COMMENT

HOW RELATIONAL CONTRACTING CAN ADDRESS MEDICAID LONG-TERM CARE’S ACCOUNTABILITY CRISIS

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States have outsourced long-term care (LTC) for many of the nation’s most vulnerable to privately-run insurers called managed care organizations (MCOs). The primary payer for LTC is Medicaid, which spends around $200 billion on LTC—a massive figure representing nearly one percent of U.S. gross domestic product. When a state Medicaid program outsources, MCOs receive a per person (capitated) payment to provide services. States leveraging MCOs have grown rapidly, up to about half of states from just eight in 2004. The broad shift to MCO control creates barriers, however, to beneficiaries attempting to access vital care, such as help getting dressed, eating, or using the bathroom. Legal routes for beneficiaries to ensure sufficient care remain weak, and agency oversight is inadequate.

This Comment puts forth two proposals. First, courts should enforce constitutional accountability by recognizing a property interest of beneficiaries in LTC benefits. Second, states must improve partnerships with MCOs. The state–MCO relationship is inherently fragile. Financial risk in managed care drives the potential for relationship fallouts if MCOs feel shortchanged. Fallouts can lead to the erosion of care access or quality, caused by a phenomenon called “shading.” New ideas from business literature provide a roadmap for better partnerships to prevent shading, using a collaborative approach to contracting known as “formal relational contracting.” This approach is an essential supplement to specific contractual incentives to ensure

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accountable LTC programs. It motivates states and MCOs toward shared LTC program goals, enables effective solutioning to program issues, and supports innovative methods for care management and beneficiary wellbeing.

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INTRODUCTION

Long-term care in the United States is in the midst of a transformation driven by privatization. States have largely transitioned care for many of the nation’s most vulnerable into the hands of privately run insurance companies called managed care organizations (MCOs). At the same time, demand for long-term care—which aids those who are aging or have a chronic illness or disability—is expected to grow rapidly because of multiple demographic trends of an aging population coupled with increasing life expectancies. A widespread push to avoid unnecessary moves to institutions, such as nursing homes, also means care is increasingly provided within the home, tracking consumer demand. Long-term care services cover basic needs, such as

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getting dressed, eating, going to the bathroom, or living independently in the community.\textsuperscript{4} The shift to MCO control through privatization creates barriers to accountability that impede quality of this vital care, especially when MCOs’ payment structure can result in a financial interest to reduce the utilization of services.\textsuperscript{5}

Issues with care upend the lives of individuals and their families. Consider a representative example: in 2016, Alejandra Negron, who struggled with a disability after a lifetime of work in a factory, relied on fifty hours a week of care from a homecare aide. Ms. Negron’s homecare assistance was made available through Medicaid, the government health care program for people with low incomes or disabilities.\textsuperscript{6} The support got her through the workweek while her two daughters and granddaughter alternated staying on nights and weekends.\textsuperscript{7} A managed care organization then cut Ms. Negron’s care in half to twenty-five hours, and rescheduled the hours to weekends.\textsuperscript{8} The change left Ms. Negron petrified at the thought of being institutionalized, and left her family scrambling, unable to help.\textsuperscript{9} This situation is far from unique.\textsuperscript{10} Studies have found such cuts in as many as a majority of cases across the bulk of MCOs contracted through Medicaid.\textsuperscript{11}

\begin{itemize}
  \item \textsuperscript{4} See HHS 2018 LTSS MEDICAID REPORT, supra note 2, at 1 (noting that LTSS provides both “assistance with activities of daily living”, such as eating or dressing, as well as “instrumental activities of daily living”, which facilitate independent living).
  \item \textsuperscript{5} See U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-103, CMS SHOULD TAKE ADDITIONAL STEPS TO IMPROVE ASSESSMENTS OF INDIVIDUALS’ NEEDS FOR HOME- AND COMMUNITY-BASED SERVICES 24 (2017) [hereinafter ASSESSMENTS FOR HCBS REPORT (GAO-18-103)], https://www.gao.gov/assets/gao-18-103.pdf [https://perma.cc/q8SP-8HCK] (“[M]anaged care plans may have a financial interest in increasing enrollments and reducing enrollees’ service utilization.”); id. at 12 (“[A] managed care plan may have incentives to reduce enrollees’ service utilization in order to reduce costs below the capitation payments that the plan receives to provide care to its enrollees and thus to maximize its profits, which could influence needs assessments used for service planning.”); see also Nina Bernstein, Medicaid Shift Fuels Rush for Profitable Clients, N.Y. TIMES (May 8, 2014), https://www.nytimes.com/2014/05/09/nyregion/medicaid-shift-fuels-rush-for-profitable-clients.html [https://perma.cc/M23W-24F5] (describing controversial managed care practices in New York, where patients were dropped from care or otherwise provided with limited services in order to increase company earnings).
  \item \textsuperscript{6} Nina Bernstein, Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients, N.Y. TIMES (July 20, 2016), https://www.nytimes.com/2016/07/21/nyregion/insurance-groups-in-new-york-improperly-cut-home-care-hours.html?_r=0 [https://perma.cc/UZU8-XG8Q].
  \item \textsuperscript{7} Id.
  \item \textsuperscript{8} Id.
  \item \textsuperscript{9} Id.
  \item \textsuperscript{10} See, e.g., LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 21 (describing litigation in New York where beneficiaries claimed that their MCO systematically threatened to or actually reduced LTSS arbitrarily and without adequate notice).
  \item \textsuperscript{11} See, e.g., id. at 16 (finding that in Virginia, half of MCOs had reduced services inappropriately in as many as fifty-three percent of cases reviewed).
\end{itemize}
The primary payer for long-term care, often referred to as long-term services and supports (LTSS), is Medicaid, covering over forty percent of all LTSS costs. Medicaid spending on LTSS—jointly funded by states and the federal government—is above $200 billion, a massive figure that represents about five percent of national health expenditures and nearly one percent of U.S. gross domestic product. Yet, the long-term care system remains underfunded by global standards and relies on a high volume of sporadic, uncompensated care from family members, leaving states with difficulty meeting individuals’ needs on insufficient budgets.

One way that states have managed budgets is to call on the aid of private MCOs. Historically, states have paid for LTSS through what is called a fee-for-service model, where states pay providers directly for services. Increasingly, states are outsourcing payments management, however, using

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12 Long-term services and supports encompasses both institutional services (e.g., nursing homes) as well as home and community-based supports. Long-Term Services & Supports, MEDICAID & CHIP PAYMENT & ACCESS COMM. (Aug. 19, 2022), https://www.macpac.gov/topics/long-term-services-and-supports [https://perma.cc/P98A-EESS].


14 Id.


16 The U.S. gross domestic product was estimated at $24.01 trillion in 2021. Gross Domestic Product, Fourth Quarter and Year 2021, BUREAU OF ECON. ANALYSIS (Feb. 24, 2022), https://www.bea.gov/news/2022/gross-domestic-product-fourth-quarter-and-year-2021-second-estimate [https://perma.cc/ED9Q-HH9D]. To derive the ratio of Medicaid spending on long-term care to U.S. gross domestic product, $200 billion is divided by $24.01 trillion to yield a figure of about 0.8%.


18 See Allison K. Hoffman, Reimagining the Risk of Long-Term Care, 16 YALE J. HEALTH POL’Y L. & ETHICS 147, 153 (2016) (“Medicaid programs for home-based care are underfunded and have long waiting lists and gaps. . . . Family and friends fill these gaps . . . .”); HHS 2018 LTSS MEDICAID REPORT, supra note 2, at 1 (“[M]ost [long-term care services and support] is delivered by informal, unpaid caregivers (such as family or friends) . . . .”).

19 See U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-528, MEDICAID MANAGED CARE: IMPROVEMENTS NEEDED TO BETTER OVERSEE PAYMENT RISKS 1 (2018) [hereinafter MANAGED CARE PAYMENT RISK REPORT (GAO-18-528)] (defining fee-for-service arrangements as arrangements where states directly pay healthcare providers for services); see also SAUCIER ET AL., supra note 1, at 18 (comparing managed care programs to traditional fee-for-service programs).
new payment models. To offer long-term care services to Medicaid recipients, about half of states contract with MCOs.20 MCOs receive a fixed per person per month payment to cover LTSS, regardless of the volume of services sought21—referred to as a “capitated” payment.22

MCOs are often the same large insurers that sell and manage private health insurance plans.23 As an example within the long-term care context, as of 2021, Fortune 5 insurer24 UnitedHealthcare operated nine managed LTSS programs nationally, covering care for 300,000 individuals.25 The Managed LTSS Institute, a collaboration between policy makers and insurers around Medicaid managed LTSS, has board members from UnitedHealthcare, Anthem, Aetna, and Centene, each of whom have operated a number of managed LTSS programs.26

Several expectations have motivated states to move to managed LTSS: greater budget certainty from capitated (per person) payments, improved care coordination and experience for consumers and their families, and increased provision of care at home rather than in institutions like nursing

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20 See Long-Term Services and Supports, supra note 12 (“As of 2021, 24 states operate managed long-term services and supports (MLTSS) programs, in which state Medicaid agencies contract with managed care plans to deliver long-term services and supports (LTSS) . . . .”).


22 In healthcare, “[c]apitation is a payment arrangement for health care services in which an entity . . . receives a risk adjusted amount of money for each person attributed to them, per period of time [e.g., per month], regardless of the volume of services that person seeks.” Capitation, Primary Care, AM. ACAD. OF FAM. PHYSICIANS (Apr. 2021), https://www.aafp.org/about/policies/all/capitation-primary-care.html [https://perma.cc/3WZP-5A2K].

23 See Hinton & Stolyar, supra note 21 (“A number of large health insurance companies have a significant stake in the Medicaid managed care market.”).


25 Michelle Martin, LTSS Programs: Fee-for-Services Vs. Managed Care, UNITEDHEALTHCARE (June 24, 2021), https://www.uhccommunityandstate.com/content/topic/profiles/ltss/ltss-programs—fee-for-service-vs—managed-care [https://perma.cc/38EY-B8FS].

homes. The number of states operating managed LTSS programs has grown rapidly, from just eight states in 2004 to twenty-four states in 2021. In monetary terms, the spending on managed LTSS has grown markedly from $6.7 billion in 2008 to $47.5 billion in 2019—an average annual growth rate of almost twenty percent over eleven years, or more than a sevenfold increase. The privatization of LTSS is here to stay.

This shift of care into the hands of private organizations raises questions of accountability. Once states contract with an MCO and set the monthly budget, there is little day-to-day involvement of the state in an MCO’s decisions. The MCO can aggressively manage benefits. In 2020, the Government Accountability Office (GAO) published a report finding that the turn to managed care has created problems in the quality and access of care across Medicaid LTSS because of deficiencies in service authorizations, care planning, care coordination, and other activities. In some states, many beneficiaries had personal care service levels reduced without justification. Since these services, such as dressing or going to the bathroom, are essential for basic needs, cuts in hours suddenly shift the responsibility to provide services to a family member or put the beneficiary at serious risk of injury.

27 See Andrea Wysocki, Jenna Libersky, Jonathan Gellar, Dean Miller, Su Liu, Margaret Luo, Alena Tourtellotte & Debra Lipson, Mathematica, Managed Long-Term Services and Supports xi-xiii (Nov. 24, 2020) [hereinafter Mathematica, Managed LTSS] (discussing state motivations for the transition to managed LTSS, resulting in better care experiences and greater provision of community-based alternatives to institutional care); see also Martin, supra note 25 (explaining that states have moved to the managed LTSS model to achieve budget certainty).

28 2019 Medicaid LTSS Annual Expenditures Report, supra note 3, at x.

