Managed Care Is Not the Right Solution for Budget Balancing and Colorado Medicaid

What is Managed Care Generally?

Managed care is an alternative to the traditional fee-for-service healthcare system, designed to contain costs while maintaining quality of care. Managed care systems have evolved over time and now include private and public (Medicaid) managed care models. Both utilize similar financial cost-containment tools and contract with nongovernmental "Managed Care Organizations (MCOs)" to manage and coordinate how patients access medical services.

Medicaid managed care systems are state-funded and serve Medicaid eligible populations. Medicaid is the exclusive provider of Long-Term Services and Supports (LTSS), which are essential health care services for people with disabilities needing institutional levels of care in nursing facilities and in community settings. Community administered LTSS benefits are called Home and Community-Based Services (HCBS).

Hasn't Colorado Tried Medicaid Managed Care Systems in the past?

Yes. Colorado has experimented with Medicaid managed care with disastrous outcomes for patients and providers. Colorado began experimenting with Medicaid managed care models and contracted with private MCOs in the 1990s with SB 97-005, the "Managed Care Bill." Problems arose quickly. One MCO filed a breach of contract lawsuit against the Colorado Department of Healthcare Policy and Financing (HCPF). After prevailing in court and costing the state $15 million in damages, the MCO abruptly left Colorado, causing significant instability in available medical services for people with disabilities receiving LTSS benefits.[1] Several years later, another MCO had to lower its provider reimbursement rates after revealing that "accounting errors and unanticipated membership growth" caused $3.37 million in losses FY 2000-01.[2] The resulting contraction in Medicaid services again disproportionately affected people with disabilities on LTSS benefits, who suddenly faced substantial decreases in, or loss of, Medicaid services.Indeed, whenever Colorado has tried to use managed care, costs increase but quality of care doesn't.

More recently in 2011, 2018, and 2025, Colorado launched Accountable Care Collaborative (ACC) Phases I, II, and III, respectively, adding Regional Care Collaborative Organizations (RCCOs) and Regional Accountable Entities (RAEs). But the ACC is not a managed care system. It seeks to manage care, but not through restricting provider access or using excessive utilization management. And while there's room to improve, initiatives like ACC are more appropriate ways to manage Medicaid costs and services than managed care systems.

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[1] *See Rocky Mountain Health Maintenance Org., Inc. v. Colorado Dep't of Health Care Pol'y & Financing ex rel. Rizzuto*, 54 P.3d 913 (Colo. App. 2001).

[2] https://kffhealthnews.org/morning-breakout/dr00006814/

How Do Medicaid Managed Care Systems' Financial Tools and Operational Structures Work?

Financially, MCOs negotiate rates with providers internally while leveraging "capitation" and "utilization management" as cost-containment tools. Structurally, MCOs use Primary Care Physicians to provide traditional and preventative care while referring patients to limited provider networks of privately contracted specialists, hospitals, and vendors. These financial and structural aspects of managed care operations, and how they disproportionately harm people with disabilities on LTSS, are discussed in turn.

How are "Capitation" and "Utilization Review" used by MCOs to control costs?

MCOs use "capitation" and "utilization review" to cut costs while theoretically maintaining the same quality of care as the traditional fee-for-service model. **Capitation** is a payment method where an MCO pays medical providers a fixed amount per period of time for each patient they are assigned (usually per person per month), regardless of the amount of services those patients actually need and use. These fixed amounts are determined by "actuarial assumptions" that predict future costs for enrolled patients' medical services based on demographic, utilization, and financial assumptions. If patients need more services than expected, MCOs absorb the excess cost of those services at a loss or don't provide them. Conversely, if patients use fewer services than predicted, MCOs keep the remaining funds as profit. Because Medicaid MCOs are funded by state and federal tax dollars, losses translate to deficits and decreased access to care while profits translate to wasted tax dollars.

Utilization review is a standardized process used by MCOs to gauge the medical necessity and quantity of services made available to patients. Medical necessity is purportedly determined pursuant to universally accepted standards of care and treatments in the medical profession. Determinations almost always take the form of Prior Authorization Request (PAR) reviews.

