and LTC dollars for the kind and venue of care they prefer. Consequently, critical price data are not generated. Without price data, businesses and entrepreneurs have no way to discern what consumers want. They lack market signals on how to invest their capital to maximize customers' satisfaction and, therefore, their own profits. Instead of the market compiling information produced by millions of purchase decisions made by consumers choosing the service and provider they prefer, managed care delivers the LTC service and financing system that corporate and government bureaucrats, representing rent-seeking individuals and enterprises, prefer. Consequently, managed care's high ambitions succumb to self-interested central planning and micromanagement.

Third Party Funding is the Underlying Problem

If fee-for-service financing is the solution, not the problem, how did managed care theory get it so wrong? Most health care, including almost all LTC, is funded by third parties. Private insurance and government entitlement programs supply most of the payments to LTC providers. [For example](#), in 2024 Medicaid paid 44.6 percent of LTC costs; Medicare, 15.2 percent; private insurance, 10.9 percent (mostly major medical, not specialized LTC insurance); other payers (also third parties), 16.5 percent. Private out-of-pocket LTC spending amounted to only 12.7 percent, half of which was spend-through of Social Security income by current Medicaid recipients, not spend down of savings.

Thus, the bulk of LTC spending comes through third parties all of whom have incentives to maximize their returns. State Medicaid programs seek to increase their share of federal funding, often using [legalized money laundering](#) methods such as provider taxes and state-directed payments. MCOs seek low-care, high profit enrollees, potentially short changing higher need patients. Providers struggle to render adequate care in the face of notoriously low Medicaid

reimbursement and MCO roadblocks. Consumers have so little skin in this game that their preferences and best interests get lost in the process.

What Can Be Done?

If the fundamental problem is third party financing that creates perverse incentives for self-dealing by the major LTC players, then the answer has to be radical change. Minimize third party payments from public programs. Target Medicaid's scarce resources to the truly needy. Divert people early from Medicaid dependency to reduce eventual Medicaid and Medicare payments for "dual eligibles." Ensure that most people most of the time pay directly for the kind and venue of care they choose. When they truly face financial risk, most people will save, invest or insure for LTC. In time, a true LTC market will develop that generates the price data needed to help businesses identify and meet consumers' needs and preferences.

But how can a freer LTC market like this be achieved? Step one is to wean the public off Medicaid. Close the loopholes that allow high income and high asset people both to qualify for benefits and to co-opt the best care available by paying privately before converting to Medicaid. Two papers explain how to [close the loopholes](#) and find the [\\$97 trillion](#), currently lying fallow in the economy, to fund this new LTC market. Neither the solution nor the private funds to pay for it are lacking. What's missing is the political will to act. But the needed resolve may come someday soon as the U.S. government spirals toward insolvency. When it can no longer service its \$40+ trillion debt, far tougher fiscal challenges will emerge than funding LTC. Most important for now is to understand why the current LTC market performs so poorly and what's needed to fix it when the opportunity to act finally arrives.