29 See U.S. Gov’t Accountability Off., GAO-17-145, Improved Oversight Needed of Payment Rates for Long-Term Services & Supports 1-2 (Jan. 2017) (explaining that the MCOs have substantial leeway to manage budgets and benefits after receiving capitated rate for members due to the incentives set by the state).

30 Cf. id. at 7 (“Once a person is determined eligible by the state Medicaid agency, . . . [t]he MCO [] develops a service plan, which includes determining the types and amount of services expected to be needed by the beneficiary . . . .”).

31 See, e.g., LTSS Access & Quality Report (GAO-21-49), supra note 1, at 18 (“In 2018, New York found that an MCO had inappropriately reduced personal care services for 88 percent of cases reviewed.”).

32 Id. at 14.

33 See Bernstein, supra note 6 (detailing how cuts in homecare services require immediate response and increased support by family members in order to sustain quality of life for patients).

34 See LTSS Access & Quality Report (GAO-21-49), supra note 1, at 34 (“Reviews completed by our selected states suggest that there may be widespread issues with MCO care management for beneficiaries of LTSS, some of which come with costs to the beneficiary in terms of injury, abuse, and neglect . . . .”).
sufficient care coordination, and beneficiaries were not given autonomy to choose who leads their care team—and quality concerns went unheeded by the states responsible for overseeing these MCOs.\(^\text{36}\)

Meanwhile, oversight of managed LTSS is complicated by the federalist division of responsibilities inherent to the Medicaid program.\(^\text{37}\) States have tremendous flexibility to design and manage the Medicaid program.\(^\text{38}\) States adhere to minimum coverage requirements and standards while the federal government supports financially by sharing in the cost.\(^\text{39}\) But states can decide the package of services offered as well as whether to deliver services through either fee-for-service or managed care.\(^\text{40}\) Importantly, in managed care delivery systems, states hold the contracts with MCOs.\(^\text{41}\) State discretion increases the complexity of supervision for federal authorities, and the GAO has pointed out gaps in supervision at the federal level.\(^\text{42}\) At the same time, courts have a limited role in policing state decisions or catalyzing federal oversight.\(^\text{43}\)

The injection of technology into decisionmaking further heightens concerns about accountability. Algorithmic tools increasingly support

\(^{36}\) Id. at 18.


\(^{38}\) See Brietta Clark, *Medicaid Access & State Flexibility: Negotiating Federalism*, 17 HOUS. J. HEALTH L. & POL’Y 241, 243-45 (2017) (describing the sources of state flexibility in Medicaid program design and management); see also Penelope Lemov, *Opening Up Medicaid*, GOVERNING (Mar. 24, 2010), https://www.governing.com/archive/opening-up-medicaid.html [https://perma.cc/UQ9T-3EHF] (“There’s a little joke that makes the rounds whenever Medicaid directors get together. It goes like this: If you’ve seen one state Medicaid program, you’ve seen one state Medicaid program.”); Kimberly A. Opsahl, Note, *Using Integrated Care to Meet the Challenge of the ADA’s Integration Mandate: Is Managed Long-Term Care the Key to Addressing Access to Services?*, 10 IND. HEALTH L. REV. 211, 230 (2013) (describing the multitude of different structures states can use to design their managed Medicaid programs).

\(^{39}\) See CONG. RSCH. SERV., R43357, *MEDICAID: AN OVERVIEW* 1 (Feb. 22, 2021) (describing the structure of the Medicaid program as featuring voluntary state participation, federal coverage requirements, and joint financing between states and the federal government).

\(^{40}\) Id. at 9, 14.

\(^{41}\) Id. at 14.

\(^{42}\) LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 34.

\(^{43}\) See Metzger, supra note 37, at 1853 (describing the doctrinal barriers to court involvement in overseeing state implementation decisions about the Medicaid program); see also infra Part I (describing barriers to accountability through courts because of limitations on the ability of beneficiaries to enforce rights, ambiguity in constitutional protections, and weaknesses in administrative law).
decisions in the long-term care space, following the broader trend of the use of artificial intelligence (AI) in healthcare. However, these tools can be highly problematic. For example, a faulty algorithmic system implemented in Arkansas led to inappropriate reductions in homecare for nearly half of the state’s Medicaid recipients. In one case, the system reduced homecare hours for an amputee due to a lack of “foot problems.” Throughout the state, Medicaid recipients with severe disabilities had no access to food, bathrooms, and medicine due to these reductions. Eventually, a court enjoined the state from using the algorithmic system, but vendors were not forthcoming in explaining how decisions were subsequently made, and the state lacked the expertise and tools needed to debug the technology. Idaho also implemented an algorithmic tool, which led to similarly drastic reductions in homecare hours. Tools like those in Arkansas and Idaho can disrupt care patterns for beneficiaries under the care of MCOs. And they can greatly undermine the accountability of care decisions—especially when coupled with privatization.

To be sure, the same features of the long-term care system that create barriers to accountability—privatization, federal-state coordination, and technology—offer their respective benefits. Privatization through managed


47 Id.

48 Id.

49 Id.

50 Id. at 801.

51 See News Release, World Health Org., supra note 45 (observing that AI could subject patients and healthcare workers to decisions that limit patient rights, decisionmaking and autonomy).

care can improve care coordination, innovation, and performance. States can provide supervision that is responsive to the local needs of the programs they oversee. And AI and technology can increase the speed and accuracy of care decisions. While these systemic benefits should be promoted, there is no room for error. Care decisions affect the most vulnerable, and behind each Medicaid recipient is a family that may already provide substantial uncompensated care. Disruptions to the care of a family member have not only human costs but also ripple effects on the economic vitality of the family unit and the community at large. The stakes are extraordinarily high.

Achieving accountable long-term care should be overdetermined. Numerous checks on the provision of care must be implemented because gaps and errors have a devastating impact on Medicaid beneficiaries’ health and wellbeing. Unfortunately, legal rights for beneficiaries, administrative law remedies, and constitutional protections are weak. Part I diagnoses the roots of the accountability crisis. Beneficiaries’ legal rights remain limited while MCO power expands, and traditional contracting by states is insufficient because of the potential for MCOs to cut back on their contractual obligations to provide access to care and maintain program quality. Part II explores steps by courts to shore up the managed LTSS accountability system. It contends that courts should more clearly articulate a property interest in LTSS, providing constitutional due process protections for beneficiaries to enforce.

Finally, Part III proposes a somewhat radical solution to shortcomings by MCOs in long-term care: improve partnerships with MCOs through a

53 See MATHEMATICA, MANAGED LTSS, supra note 27, at 53 (“MLTSS enrollees had [twenty-eight] percent higher odds of responding favorably to questions related to experience of care and quality of life . . . .”).
54 See Kathleen Gifford, Aimee Lashbrook, Sarah Barth, Mike Nardone, Elizabeth Hinton, Madeline Guth, Lina Stolyar & Robin Rudowitz, States Respond to COVID-19 Challenges But Also Take Advantage of New Opportunities to Address Long-Standing Issues, KAISER FAM. FOUND. (Oct. 27, 2021), https://www.kff.org/medicaid/report/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues [https://perma.cc/XKF3-XPFS] (“Most states reported that the COVID-19 pandemic prompted them to expand Medicaid programs to address social determinants of health, especially related to housing.”).
55 See Metzger, supra note 37, at 1850 (”[P]rivatization can inject innovation and flexibility, as well as result in improved performance.”).
56 See, e.g., id. at 1853 (“Not only is the federal government asking states to play new roles in federal programs, but it is also giving states broader discretion and control over the shape of their participation.”).
57 See WORLD HEALTH ORG., ETHICS AND GOVERNANCE OF ARTIFICIAL INTELLIGENCE FOR HEALTH 36 (2021) (“AI technologies based on high-quality data can improve the speed and accuracy of diagnosis, improve the quality of care and reduce subjective decision-making.”).
58 See, e.g., Hoffman, supra note 18, at 153 (“Medicaid programs . . . have long waiting lists and gaps . . . . [that] [f]amily and friends fill . . . .”).
59 See id. at 154 (“By one estimate, the financial losses alone . . . sustained by the average informal caregiver who leaves the workforce to care for a parent are $300,000.”).
collaborative contracting approach. The state–MCO relationship is fragile due to the financial risk inherent to managed care. Financial risk drives the potential for relationship fallout if an MCO is shortchanged by the capitated (per person) payments. A relationship fallout can lead to performance cutbacks by MCOs that harm beneficiaries, a phenomenon known as “shading.” The solution is to focus on better state–MCO relationships.

States can strengthen partnerships with MCOs through an approach known as “formal relational contracting.” Contracts lie on a spectrum: on one extreme lie handshake deals built on goodwill and trust, and at the other are arms-length transactions specified in rigid detail.\(^{60}\) Formal relational contracting bridges the gap, enabling state governments to harness the benefits of a trusting business relationship while engaging MCOs in complex managed long-term care contract requirements. Contemporary business literature provides a roadmap for states to leverage this approach with MCOs. In addition, examples on the ground show how to actualize this collaborative approach to ensure vulnerable Medicaid beneficiaries get access to high quality long-term care.

I. WHY ACCOUNTABILITY IS LACKING

In describing the barriers that create accountability gaps, it is first helpful to lay out the types of accountability gaps present in managed LTSS. Accountability issues primarily arise in two areas: access to services and quality of services. Access issues usually relate to service authorizations,\(^{61}\) while care quality issues often relate to service coordination and monitoring.\(^{62}\)

On the access side, service authorizations depend on “functional assessment tools,” which are used to determine an individual’s health and functional needs.\(^{63}\) Needs are often assessed along two dimensions. The first are basic activities of daily living that enable self-care: eating, hygiene,

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\(^{60}\) See Katsuki Aoki & Thomas Taro Lennerfors, *The New, Improved Keiretsu*, HARV. BUS. REV., Sept. 2013, at 110 (“The traditional keiretsu consisted of obligational relationships based on trust and goodwill. . . . That’s in sharp contrast to Western-style arm’s-length supplier relationships, which are governed by as much contractual clarity as possible.”).

\(^{61}\) See LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 23 (finding instances where inappropriate service authorizations reduced beneficiaries’ access to services).

\(^{62}\) See id. at 26 (discussing how in February 2020, a New Jersey MCO was found to be noncompliant due to insufficient face-to-face visits and a lack of care plans “based on client-centered principles”).

dressing, moving around, and using the bathroom. The second category are instrumental activities of daily living, which allow for independent living: communicating, shopping, housecleaning, cooking, managing finances, and managing medication. LTSS services help with both, and the assessment—along with the care planning process—translates these needs into a service authorization, which specifies the amount and types of assistance to be offered. Access problems arise when the assessment or the care planning based on the assessment is inappropriate.

A second sphere where accountability is lacking is service coordination and care monitoring, which both drive high quality care. MCOs must have procedures to ensure delivery of high quality care and they must work with the state to remediate any issues. A lack of accountability in this area can include the failure to hire care coordinators who can schedule providers to come to beneficiaries’ homes—the mere authorization of a service means nothing if it is never delivered. Or an accountability gap may include an MCO’s failure to report medication errors, abuse, or other harms to beneficiaries; this occurred in one Arizona MCO between 2018 and 2019 on 1,500 occasions, all of which went unreported. While authorizations and care plans ensure access, service coordination and monitoring ensure quality.