While capitation and utilization review are marketed as cost efficiency and accountability tools by MCOs, the data suggest otherwise. Importantly here, modern day MCOs are increasingly run by for-profit, publicly traded companies like United Healthcare and Deloitte. These companies employ proprietary algorithms and artificial intelligence platforms to conduct tasks like eligibility determinations, PAR reviews, and dissemination of notices to Medicaid beneficiaries. MCOs' algorithmic tools are implemented without effective state oversight or accountability and are difficult to understand. Processes that were historically undertaken by humans now rely on large-scale data analysis to make predictions and determinations. As many states have found out the hard way, transferring the management and administration of their Medicaid system to private management has led to serious and systemic problems.

Therefore, whereas some errors in capitation and utilization review can be logically explained, others may be attributed to legitimate "computer error." Still other "errors" undoubtedly occur because, in addition to their contractual duties with the state, MCOs have a fiduciary duty to their shareholders to maximize profits wherever possible. These dual and often duelling duties have played a part in the fact that MCO-driven Medicaid managed care implementation has paralleled damning audits and class action lawsuits in states from Tennessee to Rhode Island – most of which reveal serious harm to people with disabilities arising from decreased or lost LTSS benefits.

Do Capitation and Utilization Review Harm People with Disabilities on Medicaid LTSS/HCBS?

Yes. Capitation and utilization review both yield decreased benefits that lead to worse health outcomes for people with disabilities on LTSS benefits. Insufficiently low capitations often result from "one-size-fits-all" calculations that pool LTSS and non-LTSS patients together. Since people with disabilities utilizing HCBS/LTSS represent small percentages of Medicaid enrollees but incur significantly higher healthcare costs, capitation models misrepresent per capita allocations and underfund those benefits. But even with reduced capitation amounts available, MCOs reduce reimbursement rates for providers, particularly in HCBS settings. Compounding this, utilization review is leveraged by MCOs to withhold and arbitrarily deny LTSS/HCBS benefits to secure greater profits.

Recent data illustrate why capitation diminished available LTSS funds for people with disabilities in Medicaid managed care systems. Nationally in 2020, Medicaid LTSS recipients comprised just 6% of national Medicaid enrollment but 37% of federal and state Medicaid spending.[3] Annual per capita spending for LTSS enrollees was $38,769 versus $4,480 for non-LTSS enrollees during the same time period.[4] Similarly in Colorado FY 2023-24, Medicaid LTSS recipients represented 4.7% of enrollment and 42% of total costs.[5] Per capita, Colorado Medicaid LTSS recipients cost $6,514/month versus $47/month for non-LTSS recipients during the same time period.[6] These discrepancies in proportional costs between Medicaid LTSS enrollees and non-LTSS enrollees show how actuarial assumptions underestimating LTSS service demand can lead to capitated funds falling short of actual LTSS need depending on number of LTSS enrollees in the patient population. Resulting fiscal deficits decrease available services and increased medical costs from acute care like hospitalizations. the risk of unnecessary institutionalization. And to make matters worse, costlier institutional care adds budgetary pressures: average institutional cost per capita averaged $47,279/year in 2020.[7]

Lower rates/services/errors in ILLINOIS.[8]

Furthermore, MCOs' profit incentives have led to disproportionate PAR denials, decreased available services, and outright fraud – indicating serious problems with, and weaponization of, utilization review. Increasingly, publicly traded, for-profit firms populate the MCO marketplace. As of 2022, five Fortune 500 companies had 50% of the Medicaid MCO market.[9] As these Companies became increasingly prevalent in Medicaid managed care systems, profit maximization prevails over quality of care. A recent national OIG investigation found temporally correlated trends of Medicaid MCO PAR denial rates increasing to over two times that of industry standards: in 2019, Medicaid MCO PAR denial rates averaged 12.5% compared to 5.7% over the same period for Medicare Advantage. And 2.7 million people were enrolled in MCOs with PAR denial rates greater than 25%. Numerous surveyed MCOs (all of which

[3] https://www.kff.org/medicaid/issue-brief/how-many-people-use-medicaid-long-term-services-and-supports-and-how-much-does-medicaid-spend-on-those-people/
[4] *Id.*
[5] https://hcpf.colorado.gov/sites/hcpf/files/IHSS%20Legislative%20Report%202023-2024%20-B.pdf
[6] *Id.*
[7] https://www.kff.org/medicaid/issue-brief/how-many-people-use-medicaid-long-term-services-and-supports-and-how-much-does-medicaid-spend-on-those-people/
[8] https://illinoiscomptroller.gov/__media/sites/comptroller/FF-2019-05_web.pdf
[9] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

were operated by publicly traded, for-profit companies like Molina Healthcare, UnitedHealthcare, and Anthem) had PAR denial rates ranging up to 41%.