There are many means to address these access and quality problems; such problems implicate the Medicaid statutes, the Constitution, and the administrative agencies that oversee the programs. Two accountability pathways may be pursued by beneficiaries or their representatives in the court system: fair hearings and private causes of action. Fair hearings often revolve around challenging service authorizations that affect access to care, while

64 See Mary Grace Kovar & M. Powell Lawton, Functional Disability: Activities and Instrumental Activities of Daily Living, 14 ANN. REV. GERONTOLOGY & GERIATRICS 57, 61-63 (1994) (outlining self-care activities for functional mobility, such as bathing and showering, dressing, self-feeding, personal hygiene and grooming, and toilet hygiene).

65 See M. Powell Lawton & Elaine M. Brody, Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living, 9 GERONTOLOGIST 179, 180-81 (1969) (describing activities that allow an individual to live independently in a community, including housekeeping, preparing meals, taking medications, managing finances, shopping, use of telephone or other form of communication, and transportation within the community).

66 See LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 12 (“The MCO is contractually required to develop care plans that are . . . tailored to the beneficiary’s needs and preferences. . . . We found that physicians generally did not attend care planning meetings, but care coordinators told us they sometimes communicated with them by phone about a beneficiary’s needs”).

67 See id. at 12-13 (noting that the GAO found significant gaps in MCO care coordination for Medicare beneficiaries, including a lack of utilization data and diagnostic information).

68 See, e.g., id. at 18 (finding that an MCO in Iowa had “deficiencies in the number of care coordinators available[,]” resulting in issues with coordinating and monitoring patients’ access to care).

69 Id.
private causes of action involve an attempt to enforce Medicaid statutory requirements. Other accountability pathways involve administrative remedies and implicate both state and federal agencies responsible for overseeing Medicaid. Together, however, these legal and administrative accountability mechanisms fall short.\(^70\)

A. Routes for Beneficiaries to Enforce Rights

There are two possible routes for beneficiaries to challenge MCO decisions and advocate for accountability. The first is the fair hearing right, which is triggered by the termination or reduction of Medicaid services.\(^71\) Fair hearing appeals are essential because many MCOs regularly reduce home care hours.\(^72\) Not only have reductions been consistent, but also MCOs have been found to reduce home care hours for reasons other than beneficiary needs, such as due to a lack of documentation.\(^73\) These reductions in access put pressure on the fair hearing system. Reductions also raise questions about how to ensure systemic management, whether for care access or quality. Thus, a second—and arguably broader—route for beneficiaries to enforce accountability is enforcement of the Medicaid statutory requirements in court. This route could go beyond individual MCO decisions—to hold both states and MCOs accountable to federal requirements. The Medicaid statute, however, does not make a right of private enforcement explicit, and courts have not been favorable to private causes of action in Medicaid, limiting enforcement of the Medicaid statutory regime by individual beneficiaries in court.\(^74\)

\(^70\) For a discussion of nascent yet promising constitutional accountability mechanisms, see infra Part II.

\(^71\) See Federal Medicaid Act, 42 U.S.C. § 1396a(a)(3) (providing Medicaid patients with the opportunity for a “fair hearing” before a state agency in the case that medical assistance is denied); see also 42 C.F.R. §§ 431.200–431.246 (implementing fair hearings in state courts for individuals whose claims for assistance are denied); 42 C.F.R. §§ 438.400–438.424 (implementing the grievance and appeal system for managed care); KAISER FAM. FOUND., A GUIDE TO THE MEDICAID APPEALS PROCESS 9 (Mar. 2012) (outlining the state agency appeals process).

\(^72\) See, e.g., LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 14 (“[The GAO found] cases where the beneficiary experienced a functional decline, or their functional status did not change, but the MCO reduced the number of personal care hours authorized.”); MEDICAID MATTERS N.Y., MIS-MANAGED CARE: FAIR HEARING DECISIONS ON MEDICAID HOME CARE REDUCTIONS BY MANAGED LONG TERM CARE PLANS 37 (July 2016) [hereinafter MEDICAID MATTERS N.Y., MIS-MANAGED CARE] (“This study of fair hearing outcomes . . . reveals a disturbing pattern on the part of several [Medicaid-managed long-term care] plans to arbitrarily reduce the home care services that allow vulnerable individuals to remain safely in the community.”).

\(^73\) See, e.g., LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 16 (“In several cases . . . where the beneficiary appealed a reduction in hours . . . , the MCO upheld the denial decision based on lack of proper documentation rather than the assessment of the beneficiaries’ needs.”).

1. The Inadequacy of Appeals

Privatization has had a substantial impact on the appeal rights of Medicaid LTSS recipients. Although the fundamental statutory recourse for care decisions is the fair hearing, the move to managed care has introduced significant changes to these fair hearings, routing beneficiary concerns first through the MCO. This arrangement was challenged in the Second Circuit, but the court refused to “import wholesale” the fair hearing requirements that existed in the traditional fee-for-service model before the introduction of managed care arrangements. The extra step—requiring recipients to first appeal a care decision with the MCO before petitioning the state—can discourage access to fair hearings and obfuscate rights to care.

Partly in response to these concerns, the 2016 Centers for Medicare and Medicaid Services (CMS) managed care regulations introduced a requirement for MCOs to institute a “beneficiary support system” to help individuals understand their appeal rights. The program theoretically includes education on grievances and appeals, along with assistance in navigating the process to appeal adverse benefit determinations. These support systems, however, can be woefully under-resourced—for instance, as of July 2020, Iowa staffed 1.5 fulltime employees to provide support for 40,000 beneficiaries—and both states and CMS have been slow to address systemic issues. These deficiencies suggest the program offers little hope to beneficiaries in its current form.

Even if the resources to support beneficiaries in their appeals were not so inadequate, the appeal process is fundamentally flawed. Recipients in poor health are especially unlikely to navigate a complicated legal process to

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75 See Federal Medicaid Act, 42 U.S.C. § 1396a(a)(3) (requiring state plans for medical assistance to provide any individuals with denied claims with the opportunity for a fair hearing).
76 See 42 C.F.R. § 438.408(f)(1) (“An enrollee may request a State fair hearing only after receiving notice that the MCO . . . is upholding the adverse benefit determination.”).
77 See Bellin v. Zucker, 6 F.4th 463, 487 (2nd Cir. 2021) (“Accepting [plaintiff]’s argument would demand that we import wholesale the fair hearing requirements applicable to the fee-for-service model into this substantially different context. Finding [plaintiff]’s reading of the statutory language strained, we decline to do so.”).
78 See MEDICAID MATTERS N.Y., MIS-MANAGED CARE, supra note 72, at 8 (describing how appeal processes dissuade many from pursuing access to care).
79 ASSESSMENTS FOR HCBS REPORT (GAO-18-103), supra note 5, at 32; 42 C.F.R. § 438.71.
80 42 C.F.R. § 438.71(d)(2).
81 42 C.F.R. § 438.71(d)(3).
82 LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 24.
83 See id. at 23 (“CMS has not systematically overseen whether states have effectively implemented requirements for monitoring their managed care programs, which may have allowed problems . . . to persist.”).
challenge an MCO decision. Still others have adverse decisions settled with an MCO before the fair hearing stage, with a potentially suboptimal result. Even if the recipient reaches the fair hearing stage, another adverse decision may await on the horizon (appeal outcomes are only temporarily binding on MCOs), and the appeals process itself inflicts a toll on members and their families. One court concluded that because fair hearings offer a “particularly poor” recourse for Medicaid beneficiaries, these hearings are “not enough to assure . . . due process.”

2. Limitations on Private Causes of Action

Another weakness of the statutory Medicaid regime is that there are gaps in enforcement of federal Medicaid requirements. Private enforcement is helpful to ensure states meet Medicaid’s standards. The Medicaid act, however, does not explicitly allow beneficiaries or providers to enforce any of the federal Medicaid law or regulations, and some argue that only government officials have standing. Courts are conflicted on when providers or beneficiaries can bring suit.

These accountability barriers have increased after the Supreme Court’s decision in *Armstrong v. Exceptional Child Center, Inc.* The Supreme Court held that the Supremacy Clause does not create a private right of action to enforce certain Medicaid requirements, leaving 42 U.S.C. § 1983 as the only channel for Medicaid beneficiaries or providers to challenge alleged violations of Medicaid laws. Following *Armstrong*, circuits are split on whether

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85 See MEDICAID MATTERS N.Y., MIS-MANAGED CARE, supra note 72, at 28 (explaining that many prehearing settlements are not fully favorable to the member).
86 See id. at 29 (“It is extremely burdensome to require these individuals and families to navigate the process of requesting a hearing, obtaining the documents the plan used to make its determination, finding representation, and traveling to the hearing site, which may be far from home.”).
87 Mayer, 922 F. Supp. at 912.
89 See Huberfeld, supra note 74, at 460 (describing judicial skepticism of private enforcement of conditions on spending).
91 Id. at 326; see also WEN W. SHEN, CONG. RSC. SERV., LSB10320, COURTS SPLIT ON WHETHER PRIVATE INDIVIDUALS CAN SUE TO CHALLENGE STATES’ MEDICAID DEFUNDING DECISIONS: CONSIDERATIONS FOR CONGRESS (PART I OF II) 2 (2019) (“Thus, over time and especially after Armstrong, § 1983 has emerged as the principal vehicle for private enforcement of federal-state program requirements like Medicaid.”). The Reconstruction-era civil rights statute, 42
individuals can pursue actions to ensure a state’s adherence to Medicaid rules and standards,92 with the issue most recently raised before the Supreme Court in the 2022–23 Term.93 Without a private right of action, beneficiaries or providers cannot enforce Medicaid managed LTSS requirements against the state or the contracted MCO, further deteriorating the accountability of states to these external parties and putting more pressure on federal and state agencies to oversee MCOs.

Thus, the responsibility of federal and state officials to properly implement Medicaid’s requirements has increased in the wake of Armstrong. In Does v. Gillespie, for instance, plaintiffs brought suit to enforce Medicaid’s free-choice-of-provider provision—a Medicaid requirement that gives patients the ability to choose any “qualified” provider—to restore access to Planned Parenthood, with whom the state had terminated a provider agreement.94 The Eighth Circuit reasoned that the lack of an enforceable federal right meant that patients were only able to bring claims against federal or state officials.95 The court stated that providers could pursue “administrative appeals” with the state, or patients could “urge the Secretary to withhold federal funds” for violations of law.96 These avenues foreground state and federal administrative officials as keepers of accountability—not courts, not providers, and not beneficiaries. Yet, as is subsequently explained in Section I.B, infra, there are few legal mechanisms to ensure these agency officials act appropriately.

B. Government Oversight

State and federal agencies also have authority to oversee the operations of MCOs. States oversee LTSS management directly as holders of contracts with MCOs, and the federal government oversees activities indirectly

92 See WEN. W. SHEN, CONG. RSCH. SERV., supra note 91, at 1 (noting that five circuits permit a private right of action under 42 U.S.C. § 1983 for failure to comply with Medicaid requirements while the Eighth circuit does not).
93 Health & Hosp. Corp. of Marion Cty. v. Talevski, 142 S. Ct. 26734 (2022) (granting petition for certiorari); see also Robin Rudowitz & Laurie Sobel, What is at Stake for Medicaid in Supreme Court Case Health & Hospital Corp v. Talevski?, KAISER FAM. FOUND. (Oct. 28, 2022), https://www.kff.org/policy-watch/what-is-at-stake-for-medicaid-in-supreme-court-case-health-hospital-corp-v-talevski [https://perma.cc/9WF3-Y2EV] (“The Court will consider . . . whether the Court should reexamine its longstanding position that individuals have a right to sue in federal court to protect rights for legislation created under the Spending Clause of the constitution (e.g., federal laws including Medicaid, the Children’s Health Program, and the Supplemental Nutrition Assistance Program (SNAP)).”).
94 867 F. 3d 1034, 1037 (8th Cir. 2017).
95 Id. at 1046.
96 Id.
through regulation and review and approval of managed LTSS contracts. Both state and federal oversight falls short. And administrative law cannot remedy inadequate agency oversight, facing several doctrinal barriers to fixing systemic oversight issues. This impotency of administrative law to help with systemic mismanagement exists at both the state and federal level. Ultimately, the contract is the best accountability mechanism. But traditional contracts suffer from both poor design and execution.

1. Shortcomings in State Agency Contracting

A state’s contract with the MCO sets key expectations, such as in care management. The contract design must adhere to basic CMS guidelines, and CMS approves state–MCO contracts. CMS has a number of requirements that states must include in their contracts with MCOs. CMS contract guidelines, however, remain extraordinarily vague. Design guidelines include broad standards like “ensur[ing] services are su[fficient] to achieve their purpose,” “implement[ing] procedures to deliver care,” and “hav[ing] a quality assessment and performance improvement program.” States have flexibility to design the essential terms of care access and quality as well as the oversight mechanisms.

These state–MCO contracts can fail both in design and execution. For instance, design problems can exist in data collection, such as states not requiring key information about care appeals, including simple counts of how many beneficiaries had care reduced or what is the nature of the appeal. Furthermore, problems may arise when states do not require reporting in a standardized way that would facilitate data analysis and quantitative decisionmaking to address issues.

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97 See LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 9 (“A state’s contract with MCOs is the key vehicle for setting minimum requirements for care management.”).
98 See 42 C.F.R. § 438.3(a) (“The CMS must review and approve all MCO, [prepaid inpatient health plan], and [prepaid ambulatory plan] contracts . . . .”); see also Medicaid and Children’s Health Insurance Program (CHIP) Programs, 81 Fed. Reg. 27,498, 27,533 (May 6, 2016) (“Oversight protections are built into this final rule, including CMS’ review and approval of managed care plan contracts as well as CMS’ review and approval of the rate certifications for consistency . . . .”).
100 See, e.g., Medicaid and Children’s Health Insurance Program (CHIP) Programs, 81 Fed. Reg. at 27,508 (“We believe it is inappropriate for CMS to define these terms at the federal level when states need to define these terms when establishing and implementing their grievance and appeal system and procedures for their respective programs.”).
101 LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 10.
102 Id. at 22.
103 Id.
Even if contract design problems are minimized, state–MCO contracts often fail in execution. The prevalence of execution failures in state–MCO contracts suggests that troubling outcomes with managed LTSS are systemic. In Virginia, “three of six MCOs had inappropriately reduced services” for thirty-three to fifty-three percent of beneficiaries sampled.104 In New York, an MCO unjustifiably reduced service levels in eighty-eight percent of cases reviewed.105 Another MCO did not regularly update care plans in as many as eighty-three percent of cases, making it more difficult to ensure care adapted to the changing needs of the beneficiaries with complex health conditions.106 Even though law sometimes requires a doctor to oversee care decisions,107 the widespread nature of reductions raises questions about the extent to which MCOs may preference financial self-interest. Concerns about the accountability of MCOs in contract execution are both prevalent and severe.

2. Shortcomings in Federal Agency Oversight

CMS also has leverage to improve state MTLSS programs through better policy and oversight. CMS can withhold funding from states, implement state–MCO contract requirements—including MCO monitoring requirements for states—and ensure that states have quality programs with adequate reporting.108 CMS has built a number of oversight mechanisms in its 2016 final rule, such as the requirement to submit annual reports on managed Medicaid programs.109 The GAO has concluded, however, that “CMS lacks an oversight strategy specific to MLTSS and a complete picture of the access and quality problems in MLTSS programs.”110 The GAO recommended a two-part solution—first, to implement an oversight plan and then, to assess quality and access problems.111 As of December 2022, CMS

104 Id. at 16.
105 Id. at 18.
106 Id.
107 See 42 C.F.R. § 438.210(b) (requiring that the state–MCO contract require the MCO to consult with the requesting medical provider when appropriate).
110 LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 34.
111 Id.
did not concur with the GAO recommendations, though the GAO has noted
some recent progress toward oversight and visibility into problems.\footnote{112}{See id. (showing while the CMS did not concur with the GAO’s recommendations for executive action, CMS had “planned oversight changes”).}

CMS could undoubtedly do more to address service authorization issues. A national tool for assessments, for instance, could have advantages. It could set standards for care levels that correlate with need by comparing data across states.\footnote{113}{MACPAC LTSS ASSESSMENT REPORT, supra note 63, at 79.} Standardization would make it easier for both courts and CMS to ensure each beneficiary receives the right support. A standardized tool could also help make payment for beneficiaries more consistent with the intensity of care they require.\footnote{114}{Id. at 78-80.} At the same time, however, there is little evidence to support one tool over another, and state flexibility to design these tools allows for productive stakeholder input.\footnote{115}{See ASSESSMENTS FOR HCBS REPORT (GAO-18-103), supra note 5, at 19 (citing New York, North Carolina, and Kentucky as states that separated assessments from entities with a financial interest in assessment results, which reportedly improved assessments).}

Another approach used in some states is to separate the entity assessing care needs from the entity with a financial stake, ultimately requiring a third party other than an MCO to perform needs assessments.\footnote{116}{LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 26.} This approach holds promise, especially where financial conflicts of interest drive systematic reductions in services. Further, CMS could require compliance by states. That approach may be complicated and costly to implement, however, and could face significant pushback locally and nationally.

Although there is more CMS could do, federal officials remain distant from access and quality issues on the ground. CMS often learns of problems through beneficiary complaints, family members, or media reports.\footnote{117}{LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 26.} In Virginia, CMS learned of inappropriate service cuts through beneficiary, family member, and caregiver complaints.\footnote{118}{Id. at 27.} In New Jersey, CMS learned that the state froze enrollment in a plan through media reports.\footnote{119}{See Brief of Former Health & Human Services Officials at 5, Douglas v. Indep. Living Ctr. of S. Cal., Inc., 565 U.S. 606 (2012) (Nos. 09-958, 09-1158, 10-283) (arguing that private enforcement actions historically have and, as a practical matter, must continue to aid HHS in ensuring compliance).} In Arizona, CMS learned of serious problems through the work of the GAO and other stakeholders.\footnote{120}{Id. at 27.} To surface issues, CMS has also relied on the private rights of action described above, which have been seriously curtailed.\footnote{121}{Id. at 27.}
These oversight gaps, in part, reflect both a lack of reporting by states and a lack of comprehensive monitoring. The gaps are not surprising, however, given the reality that CMS is too far removed from the state–MCO relationship to be responsive to either acute or systemic problems. Even if CMS discovers a problem contemporaneously with the state, the state, as the holder of the contract, has immediate leverage to resolve the issue. The state also has complete control over the procurement process, which states may use to resolve issues by developing new contracts or finding new partners.122 Although CMS may address problems over the long run by requiring states to implement and report performance improvement plans, states remain squarely in the driver’s seat. Certain policy changes and a more comprehensive monitoring system are a start by CMS, but CMS is not set up to perform the day-to-day management and oversight that LTSS programs demand.

3. Administrative Law’s Failure to Remedy Mismanagement

Federal and state administrative laws have weaknesses in dealing with systemic mismanagement by agencies. Federal administrative law does not have the authority to compel affirmative action by CMS to remedy systemic problems. This failure is the result of several doctrinal limitations associated with the Administrative Procedure Act (APA). The “final agency action” rule requires that an agency action be at stake in any challenge; the court cannot take a systemic approach that focuses more broadly on the programs giving rise to the suit.123 In addition, there is a higher bar for courts to compel agencies to take action than to enjoin an action, and it is often inaction that creates problems in systemic oversight.124 Moreover, there is a possibility that agencies can use authority to waive enforcement of key rules.125 Finally,

122 See U.S. GOV’T ACCOUNTABILITY OFF., GAO-21-229, CMS NEEDS TO IMPLEMENT RISK BASED OVERSIGHT OF PUERTO RICO’S PROCUREMENT PROCESS 7 (2021) (“CMS has not overseen the Medicaid procurement process in any state or territory.”); see also GEORGETOWN UNIV. HEALTH POL’Y INST., MEDICAID MANAGED CARE PROCUREMENT 5 (2022), https://ccf.georgetown.edu/wp-content/uploads/2022/07/MCO-procurement-v4.pdf [https://perma.cc/J3PG-LNMR] (noting that the state–MCO procurement processes results in the revision and improvement of state contracts or the end of relationships with low-performing MCOs).

123 See Metzger, supra note 37, at 1872 (“[A] suit [must] be brought against discrete agency actions rather than against the agency’s broader policies or programs that those actions reflect.”).

124 See Heckler v. Cheney, 470 U.S. 821, 831 (1985) (“This Court has recognized on several occasions over many years that an agency’s decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency’s absolute discretion.” (internal citation omitted)).

125 See Cary Coglianese, Gabriel Scheffler & Daniel E. Walters, Unrules, 73 STAN. L. REV. 885, 891 (2021) (“Obligation imposition is only one side of the coin. Governmental authorities also exert
limitations exist on the use of the APA’s procedural due process requirements to set fairness standards. Together, these constraints prevent courts from issuing substantive directives to agencies to provide better general oversight and management under the APA.

State administrative law also falters. Although challenges under state administrative law may have advantages over federal court litigation, whether procedurally or strategically, state administrative law would produce significant variability in accountability (because of state-by-state litigation) and potentially infringe on gubernatorial power. It is unclear the extent to which state courts would push on state-MCO relationships to ensure accountability, as the role of state administrative law generally is vastly understudied and variable. Given that governors and their administrations typically have more flexibility, the power of state administrative law to ensure accountability does not look promising.

II. PATHWAYS FOR CONSTITUTIONAL ACCOUNTABILITY

Creating clarity in constitutional protection for service authorization—especially in the case of personal care hours—can help with accountability problems, as it gives constitutional weight to certain concerns around care access. Since due process issues are potentially implicated across initial service level determinations, reductions, plan transfers, and significant power to alleviate obligations—power that can also be misused and create dramatic consequences for public welfare.

126 See Vt. Yankee Nuclear Power Corp. v. Nat. Res. Def. Council, Inc., 435 U.S. 519, 524 (1978) (noting that agencies are free to grant additional procedural rights at their discretion, but that reviewing courts are generally not free to impose them if the agencies themselves have not granted these rights and procedures).

127 See generally 165 AM. JUR. TRIAL 413, § 17, Westlaw (database updated Nov. 2022) (describing how state court challenges to the reduction or termination of Medicaid benefits often provide advantages as compared to federal litigation).

128 See Miriam Seifter, Gubernatorial Administration, 131 HARV. L. REV. 483, 488 n.25 (2017) (noting that legal literature pays little attention to state administrative law and its institutional design).

129 See id. at 491 (“There are fifty different approaches to each development discussed herein, and a reader may justifiably retort that any given observation does not resonate in her state.”).

130 See id. at 489 (“Governors also face some checks . . . but the ultimate picture is one of authority and flexibility rather than constraint.”).

131 See Bellin v. Zucker, 6 F.4th 463, 480 (2nd Cir. 2021) (describing how administrative review is possible for claims in which beneficiaries have a property interest in the initial determination of personal care services hours).


terminations,\textsuperscript{134} a finding of a protected interest in LTSS benefits can heighten MCO standards. Finding that patients had a constitutionally protected interest in personal care hours, in particular, would ensure that no beneficiary has vital support reduced without a showing of a change in condition (or prior mistake) that warrants the change. It would also bring transparency to proprietary tools and algorithms used in service authorizations.\textsuperscript{135} Courts should require a transparent demonstration of the logic underlying service authorizations—whether the MCO uses an algorithm, service authorization tool, or another system. The potential constitutional protections discussed in this Part will not solve accountability problems, but they are a step in the right direction.