A good case study for this national trend is in New York State, where the New York Legal Assistance Group audited the Medicaid managed care program providing nearly 300,000 people with disabilities capitated LTSS benefits in a system expending $15.5 billion in 2020.[10] The Project revealed that alarming percentages of people with disabilities enrolled in LTSS programs received no long-term care services whatsoever in 2018, with large variations between MCO and state region. Furthermore, most MCO plans authorized minimal amounts of home health care hours, with a distribution curve resembling "a cliff" when looking towards higher weekly home health care hour allotments. For perspective, 9 MCO LTSS plans authorized less than 80 hours per month for more than 50% of their statewide enrollees. Finally, most MCO LTSS plans made substantial profits, even after paying all "administrative expenses," which included salaries, rent, advertising, marketing, contributions and donations, lobbying expenses, entertainment costs, interest, fines and penalties, and state income taxes. Five MCO plans made over $30 million, with one MCO making $69 million.

Thus, capitation and utilization review lead to lower available funds for LTSS in the face of increased costs and barriers to care. Instead of managing costs and assuring quality of care, Medicaid managed care incentivizes MCO profits that result from financial tools and associated incentives in those healthcare systems.

How Do Medicaid Managed Care Model Structures Harm People with Disabilities on LTSS Benefits?

Available data universally suggest that people with disabilities prefer to live in community settings whenever possible, where they have better health outcomes at lower cost. Despite these realities, Medicaid managed care would bring Colorado in the opposite direction, increasing risk of unnecessary institutionalization for people with disabilities and providing outsized financial benefits for investors in private MCOs.

In 1988, almost 90% of Medicaid LTSS funds were spent on institutional care in nursing facilities. But as state Medicaid programs began to shift resources towards community integration and HCBS, the percentage of LTSS spent on HCBS jumped from 12% in FY 1988 to almost 60% in FY 2019, reflecting a clear preference among people with disabilities to live outside of nursing facilities in community settings if provided resources to do so.[11] Recent data reveal more than 3 million Americans receive HCBS through 1915(c) waivers and 2.5 million through Medicaid State plans.[12] As alluded to above, this is more cost-effective. Average annual LTSS costs for seniors and adults with physical disabilities in community settings is $18,000/year relative to $73,000/year in institutional settings.[13]

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[10] https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf
[11] Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019." Chicago, IL: Mathematica, December 9, 2021.
[12]https://www.healthaffairs.org/content/forefront/medicaid-home-and-community-based-services-and-supports-can-chart-pathways-independence
[13] *Id.*

In Colorado, the recent DOJ investigation found that HCPF "has consistently acknowledged that community-based care is more cost-effective than nursing facility care while yielding better health outcomes."[14] In 2019, HCPF spent more than $1.25 billion to serve approximately 15,000 nursing facility residents while spending $457,186,592 to serve approximately 29,000 EBD waiver recipients in community settings.[15] Ensuing state initiatives to integrate people with disabilities into community settings continued to show both cost-effectiveness and preference. Despite a 9.44% increases in enrollment and an associated 28% increase in net costs, HCBS still generate cost savings compared to institutional alternatives: the cumulative average per capita expense for all HCBS services under EBD and CIH waivers for FY 2023-24 was $69,673/year while the institutional LTSS per capita expense was $103,287/year.[16] And in FY 2023-24, 56,370 Coloradans with disabilities received HCBS in preferred community settings, representing 65% of the total LTSS population.[17]

However, despite clear consumer preferences and cost-effectiveness, Medicaid managed care often leads to increased institutional care for people with disabilities at the expense of preferred HCBS. This occurs for several reasons, none of which include people with disabilities' interests or health care outcomes.

First, restricted access to certain MCO-contracted providers and reduced pay rates for community care providers limit the number of available HCBS services, leading to provider and caregiver shortages. In Texas, an investigation found that the MCO home healthcare system was "disastrously underfunded," leading to overworked, unqualified, and underpaid caregivers – a deadly combination that resulted in tens of thousands of allegations of abuse and neglect among people with disabilities in community settings.[18] MCOs also delay or deny PARs for HCBS like home health care, impose strict limits on allotted hours of care, and fail to approve appropriate pay rates for community caregivers. These restrictions played out in Tennessee's Medicaid managed care program called TennCare and forced many people with disabilities out of their homes and into nursing facilities.[19] Exclusionary effects on available HCBS providers are particularly pronounced in rural areas – a challenge Colorado knows all too well.