A. Possible Accountability Mechanisms

The Supreme Court has declared that “due process is flexible and calls for such procedural protections as the particular situation demands.”\textsuperscript{136} But in practice, protections for LTSS benefits are not so certain. The threshold issue in procedural due process cases is whether an interest (e.g., in welfare benefits) is a protected property or liberty interest under the Fourteenth Amendment.\textsuperscript{137} A property interest exists where there are “rules or mutually explicit understandings that support [a] claim of entitlement to the benefit" that can be invoked at a hearing.\textsuperscript{138} Abstract need, abstract desire, or unilateral expectation are not enough.\textsuperscript{139} Courts recognize that Medicaid benefits generally fit the \textit{Goldberg} model of entitlements and are a protected property interest, which cannot be terminated without due process protections.\textsuperscript{140}

\begin{footnotesize}
\begin{enumerate}
\item See \textit{Weaver v. Colo. Dep’t of Soc. Servs.}, 791 P.2d 1230, 1232 (Colo. App. 1990) (noting that a beneficiary could be deprived of continued benefits only by means of a procedure that complied with the tenets of due process of law).
\item See \textit{Bloch-Wehba}, \textit{supra} note 52, at 1275 (“The privatization and automation of decision-making regarding Medicaid benefits present clear tensions with principles of procedural due process.”).
\item \textit{Goldberg v. Kelly}, 397 U.S. 254, 262 n.8, 263 (1970) (concluding that it is proper to regard welfare benefits as property rather than a mere gratuity, and noting that procedural due process should be afforded where an individual would suffer a loss of property in losing a government benefit).
\item \textit{Bd. of Regents of State Colls. v. Roth}, 408 U.S. 564, 577 (1972) (emphasizing that to have a property interest in a benefit, a person clearly must have more than a unilateral expectation, abstract need or desire for the benefit).
\end{enumerate}
\end{footnotesize}
Notably, the Second and Ninth Circuits are beginning to define the contours of protections around a property right in LTSS benefits specifically\(^{141}\)—which could be important in ensuring access to care. These protections remain vague and fact-specific, however, and would not amount to a substantive right to access or quality of care. To move in this direction, something more like a “duty to supervise” would be required, which would make administrative officials accountable for good management—including rooting out and solving problems with managed LTSS programs. This approach would take novel constitutional readings, however, to establish. As it stands, the potency of the Constitution to ensure accountability is uncertain. Section II.B, infra, will argue for improving these constitutional protections.

1. Procedural Due Process

Procedural due process protections hold some promise to aid access to personal care services within LTSS. Personal care services are core to LTSS—helping beneficiaries with daily activities like bathing and dressing.\(^{142}\) Multiple circuits seem open to considering that a level of personal care services qualifies as a protected property interest for the purpose of procedural due process protections under the Constitution. This would greatly aid MCO accountability because MCOs largely have discretion in determining the number of service hours a beneficiary is authorized to receive.\(^{143}\) Constitutional protections could help ensure this discretion is not abused through arbitrary reductions to care.

In 2021, the Second Circuit addressed the question of whether a service level is constitutionally protected, ultimately remanding it as a factual issue.\(^{144}\) The plaintiff argued that she was entitled to twenty-four hour personal care services, using the relevant criteria.\(^{145}\) In determining care hours, the relevant New York state regulations for service authorizations requires, inter alia, a physician’s order, a social assessment, and a nursing assessment.\(^{146}\) Plaintiff’s scores based on the stated criteria determined the

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\(^{141}\) For a full discussion of the relevant caselaw, see infra subsection II.A.1.

\(^{142}\) See LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 3 n.8 (“Personal care services assist beneficiaries with activities of daily living, such as bathing, dressing, and toileting.”).

\(^{143}\) Id. at 3.

\(^{144}\) See Bellin v. Zucker, 6 F.4th 463, 468 (2nd Cir. 2021) (remanding the case for further consideration of the limits on the managed long-term care plan’s ability to make determinations of personal care hours).

\(^{145}\) See id. at 460 (describing how a fair hearing appeal reviewed an evaluation of plaintiff’s condition and concluded that plaintiff was entitled to twenty-four hour, live-in care because MCOs are required to provide a particular level of personal care services upon satisfying certain criteria).

\(^{146}\) See N.Y. COMP. R. & REGS. tit. 18, § 505.14(b) (2019) (outlining the criteria for authorization of services and various necessary assessments).
outcome. The court generalized this result to suggest that satisfaction of
certain criteria could entitle beneficiaries to various levels of care, based on
state statutes and regulations.\textsuperscript{147} Thus, rules or “mutually explicit
understandings” supported claims to entitlement.\textsuperscript{148} The Second Circuit
remanded, instructing the district court to apply the fact-specific test for
existence of a constitutionally protected property interest, which is that
“statutes or regulations meaningfully channel[] discretion by mandating a
defined administrative outcome.”\textsuperscript{149}

The Ninth Circuit has also suggested that there is a protected property
interest in a given level of LTSS services. The court examined whether the
Idaho Department of Health and Welfare could reduce individual budgets for
members of a Medicaid LTSS program without adequate due process
protections and notice.\textsuperscript{150} The court first found a property interest in
benefits.\textsuperscript{151} Then the court reasoned that “[i]f a participant’s new calculated
budget is lower than his current budget, the participant has lost the right to
craft a service plan that is equal in value to his current service plan,” thus
depriving them of their property because the value of the plan was
diminished.\textsuperscript{152} By concluding that a budget reduction amounted to a
diminution in service plan value, the court indicated that the extent of
services has protection as a property interest, beyond the mere protection for
services at any level.

Even as courts have begun to apply procedural rights to the LTSS context,
accountability is still limited by flawed fair hearing systems.\textsuperscript{153} If a protected
interest is found, then the level of process that is due (e.g., whether a pre-
determination hearing must be given or whether cross-examination is
required) depends on a balancing test laid out in \textit{Mathews v. Eldridge}.
\textsuperscript{154} Under
that test, additional procedures are required if the value of additional
procedures weighted by the interest of the claimant is greater than the
increased burden on the government.\textsuperscript{155} The state retains significant flexibility
in defining the contours of state fair hearings, however, so any procedural due

\textsuperscript{147} Id.
\textsuperscript{149} Kapps v. Wing, 404 F.3d 105, 113 (2nd Cir. 2005) (alteration in original) (quoting Sealed v.
Sealed, 332 F.3d 51, 55 (2d Cir. 2003)).
\textsuperscript{150} K.W. ex rel. D.W. v. Armstrong, 789 F.3d 962, 966 (9th Cir. 2015).
\textsuperscript{151} Id. at 973.
\textsuperscript{152} Id.
\textsuperscript{153} For a discussion of problems associated with fair hearings, see supra Part I.
\textsuperscript{154} 424 U.S. 319, 335 (1976).
\textsuperscript{155} Id. at 348.
process protections should not be confused as a substantive right. Nonetheless, there could be meaningful benefits from this procedural constitutional protection, such as a requirement of showing “change of condition” and ensuring decisionmaking transparency before reducing services, as discussed in Section II.B, *infra*.

2. The Duty to Supervise

Another approach to granting constitutional protections for LTSS benefits is to read a duty to supervise into the Constitution that would compel agencies to manage effectively. In response to concerns about systemic failures of program management across government, Gillian Metzger argues for a duty to supervise, contending that congressional “delegation creates a duty to supervise delegated power.” Bases for this constitutional duty to supervise could lie in the Take Care Clause—requiring the President to “take Care that the Laws be faithfully executed”—or the values at stake in due process protections—which ensure delegated power is not wielded arbitrarily.

Although Metzger’s duty to supervise is threatened by challenges in application, these may not be insurmountable. For example, practical questions might arise in giving content to the duty—determining which monitoring or advisory functions are required—and state governments generally have substantial leeway in making complex program choices in collaboration with MCOs. But courts could give meaning to the duty to supervise in standardizing best practices and building out applications of sufficient oversight. The duty to supervise ultimately may not be justiciable, but it has enough theoretical power to hold promise for improvement of government oversight, including oversight of managed LTSS and other programs.

156 See Shakhnes v. Berlin, 689 F.3d 244, 256 (2d Cir. 2012) (pointing out that, although the Medicaid Act does not define “a fair hearing,” Goldberg can imply certain procedural standards, such as ninety-day decision windows and rights to decisions associated with hearings).

157 See generally Metzger, *supra* note 37 (describing the origin and impact of a duty to supervise).

158 Id. at 1895.

159 U.S. CONST. art. II, § 3.

160 See Metzger, *supra* note 37, at 1896-99 (discussing the constitutional grounds for the duty to supervise as it relates to due process).

161 Cf. id. at 1901 (arguing that the duty to supervise would become more challenging in instances where agencies collaborate with a diffuse group of stakeholders rather than centrally managing projects).

162 See id. at 1916 (“Over time, courts would likely develop context-specific standards for what constitutes adequate supervision . . . .”).

163 See id. (“The risk of intruding on political branch prerogatives thus appears significantly greater, as does the likelihood of exceeding judicial competency, particularly the courts’ ability to render coherent and consistent decisions.”).
B. Opportunities for Better Protections

Building on the recent decisions discussed in Section II.A, supra, courts should institute constitutional due process protections that protect beneficiaries' access to care under MCO management. Courts can examine MCO actions under the Constitution's due process principles because MCO conduct could be considered “state action,” a prerequisite to judicial scrutiny under the Fourteenth Amendment. MCO decisions should be considered state action because MCO functions were “traditionally the exclusive prerogative of the State,” a condition which has been found to satisfy the state action requirement.

MCO administration results from the wholesale transfer of management for LTSS programs by the state, supporting a finding of state action. The Second Circuit has applied a similar rationale to determine that home health agencies are state actors, given the heavy involvement of state and county entities in controlling their operations, affirming the trial court's conclusion that “it is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.” Although the Supreme Court has expressed skepticism about nursing homes as state actors, MCO care decisions seem to squarely fall under the umbrella of the state action doctrine, due to the programmatic transfer of benefits administration in managed care. Some recent litigants have not challenged whether MCOs are state actors, taking this conclusion for granted.

Therefore, finding state action by MCOs, courts should treat managed LTSS benefits, and personal care hours specifically, as constitutionally protected by recognizing that levels of personal care hours are a property right. Even though states use a plethora of functional assessment methods to

164 See Jackson v. Metro. Edison Co., 419 U.S. 345, 349 (1974) (“The District Court granted Metropolitan's motion to dismiss petitioner's complaint on the ground that the termination did not constitute state action, and hence was not subject to judicial scrutiny under the Fourteenth Amendment.”).
165 Id. at 353.
166 See generally HHS 2018 LTSS MEDICAID REPORT, supra note 2 (outlining the recent historical shift to the privatization of long-term care programs); see also supra notes 19, 20, and 27 and accompanying text.
167 Catanzano v. Dowling, 60 F.3d 113, 118 (2nd Cir. 1995) (quotation and citation omitted).
168 See Blum v. Yaretsky, 457 U.S. 991, 1011-12 (1982) (rejecting the claim that nursing homes perform a function that amounts to state action).
169 See Evans v. Newton, 382 U.S. 296, 301 (1966) (finding state action when government is “entwined in [private actor's] management or control”).
170 See Bellin v. Zucker, 6 F.4th 463, 475 (2d Cir. 2021) (“Neither the State nor [the MCO] contest[] that [the MCO] is a state actor in this context.”).
determine care hours, which means they satisfy the requisite characterization as “rules or mutually explicit understandings” to justify a property right. Once courts have found protected property in a particular level of service for LTSS benefits, they can use due process principles to impose standards around long-term care.

1. Requiring Evidence of Change for Reductions

One area where constitutional standards are sorely needed is reductions in personal care hours. MCOs generally only need to show “medical necessity” to justify their decision on support levels for basic needs of beneficiaries. For instance, a recent Medicaid fair hearing in Pennsylvania concluded that a reduction in care hours by more than seventy percent was not “necessarily arbitrary” because the MCO made a showing of “medical necessity,” even though nothing had changed in the beneficiary’s circumstances to suggest how the beneficiary’s needs had changed. Although a “medical necessity” standard is logical, MCOs have been found to systematically exert pressure to reduce the hours authorized—even against the wishes of a treating physician. Thus, the standard of “medical necessity” is very slippery. The untoward result, like that in Pennsylvania, is that service levels can drop drastically for beneficiaries even when nothing in their circumstances has changed.

Absent clear evidence of a prior mistake, reductions in care without a change in circumstances are an affront to due process principles. Once courts consider LTSS benefits protected property interests, they should require MCOs to demonstrate a change of condition (or prior mistake) to allow a reduction in services for a beneficiary. Procedural due process includes

171 See MACPAC LTSS ASSESSMENT REPORT, supra note 63, at 68 (counting at least 124 assessment tools in use by states).
172 For a discussion of arguments in favor of finding a protected property interest in benefits because of well defined criteria for service authorization, see supra subsection II.A.1.
173 Perry v. Sindermann, 408 U.S. 593, 601 (1972) (citing Bd. of Regents of State Colls. v. Roth, 408 U.S. 564, 577 (1972)).
174 See, e.g., John B. v. Emkes, 852 F. Supp. 2d 957, 971 (M.D. Tenn. 2012) (“[A]n MCO’s denial of a service ordered by a licensed physician or other provider based on lack of medical necessity will be sustained only if no fewer than three different reviewing physicians . . . all agree that the service is not medically necessary.”).
175 Appeal of: A G, Case No. 460654752-001, at 16 (Pa. Dept of Hum. Servs. July 31, 2020) (“Clearly, the loss of 122 hours per week is a drastic decrease. That does not mean it is necessarily arbitrary. Having received an amount of hours in the past is not, in itself, evidence of a need for those hours in the future.”).
176 See id. (explaining that personal care hours are approved based on a holistic assessment and not just the physician’s prescription); see also LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 3 (“[T]he MCO has discretion in determining the number of service hours a beneficiary is authorized to receive.”).
evidentiary requirements under the “opportunity to be heard”\textsuperscript{177} as well as limitations against arbitrary decisionmaking.\textsuperscript{178} It defies reason that an MCO could provide a certain level of care hours one day, then cut care hours drastically upon the same material evidence. Showing a change of condition (or mistake in previous service authorization) prevents arbitrary decisionmaking.

Additional procedural due process standards must be worth it. To justify an additional procedural protection in the case of care hour reductions, the relevant standard under \textit{Mathews v. Eldridge} is that the value of any additional procedures in preventing an error in deprivation of a property interest, coupled with the interest of the claimant, must outweigh the additional burden of those procedures on the government.\textsuperscript{179} The first consideration here is the value of the procedures in preventing an erroneous deprivation of a property right. Toward this end, the requirement for a showing of a change in condition ensures accuracy and thoughtful reasoning in care decisions. Once a Medicaid consumer receives a determination of care hours, that should not change arbitrarily at reassessment or during a transfer from one MCO to another—unless the MCO can show that the first determination was based on faulty information or a mistake. This change would constitute inaccurate decisionmaking that undermines due process.

The interest of the claimant in procedural protection is also strong. A reduction in care without a change in condition undermines the health of the individual along with the welfare of society. Beneficiaries who are victim to arbitrary care reduction decisions no longer receive the support on which they have come to rely for their health and autonomy. The families and loved ones who care for those beneficiaries must scramble to reorganize their lives to prevent disaster. This residual impact can lead to workforce dropout and takes a toll on the life of caregivers.\textsuperscript{180}

To be sure, constitutional protection of care hours could impose additional costs on states and plans that currently underperform on Medicaid program requirements. But states and MCOs have a duty to navigate these challenges

\textsuperscript{177} See Goldberg v. Kelly, 397 U.S. 254, 267 (1970) (finding that principles of due process, such as the opportunity to be heard, requires an effective opportunity to defend by, among other things, “presenting . . . arguments and evidence”); see also Paul R. Verkuil, \textit{A Study of Informal Adjudication Procedures}, 43 U. Chi. L. REV. 739, 760 (1976) (listing ten “procedural ingredients” mandated by Goldberg, including "oral presentation of evidence").

\textsuperscript{178} See, e.g., Pollnow v. Glennon, 757 F.2d 496, 501 (2d Cir. 1985) ("[D]ue process requires that government officials refrain from acting in an irrational, arbitrary or capricious manner . . . .").

\textsuperscript{179} See Mathews v. Eldridge, 424 U.S. 319, 335 (1976) (setting out the consideration of three factors for the specific dictates of due process); see also supra notes 154–156 and accompanying text (recognizing the state’s significant flexibility under the Mathews factors).

\textsuperscript{180} Cf. Hoffman, supra note 18, at 153-54 (arguing that underfunding for home-based Medicaid care heaps increasingly complex responsibilities onto family and friends).
to protect beneficiaries’ rights. These costs are negligible in relation to the
benefit of ensuring needed care is provided and beneficiary rights are
protected. The requirement of a showing of change of condition upholds the
rule of law and prevents significant harm to society, outweighing any
additional cost to states and plans.

A constitutionally mandated “change in condition” requirement is
especially necessary because other protective mechanisms are in jeopardy. For
instance, until 2021, New York required by regulation a showing of change of
condition to reduce services. A181 This regulation stems from a 1996 class action
suit against New York City and state agencies that alleged inappropriate
reductions of home care for recipients. A182 The due process argument by the
court turned on the “absence of standards” around reductions, which the court
said led to “capricious” decisions, including reducing services without
showing any change in a beneficiary’s condition. A183 The state’s subsequently
implemented regulations require an MCO to “identify the specific change in
the client’s medical or mental condition or economic or social circumstances
from the last authorization or reauthorization . . . .” A184 If a mistake is alleged,
the MCO had to identify the “specific mistake” that occurred in order to
justify a service reduction. A185 However, New York’s procedural rights
regulations have recently gone back to “medical necessity.” It is no longer the
case that a plan must show a change of condition to reduce services. A186 The
rollback of regulatory fixes is an important indicator that a constitutional
stopgap is needed.

A181 See David Silva & Valerie Bogart, Medicaid Personal Care or Home Attendant Services, W.
[https://perma.cc/2CK5-VJAZ] (Dec. 9, 2021) (describing the difference between the previous and
the new regulations); see also Summary of Express Terms, N.Y. STATE, 175-80,
[https://perma.cc/NZK2-XGCJ] (describing the regulatory changes that loosen the changed
circumstances requirements).

A182 See Silva & Bogart, supra note 181 (“The agency [that] reduce[ed] services (local district,
managed long-term care) or managed care plan) [had] the burden of proof to show a change in
the individual’s medical condition or circumstances justifie[d] the reduction, or that a mistake was made
in the original authorization, and certain other limited reasons. . . . This regulation implement[ed]
§505.14(b)(5)(e))).


A186 See Silva & Bogart, supra note 181 (suggesting amendments to the state regulation, effective
Nov. 8, 2021, treat as a valid reason for reduction that an assessment demonstrates that the previously
authorized services were more than medically necessary); see, e.g., N.Y. CODE RULES & REGS. tit.
18 § 505.14(b)(5)(v)(c)(2)(viii) (2021) (permitting reductions in services based on advancements in
technology).
2. Bringing Transparency to Care Decisions

Transparency is core to due process as well. Procedural due process also includes evidentiary requirements for transparency. 187 Somewhat surprisingly, ensuring access to care through service authorization is not a simple or easily understood process. 188 The range of tools available to assess functional needs is striking. As of 2016, there were some 124 functional assessment tools in use across states. 189 MCOs often have discretion to use a functional assessment tool of their choosing, but there is little information about these tools partly because some are “proprietary.” 190 Thus, service authorizations that rely on these tools suffer from complexity, lack of transparency, and unfairness concerns, particularly when an MCO begins to implement systematic reductions to amounts of service. MCOs should have to explain their decisions to beneficiaries—no matter which of the approximately 124 assessment tools they use. A procedural due process right would guarantee a transparent explanation.

Again, the requirement of transparency must pass muster under the Mathews test. A potential problem with due process protections in the case of algorithms is that the Mathews test may not justify the cost associated with unravelling a computer code used to make a service authorization. 191 This code is likely to be somewhat complex and require extended explanation. And the interest of the individual claimant may be small in relation to the cost of expert testimony and production of computer code. 192 Reframing the Mathews test, however, would lead to the conclusion that the benefits in the long run—avoiding the recurring harm to beneficiaries’ rights to care—are worth the costs of explanation and production in any individual case. 193 Thus, even if algorithms are used in service authorization decisions, procedural due process should still be strong enough to force transparency.

187 See Verkuil, supra note 177, at 760 (interpreting Goldberg v. Kelley’s requirements for procedural due process in welfare adjudications, including “timely and adequate notice” and “a statement of reasons for the determination and an indication of the evidence relied on”).
188 MACPAC LTSS ASSESSMENT REPORT, supra note 63, at 76 (describing the wide variation in information collected and noting that many states document assessments on paper rather than electronically, making aggregate analysis difficult).
189 Id. at 68.
190 Id.
191 See Danielle Keats Citron, Technological Due Process, 85 WASH. U. L. REV. 1249, 1284 (2008) (“Computer systems fundamentally change the costs and benefits of additional process in ways Mathews could not have anticipated.”).
192 Id.
193 See id. at 1286 (suggesting that in conducting a Mathews cost-benefit analysis, the fixed cost of deciphering an algorithm should be compared with the benefits to the current case and any future cases which would be prevented by the analysis).
III. THE BEST APPROACH: FORMAL RELATIONAL CONTRACTING BY STATES

Even if the courts or CMS could do more, the state–MCO contract remains the most effective vehicle for accountability between a state Medicaid program and the MCO. The effectiveness of the contract depends, however, on the quality of the relationship between an MCO and the state holding the contract.\textsuperscript{194} Although the contract provides states with leverage, states are not always able to hold MCOs accountable to contract standards.\textsuperscript{195} A gap may exist between contract design and execution. Contract performance involves a host of unobservable efforts because the private MCOs control day-to-day operations.\textsuperscript{196} Thus, a key approach for improving MCO accountability is ensuring a good working relationship between the state and an MCO, in which the state can rely on an MCO to make day-to-day decisions that accord with the goals of the managed LTSS program.\textsuperscript{197}

A. Why Traditional Contracts Fail in Managed Long-Term Care: Shading

Deficits in contract execution loom large in managed care. Many of these are the result of “shading.” Shading may be thought of as pursuing the letter rather than the spirit of a contract.\textsuperscript{198} Shading on contracts was first described by economists John Moore and Oliver Hart,\textsuperscript{199} the latter of whom won a 2016 Nobel Prize in economics for his contributions to contract theory.\textsuperscript{200} Hart and Moore distinguished perfunctory performance from consummate performance. Perfunctory performance may be court-enforced and involves

\textsuperscript{194} See Metzger, supra note 37, at 1851-52 (arguing that the contract can be an effective mechanism for accountability in the privatization context when the government takes on sufficient responsibility).