In this sense, Medicaid managed care will only amplify existing discrepancies between urban and rural community settings regarding (1) availability and quality of health care providers (particularly specialists and safety net providers), (2) medical transportation, (3) available and competent caregivers, and (3) administrative inefficiencies that lead to longer wait times for critical care. Medicaid managed care systems have myriad examples of rural safety-net institutions experiencing increases in workload and financial stress.[20] Mental health services have been among the hardest hit rural healthcare sectors. As of September 2024, 61.85% of mental health professional shortages were located in rural areas.[21] Unmet

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[14] https://archive.ada.gov/olmstead/documents/colorado_lof.pdf
[15] *Id.*
[16] https://hcpf.colorado.gov/sites/hcpf/files/IHSS%20Legislative%20Report%202023-2024%20-B.pdf
[17] *Id.*
[18] https://www.statesman.com/in-depth/news/investigates/2022/09/22/texas-medicaid-waiver-system-for-disabled-issues-of-abuse-neglect-death/68304630007/
[19] https://www.reuters.com/legal/government/tennessee-wrongly-kicked-thousands-off-medicaid-judge-rules-2024-08-27/
[20] https://pmc.ncbi.nlm.nih.gov/articles/PMC1447124/
[21] https://www.ruralhealthinfo.org/topics/healthcare-access

medical needs have expansive impacts, and are documented to increase stress, worsening mental health, decreased physical and financial independence, and decreased community economic activity.[22]

Furthermore, MCOs' documented relationships with the nursing facility industry underscore how managed care systems would direct Colorado Medicaid dollars into nursing facilities owned by MCO-affiliated corporations. MCOs reinforce an institutional system with significant lobbying power that secures Medicaid funding to nursing facilities at the expense of preferred community settings. MCOs' business partnerships with nursing facilities would generate continued administrative sabotage and underfunding of competing HCBS providers. Resulting reductions in access to community-based services for people with disabilities often lead to unnecessary institutionalization and increased MCO profit margins.

For example, a Florida class action lawsuit filed in 2024 revealed how the state's managed care plans have unilaterally and illegally sabotaged people with disabilities living in community settings. The plaintiffs experienced puzzling reductions or outright denials of critical services that ignore actual needs while using criteria not found in any rule. The plaintiffs also reported having encountered misleading or vague notices, inaccurate assessments, and a variety of tactics to prevent them from being informed – tactics that were systemic.[23] These issues are systemic throughout Medicaid managed care plans across the country. A 2021 study by the Urban Institute highlighted the administrative complexities and bureaucratic hurdles within many Medicaid managed care systems that led to delays and unmet needs for essential services.[24] MCO-generated barriers to care have caused many people with disabilities to be institutionalized.

Thus, Medicaid managed care is structurally deficient because it is self-serving. MCOs create limited provider networks, decrease critical services, and inherently favor institutionalized care for people with disabilities needing LTSS. While this may boost MCO shareholder profits, the Medicaid managed care model produces dangerous and costly outcomes for patients including hospitalizations, neglect, HCBS waiver waiting lists, and/or increased institutionalization.

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Taken together, Medicaid managed care's financial and structural deficiencies would only exacerbate Colorado's existing Medicaid budgetary deficit. Because MCOs have every incentive to promote profits at the expense of community-based health care, Medicaid managed care would drive up Colorado's health care costs for people with disabilities, limit their autonomy, and reverse decades of increased community integration pursuant to *Olmstead*. While this suite of outcomes is bad enough *without* imminent budget

[22]https://www.urban.org/sites/default/files/2024-03/Insights%20from%20Nonelderly%20Adults%20with%20Disabilities%20on%20Difficulties%20Obtaining%20Home-%20and%20Community-Based%20Services%20and%20Other%20Health%20Care.pdf

[23]https://static1.squarespace.com/static/6283b20d7013340d81fd360f/t/66f1bd26ceb0705eec51e8d7/1727118631238/1+Complaint-Grant+v+Weida.pdf

[24]https://www.urban.org/sites/default/files/2024-03/Insights%20from%20Nonelderly%20Adults%20with%20Disabilities%20on%20Difficulties%20Obtaining%20Home-%20and%20Community-Based%20Services%20and%20Other%20Health%20Care.pdf

cuts, it is certainly antithetical to the "cost-effective, quality healthcare" outcomes that managed care models are being introduced to achieve.

Most importantly, the negative effects of Medicaid managed care systems discussed above contradict HCPF's stated goals and initiatives as communicated to the Joint Budget Committee in the 2025 legislative session.[25] Some of these goals include: (1) expanding provider networks to include more behavioral health providers, specialists, and rural resources; (2) transforming HCBS for people with disabilities; (3) stabilizing the LTSS ecosystem; (4) better managing Medicaid costs; (5) ensuring appropriate Medicaid payments in balancing provider administration; (6) preventing avoidable ER visits and hospital care; (7) protecting member coverage affordability, benefits and services; and (8) strengthening the transition processes integrating people with disabilities into community settings.[26] Outsourcing Medicaid administration to MCOs concurrent with HCPF's post-PHE Unwind goals and initiatives would be self-defeating to say the least, especially considering Colorado's past issues with Medicaid managed care.

Generally, while a Medicaid managed care system may seem like a useful option to cut costs amidst the current budget crisis, the objective realities and available data clearly demonstrate that managed care is impractical for Coloradans with disabilities utilizing LTSS benefits and antithetical to long run fiscal sustainability.

Real-World Examples of Harm from Medicaid Managed Care

1. North Carolina's Attempts at MCO Reform[27]

- Delays in the state's Medicaid program have some people waiting weeks or months for care. There are also reports of people dying as they wait to be assessed for services, according to Disability Rights North Carolina.
- According to the state's $24 million no-bid contract with Carolinas Center for Medical Excellence, assessments and patient notification should occur within 14 days. It has been more than five months for Edna Street.
- Cheryl Burleson works for a local health care company that provides in-home care. She says Edna Street has fallen through the cracks. "The amount of time is absolutely unacceptable," she said. "Once it hit the state level, it got lost in the big black hole ... I think they implemented a system before it was ready to roll."

[25] https://leg.colorado.gov/sites/default/files/images/hcpf_smart_act_2024_.pdf
[26] *Id.*
[27] https://www.wral.com/news/local/wral_investigates/story/8570273/

2. Connecticut's Non-Emergency Medical Transportation (NEMT) Program[28]

In Connecticut, changes to the NEMT program, which provides transportation for Medicaid recipients to medical appointments, led to significant challenges:

- **Service Reliability**: The shift to a brokered system that utilized ride-sharing services like Uber and Lyft resulted in unreliable transportation, causing patients to miss critical medical appointments.
- **Impact on Vulnerable Populations**: Individuals with complex medical or mental health needs were particularly affected, facing increased difficulties in accessing necessary care.

3. South Carolina's Group Homes for Individuals with Mental Illnesses[29]

A federal lawsuit against South Carolina alleged that the state's reliance on group homes for individuals with serious mental illnesses limited their opportunities for independent living:

- **Lack of Community Integration**: Residents in these group homes had minimal interaction with the broader community and limited support for achieving independence.
- **Insufficient Support Programs**: The state lacked adequate funding and support for assertive community treatment programs, which are essential for helping individuals transition to independent living.

5. Service Reductions in Florida[30]

- The implementation of Florida's Statewide Medicaid Managed Care Long-term Care Program led to arbitrary service reductions for individuals with disabilities. Inadequate care planning and lack of information about available services placed beneficiaries at risk of unnecessary institutionalization.

6. TennCare Block Grant Structure Funding Jeopardizes Benefits for People with Disabilities[31]

- On January 8, 2021, CMS approved TennCare's block grant. Disability Rights Tennessee (DRT) has stated previously in public comment and maintains that this change in funding structure has grave consequences for Tennessee and those insured by TennCare.
- The implementation of the TennCare III waiver allowed the state to adopt a closed prescription drug formulary, limiting the range of medications covered, particularly specialty drugs required by individuals with disabilities, restricting access to necessary treatments.
- As initially predicted by DRT, this resulted in a class action lawsuit against TennCare.

7. High Rates of PAR Denials[32]

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[28] https://www.ctinsider.com/opinion/article/medicaid-amann-ct-transportation-20199744.php

[29] https://apnews.com/article/federal-lawsuit-mental-health-south-carolina-homes-506523f9be9a9f2232363e94d1ff29ef

[30] https://disabilityrightsflorida.org/newsroom/story/medicaid_beneficiaries_sue_over_implementation_of_medicaid_managed_care_pro

[31] https://www.disabilityrightstn.org/drt-opposes-cms-approval-of-tenncare-medicaid-service-to-block-grant/

[32] https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf

- A 2023 report revealed that certain Medicaid managed care plans, particularly those operated by Molina Healthcare, denied over 25% of prior authorization requests in 2019. Such high denial rates can significantly hinder access to necessary medical services for individuals with disabilities.