\textsuperscript{195} See Jeremy Rubel, Expanding Access to Care Through Public Services: A Discussion with a Medicaid Director, PULSE (Jan. 7, 2022), https://www.whcbc.org/pulse/expanding-access-to-care-through-public-service-a-discussion-with-a-medicaid-director [https://perma.cc/4Q7K-LP7R] (“[T]he state already has a lot of power in contracts with MCOs, but just because the rights are on paper doesn’t mean the state is able to execute.”).

\textsuperscript{196} Metzger, supra note 37, at 1850 (articulating the unobservability of private vendor actions in the privatization context).

\textsuperscript{197} See Rubel, supra note 195 (“I try to get my teams excited about contract management because you can make a big difference if you’re dedicated and persistent.”).

\textsuperscript{198} See Oliver Hart & John Moore, Contracts as Reference Points, 123 Q.J. ECON. 1, 3, 6 (2008) (labeling following the letter of the contract as “perfunctory performance” and following the spirit of the contract as “consummate performance” and indicating that shading is the withholding of consummate performance while providing perfunctory performance).

\textsuperscript{199} David Frydlinger, Oliver Hart & Kate Vitasek, A New Approach to Contracts, HARV. BUS. REV., Sept.–Oct. 2019, at 120.

following the bare contract terms, doing the minimum of what is required.\textsuperscript{201} Consummate performance, meanwhile, means pursuing the contract's underlying objectives.\textsuperscript{202}

Shading occurs when a party decreases consummate performance as a result of feeling shortchanged.\textsuperscript{203} Formally, shading on a contract is “a retaliatory behavior in which one party stops cooperating, ceases to be proactive, or makes countermoves”—dropping from consummate to perfunctory performance, from the spirit to the letter, or worse.\textsuperscript{204} This risk of being shortchanged, inherent in the managed care arrangement, forms a powerful background condition that can motivate shading. Underperformance due to shading takes place at the detriment of beneficiaries.

1. Drivers of Shading

State–MCO contracts in LTSS fail to maintain accountability because of this potential for shading, which is driven by the capitated payment arrangement. Managed care arrangements are fundamentally uncertain: the payment is well defined because capitated payments are fixed in advance, but the capitated payment is established without knowledge of the exact future services required by beneficiaries.\textsuperscript{205} This uncertainty exposes the MCO to the risk that utilization costs will exceed payments. In aggregate, such discrepancies can squeeze margins or add up to losses for the MCO.

Managed care arrangements include this risk by design. In practice, the state and MCO work together to set fair rates based on available information, such as historical cost and utilization statistics.\textsuperscript{206} But there is a consistent and inevitable risk that the MCO will see itself shortchanged. Even though rates must be actuarily sound,\textsuperscript{207} one could speculate that auditors may set assumptions at the far end of ranges, increasing the risk that an MCO could incur a loss. And the capitation arrangement does not allow for adjusting payment to final cost for a beneficiary. That adjustment would defeat the

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\textsuperscript{201} Hart & Moore, supra note 198, at 3.
\textsuperscript{202} Id.
\textsuperscript{203} See Hart & Moore, supra note 198, at 2 (“A party who is shortchanged shades on performance[. . . .]
\textsuperscript{204} Frydlinger et al., supra note 199, at 120–21.
\textsuperscript{205} See MANAGED CARE PAYMENT RISK REPORT (GAO-18-528), supra note 19, at 4 (explaining the capitated payment model).
\textsuperscript{206} See id. at 12 tbl. 2 (outlining the risks associated with managed care payments and describing the types of data that, if incorrect, can affect the fairness of capitation rates).
\textsuperscript{207} See, e.g., 42 C.F.R. § 438.7 (requiring that the data used for rate-setting be described with detail sufficient to allow for the application of actuarial principles during review by CMS or other parties).
fundamental structure of managed care. Thus, payments often fall short, leading to the possibility of shading.

Theoretically, parties that are uncertain about the future at the time of contract formation can agree on how to respond to particular circumstances, making the contract contingent on future conditions.208 Thus, the state and the MCO may try to contract around rate-setting problems by implementing risk adjustment. Risk adjustment stratifies expected costs for a beneficiary based on their care needs.209 The more involved the needs, the higher the expected costs. Any subjectivity in interpretations about what condition to trigger in the future, however, could lead to disagreement.210 And disagreement due to subjectivity opens the possibility that one party will feel undercompensated for its efforts and shade as a result.211

Risk-adjusted payments in managed LTSS result in this type of subjectivity. In acute services, diagnoses on claims are a reliable indicator of cost.212 Risk-adjustment of costs in LTSS, however, is far less certain because it relies on data about functional limitations and other measures not always included in claims.213 States like New York have made some progress toward risk-adjusting by linking functional assessment information with costs through uniform records of need levels for beneficiaries and tying these need levels to costs of services.214 But risk-adjustment in managed LTSS continues to have serious methodological limitations.215

After-the-fact risk adjustment also does not mitigate the potential for parties to perceive they are shortchanged. States have flexibility to choose a risk adjustment model, and states’ after-the-fact risk adjustment must be budget neutral—meaning increases in payment to an MCO must be offset

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208 See Hart & Moore, supra note 198, at 18 ("Why can agreements between two parties who will both learn the state of the world not be made state contingent?").


210 See Hart & Moore, supra note 198, at 18 ("State-contingent agreements are more problematic if . . . the state in question is a (more) subjective value-cost pair. Subjectivity opens the door to differing interpretations.").

211 See id. at 18-19 (explaining how differing interpretations can lead one party to feel underpaid and respond by shading).

212 MATHEMATICA, RATE-SETTING, supra note 209, at 10.

213 Id.

214 Id.

215 See MEDICAID & CHIP PAYMENT & ACCESS COMM., MEDICAID MANAGED CARE CAPITATION RATE SETTING 7 (2022), https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf [https://perma.cc/MF8C-BKYK] ("While some risk adjustment tools are better than others in predicting costs, even the most accurate explain less than 30 percent of variation in medical costs across individuals on a prospective basis . . . .") (citation omitted)).
through lower payments to others.\textsuperscript{216} Having profits reduced or eliminated by after-the-fact risk-adjustment is likely to appear unfair to the party at a loss, regardless of the methodology states choose, as self-serving biases color perceptions of fairness.\textsuperscript{217} Thus, these risk adjustments trigger the potential for feelings of aggrievement.

MCOs may also engage in shading as retaliation for other forms of perceived unfairness. Although concerns about capitation may be a primary driver of shading—and is a persistent feature of the managed care contract—an MCO could feel shortchanged in other ways. Unanticipated administrative challenges, delayed payments, or views that the state is uncooperative or unhelpful may also lead indirectly to a sense of aggrievement—or the view that the capitated payment is not enough to compensate for the toil.\textsuperscript{218} Thus, when the state, as the buyer of MCO services shades by behaving uncooperatively, it could lead the MCO to respond in kind.\textsuperscript{219}

2. How Shading Manifests

If the MCO feels shortchanged by the state, it may engage in perfunctory rather than consummate performance.\textsuperscript{220} Shading does not have to be conscious, as if done in bad faith.\textsuperscript{221} A party that does not get what they want out of the contractual relationship may simply lack the motivation to do more than the bare minimum, a form of shading.\textsuperscript{222} Whether shading is caused directly or indirectly, or occurs in good or bad faith, it can have significant impacts on care. When an MCO cuts back on performance, in even subtle ways, it can lead to bad outcomes for beneficiaries.

\textsuperscript{216} Id.

\textsuperscript{217} See Linda Babcock & George Loewenstein, Explaining Bargaining Impasse: The Role of Self-Serving Biases, 11 J. ECON. PERSPS. 109, 110 (1997) (describing how self-serving biases can make bargainers avoid settlements perceived as unfair).

\textsuperscript{218} See Hart & Moore, supra note 198, at 10-11 ("The buyer can also make life difficult for the seller by quibbling about details of performance, by delaying payment, or by giving a bad reference. . . . In spite of these conflicting feelings of entitlement . . . trade will occur. However, each party will feel aggrieved and will shade.").

\textsuperscript{219} Id.

\textsuperscript{220} See id. at 3-4 ("[W]e distinguish between perfunctory performance and consummate performance, that is, performance within the letter of the contract and performance within the spirit of the contract. Perfunctory performance may be judicially enforced, whereas consummate performance cannot." (footnote omitted)).

\textsuperscript{221} Frydlinger et al., supra note 199, at 121 ("The aggrieved party often cuts back on performance in subtle ways, sometimes even unconsciously, to compensate.").

\textsuperscript{222} See id. at 121-22 (describing how shading manifests when a company "ceases to be proactive"); see also Hart & Moore, supra note 198, at 9 ("A third example [of shading] would be 'working to rule': the seller abides by the strict terms of the contract and offers no more.").
Shading may take several forms. Hart and Moore use an example of a contract for a wedding cake to illustrate three forms of shading. First, the baker can shade by reducing quality by curbing the ingredients or baking with less care. Second, the baker may shade by withholding cooperation. There may be last-minute logistical details to work out, and the baker would normally cooperate to figure them out. But the baker that feels shortchanged by the contract may refuse to cooperate. Finally, the baker may shade by “working to rule” — doing the bare minimum and no more.

All three forms of shading appear in the context of MCOs. Take, for example, deterioration in quality of services. Virginia’s MCO contracts required MCOs to seek out additional information from beneficiaries before making adverse care determinations. However, between 2018 and 2019, half of the state’s contracted MCOs—three out of six—denied or reduced services without pursuing the requisite information, and after cutting services they did not follow up on the beneficiaries’ status. Both of these failures by the MCOs are, in part, failures of proactivity. The contract required MCOs to help beneficiaries submit information that would support their requests, and the MCOs cut back by not providing this support—likely instances of shading. Even though the contract generally required these efforts, the MCO subtly underperformed. This small difference in performance led to a huge impact: The result was beneficiaries not getting access to care.

In other cases, MCOs may withhold cooperation. Cooperation includes reporting problems in a timely manner so the parties can address them. For example, between 2018 and 2019 in Arizona, three of four MCOs did not report multiple quality of care concerns. These could be quite serious, in some cases involving large medication errors, abuse, or harm. When an MCO fails to raise issues with state agencies, it withholds a kind of cooperation. Thus, suppressing this key information on care quality is another likely instance of shading.

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223 Hart & Moore, supra note 198, at 9.
224 Id.
225 Id.
226 Id.
227 LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 16-17.
228 Id. at 17.
229 See id. at 16-17 (“All three MCOs either denied or reduced services for beneficiaries before seeking additional information that may have justified the beneficiary’s request, as required by contract.”).
230 Id.
231 Id.
232 Id. at 18.
233 Id.
Finally, there is shading by “working to rule.”234 For instance, a motivated MCO should collect and analyze data on a range of issues. These data could be useful for contract administration and management, independent of state or federal requirements. Data might include changes to care plans, appeals, and appeal reasons and status.235 In several states, however, MCOs were found to not collect key data or standardize data for analysis unless required to do so by the contract.236 This failure to collect and analyze important operational data is likely an example of “working to rule.” Although a motivated partner would take reasonable steps above and beyond the contract—such as tracking and reporting key metrics—one set on shading will stick to the contract’s precise terms and do nothing more.

3. Addressing Alternative Explanations

In the MCO context, it is not knowable whether these cutbacks result from aggrievement or retaliation. One alternative explanation is that cutbacks result from a lack of resources or an interest in profit maximization. This explanation is unconvincing, however, because an MCO can solve many problems without significant resource additions. Helping beneficiaries submit additional requisite documentation is possible by simply instructing staff on when and how to accommodate information submissions. Surfacing issues to the state requires a simple call or email. Although collecting useful data sometimes requires investments in new or different IT systems, often these systems are already in place and the needed changes are costless operational ones: to input the requisite data or pull the right reports. Thus, it is not likely that resourcing is to blame for these failures.