8. Complicated Administrative Medicaid Processes Nationwide[33]

- Individuals with disabilities often face complex and burdensome Medicaid application and renewal processes. These challenges can lead to delays or loss of essential services, impacting their health and well-being.
- Frances, a self-advocate from Colorado, has received Medicaid for over 40 years. Still, she encounters many difficulties in navigating the Medicaid system. According to Frances, "It is frustrating because I do not know what my co-pay is on a doctor visit and I will receive a bill that I do not understand. When I call to ask for more information, it is often hard to talk to a person and get a call back when I leave a message."
  Many people on Medicaid are required to reapply or prove they are still eligible for services on a yearly or even semi-annual basis. For Frances, this is the biggest barrier. "I have to work with the Department of Human Services and submit proof of housing and income," she says. "But because they are not meeting with people in person, I have to fax these documents, and it is very difficult to get a hold of someone at the office to do this. I wish I could submit this paperwork in person."

9. Division of Services for People with Disabilities (DSPD) Difficulties Funding HCBS in Utah[34]

- There are more than 3,200 Utah families on the wait-list for help caring for a loved one with a disability. The funding comes through the Division of Services for People with Disabilities (DSPD), and for some, the wait-list is now 10 years long.
- Fred Tripeny is 15 and has a complex medical history; he was diagnosed in the womb with hydrocephalus and eventually was diagnosed with cerebral palsy and autism. His mother Mary Tripeny is his primary caregiver. She explained, "He's developmentally delayed which is frustrating but he's a dear to be around, he brings joy to everybody's life." After five years of waiting, Fred is number 243 on the waiting list.

10. Texas STAR+PLUS Medicaid Waiver (2021): Capitation rates were too low to cover high-need enrollees, leading MCOs to cut funding for in-home nursing and personal care services.

Examples from Sen. Robert Casey's April 4, 2019 Letter[35] to the Inspector General of DHHS

11. Superior Health Plan, a subsidiary of Centene, denied round-the-clock nursing care to D'ashon Morris, a child who needed a tracheostomy tube to help him breathe. Because D'ashon was a toddler, who would routinely pull out his tracheostomy tube, his doctors and nurses recommended around-theclock nursing care to ensure his health and safety. Superior Health Plan denied that request. As his nurses warned, D'ashon pulled out his tracheostomy tube during one of the hours when he was without direct

[33] https://thearc.org/blog/using-medicaid-is-complicated-that-hurts-people-with-disabilities/
[34] https://www.abc4.com/news/disability-funding-crisis-a-special-report/
[35] https://www.ancor.org/wp-content/uploads/2022/08/Casey_Letter_HHS_OIG_Medicaid_Managed_Care.pdf

care and spent so much time without oxygen that he now has limited brain function. His quality of life was severely affected by Superior Health Plan's denial of care.[36]

12. In addition to heart breaking stores like D'ashon's, there are allegations of other MCOs systematically denying coverage for claims or pressuring employees to deny high-cost requests for coverage. The Des Moines Register investigated the practices of Medicaid MCOs in Iowa and found routine denials of care, endless appeals and numerous failures by MCOs to provide timely notification to people with Medicaid of their right to appeal.[37]

13. In another case, the Medicaid MCO, Amerigroup, denied access to regular in-home medical services to Betty Frink, a woman with pancreatic cancer who was homebound and needed nurses or social workers to help assess her pain levels, diabetic management and other medical conditions. After being denied care, and several appeals, a District Court judge finally found that Amerigroup's decision to deny Betty's care was "unreasonable, arbitrary, capricious or an abuse of discretion."[38]

[36] Dallas Morning News, Pain & Profit: Investigating Medicaid Managed Care in Texas (June 2018) (https://www.dallasnews.com/news/medicaid-managed-care/collection/pain-profit-investigating-medicaid-managedcare-texas).
[37] Des Moines Register, Care Denied: How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals (2018) (http://features.desmoinesregister.com/news/medicaid-denials/).
[38] https://www.ancor.org/wp-content/uploads/2022/08/Casey_Letter_HHS_OIG_Medicaid_Managed_Care.pdf