Another explanation for these performance failures is a lack of competence or focus, which is solvable through improved contractual incentives. Contractual penalties or incentives, however, do not eliminate the conditions that give rise to shading. If a state puts in place penalties associated with contract specifics, states and MCOs would still argue about when these should trigger,237 along with who is at fault.238 It is hard to show, for instance, that an MCO did not do enough to aid a beneficiary in providing documentation. The MCO will argue that it gave the beneficiary a chance.

234 Hart & Moore, supra note 198, at 9.
235 See, e.g., LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 22 (providing examples of states that did not require reporting of data such as the number of beneficiaries who have had service reductions or the nature of expedited appeals).
236 Id.
237 See Hart & Moore, supra note 198, at 18-19 (outlining how any subjectivity propagates shading because of differing interpretations by the parties).
238 Blame-shifting and finger-pointing is reduced under the formal relational contracting approach. See discussion infra subsection III.B.3.
The state may argue that it should have followed up again. It is also hard to show a lack of cooperation in reporting issues—the state does not know what it does not know. When the parties disagree, the MCO may feel the state is being unfair, and retaliate.

The judicial system is not an efficient factfinder on the details of these cases. Establishing a violation—showing that the MCO failed to achieve consummate performance—is not clearly judicially manageable, making enforcement costly or impossible through courts. For good faith obligations to be judicially manageable, a commitment to partnership is required, as a recent case in the United Kingdom suggests, interpreting the implications of a relational contract. At the same time, although CMS permits states to conduct operational reviews of contract performance, it is impossible for the state to watch every interaction between MCOs and beneficiaries to verify who is right about performance issues. The cost of monitoring is too high, especially under tight state budgets. The uncertainty that enables shading remains despite contractual specificity and incentives.

B. Formal Relational Contracting as a Solution to Shading

Business scholars advocate for a “formal relational contract process” to prevent shading and encourage consummate performance. Traditional contracts distill an agreement to well-defined obligations. In contrast, a relational contract often involves a “handshake” deal with vague terms, such as a requirement to engage in “best efforts,” due to the parties’ inability to identify a future state or to specify responses to complex conditions—even if those conditions are known. A representative example of a relational contract is an employment contract, in which a firm retains the employee to

239 See Hart & Moore, supra note 198, at 6 (distinguishing between performance within the “letter” of the contract versus the “spirit”, which concerns the quality of performance).
241 See Armen A. Alchian & Harold Demsetz, Production, Information Costs, and Economic Organization, 62 AM. ECON. REV. 777, 780 (1972) (describing the prohibitive costs of monitoring the quality of every individual’s contribution in any team enterprise).
242 Frydlinger et al., supra note 199, at 121.
243 See Charles J. Goetz & Robert E. Scott, Principles of Relational Contracts, 67 VA. L. REV. 1089, 1091 (1981) (“A contract is relational to the extent that the parties are incapable of reducing important terms of the arrangement to well-defined obligations.”).
244 Id.; See also Frydlinger et al., supra note 199, at 121 (“The benefits of informal ‘handshake’ deals have been studied and promoted over the decades . . . ”).
work in its interest while providing little detail on precise obligations in the contract itself.\textsuperscript{246} Between organizations, a relational contract can be thought of as a primary alternative to housing all functions under one roof through vertical or horizontal integration.\textsuperscript{247}

The “formal relational contract” builds on relational contracts by “specifying] mutual goals and establish[ing] governance structures to keep the parties’ expectations and interests aligned over the long term.”\textsuperscript{248} A contract may exist on a spectrum between traditional and relational, as it may specify some terms in detail while leaving other terms open ended.\textsuperscript{249} The formal relational contract balances rigidity and flexibility.\textsuperscript{250} Written goals in the contract formalize a shared vision; principles ensure collaborative problem-solving; robust governance structures create transparency to foster trust. These mechanisms keep parties aligned, ensuring that disputes or dissatisfaction do not lead to shading.

Some may consider formal relational contracting “fluffy”\textsuperscript{251} or wishful. But this approach is well-adapted to deal with shading, especially in the context of government procurement. The approach was developed from an analysis of U.S. Air Force outsourcing arrangements between the Air Force and private vendors.\textsuperscript{252} In the early 2000s, researchers analyzed a multitude of outsourcing relationships to determine why some succeeded and others failed.\textsuperscript{253} What set successful relationships apart from non-successful ones was a shared vision and trust.\textsuperscript{254} The shared vision often centered around innovation, value creation, and rewarding outcomes; trust was built around

\textsuperscript{246} Goetz & Scott, supra note 244, at 1091.
\textsuperscript{247} See Ronald Coase, The Nature of the Firm, 4 ECONOMICA 386, 392-93 (1937) (describing the tradeoff between integration and relying on the market); see also Goetz & Scott, supra note 244, at 1091 (offering vertical integration as an alternative to the relational contracting approach).
\textsuperscript{248} Frydlinger et al., supra note 199, at 119.
\textsuperscript{249} See Goetz & Scott, supra note 244, at 1092 (“In conventional contracts, the parties generally are able to reduce performance standards to rather specific obligations. By contrast, relational contracts create unique, interdependent relationships, wherein unknown contingencies or the intricacy of the required responses may prevent the specification of precise performance standards.”).
\textsuperscript{250} See Frydlinger et al., supra note 199, at 121 (noting that the “keiretsu model” is too inflexible, while informal handshake deals are not sufficiently reliable, leaving formal relational contracting an alternative that “addresses these deficiencies”); see also Hart & Moore, supra note 198, at 4 (“A flexible contract has the advantage that parties can adjust the outcome to the state of the world, but the disadvantage that any outcome selected will typically cause at least one party to feel aggrieved and shortchanged[. . . .] An optimal contract trades off these two effects.”).
\textsuperscript{252} Id. at 129.
\textsuperscript{253} Id. at 134.
\textsuperscript{254} Id.
transparency. Far from “fluffy,” these factors—vision and trust—differentiated success from failure. And as the example below illustrates, the “formal relational contract” process is not wishful but very realistic, even in complex healthcare situations. It is a simple approach with enough leverage to address the accountability and performance issues in managed long-term care.

1. History of Relational Contracting Approaches

The study of relational contracts has largely centered on supplier relationships in the auto industry. Starting in the 1980s, Japanese manufacturers practiced keiretsu, a partnership approach for supplier relationships which emphasizes trust and goodwill. This relational approach stood in contrast with “Western-style arm’s-length supplier relationship” governed by traditional, detailed contracts. In the 1990s, Chrysler brought keiretsu to the United States and invested in supplier relationships, often using oral agreements, sharing savings and innovating with car part suppliers—and achieving remarkable results of bringing costs down by twenty to forty percent and development time down from 234 weeks to 160 weeks. Toyota also continued its relational approach in the early 2000s, writing vague contracts that focused on goals and efforts to encourage suppliers to “go the extra mile” —to innovate, cut costs, and meet customer needs.

Even with real-world examples, relational contracting has long been a “paradoxical” business practice to scholars—why wait to specify terms when they could be written up-front—that has spawned considerable legal, economic, and business theory.

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255 Id.
256 See Jeffrey H. Dyer, How Chrysler Created an American Keiretsu, HARV. BUS. REV., July-Aug. 1996, at 42-43 (describing how Chrysler employed keiretsu in its supplier relationships, building on previous models from Japan).
257 See Aoki & Lennerfors, supra note 60, at 110 (describing how keiretsu at Toyota has changed over time).
258 Id.
259 Dyer, supra note 256, at 43.
260 Aoki & Lennerfors, supra note 60, at 110.
261 See, e.g., Vitasek et al., supra note 251, at 126 (providing an overview of evolving theory on relational contracts).
262 Id.
other party’s vulnerability, and shading occurs when one party feels “shortchanged” by the other and defaults to perfunctory performance. Relational contracts eschew these problems in favor of mutually beneficial outcomes.

2. An Example of the Approach in Practice

The formal relational contracting approach harnesses the benefits of relational contracting. A recent case involving contracting for inpatient care—a complex healthcare situation—is instructive. The Vancouver Island Health Authority and South Island Hospitalists—a partnership of administrators and doctors working together to deliver inpatient care—decided to pursue formal relational contracting in 2016 after many contentious renegotiation attempts for an expiring contract. In addition to markedly improving satisfaction among both parties, this contracting approach helped them reduce costs, improve revenue, and adapt to new laws and regulations.

The parties worked together across three phases to build the contract—roughly divided into a relationship-building phase, contract design phase, and contract management phase. In the relationship-building phase, the parties focused on developing a “partnership mentality” by setting up a collaborative contract design process and adopting a shared vision and goals. The shared vision included “excellence in patient care,” to build a quality system; maintaining a “strong partnership,” to foster a healthy working relationship; and ensuring a “best-value” service, to sustain operational excellence with efficient budgeting and billing.

The second phase was contract design. At the outset there was a commitment to six guiding principles—reciprocity, autonomy, honesty, loyalty, equity, and integrity—in order to resolve potential disputes. Reciprocity, for instance, involved a commitment to “conduct ourselves in the spirit of achieving mutual benefit and understanding.” The commitment is vague but offers a starting point for dialogue. These guiding principles also

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263 Frydlinger et al., supra note 199, at 120.
264 See Hart & Moore, supra note 198, at 2 (“A party who is shortchanged shades on performance, which causes a deadweight loss.”).
265 Frydlinger et al., supra note 199, at 121-22.
266 See id. at 125 (“The number of people who expressed a positive attitude toward the relationship increased by 84% in just two years.”).
267 Id.
268 For a discussion of how to follow this approach while maintaining compliance with state procurement laws, see infra Section III.C.
269 Frydlinger et al., supra note 199, at 122.
270 Id.
271 Id. (quotation marks omitted).
incentivize resolving differences rather than going to court, as both parties share the risk of breaching the aspirational standards set by the guiding principles.\textsuperscript{272} Next, the parties moved to the detailed contract terms with a “problem-solving mentality instead of a negotiations mentality.”\textsuperscript{273} This step is supported by transparency about economics and constraints faced by both entities.\textsuperscript{274}

The final phase implemented a formal governance approach to manage the contract.\textsuperscript{275} The contract laid out a structure of “governance teams” to pursue shared goals by monitoring benchmarks and milestones.\textsuperscript{276} For instance, the “relationship team” focused on monitoring the parties’ relationship, and the “best value team” focused on finance, billing, and other efficiency concerns.\textsuperscript{277} Each team contained a counterpart from each organization, helping people know who to call when issues arose.\textsuperscript{278}

As these governance teams illustrate, the formal relational contracting approach engages staff at multiple levels of the two entities.\textsuperscript{279} The team that rewrote the Vancouver Island Health Authority and South Island Hospitalists had twelve administrators and twelve hospitalists.\textsuperscript{280} The improved relationship that formal relational contracting creates, then, may result from a series of relationships between staff at the two contracting parties. These relationships are preserved by the ongoing governance approach described above, which pairs counterparts. The relationships formed through formal relational contracting plausibly act to motivate staff across levels in both organizations involved in the contract, preventing shading at any level from frontline to management.

3. Why Formal Relational Contracting Is a Necessity

Some may see formal relational contracting as disproportionate to the problem, and that not all accountability or performance issues are instances of shading. These critiques could lead one to conclude that legal protections or performance incentives are sufficient to resolve issues. For instance, in

\begin{itemize}
\item \textsuperscript{272} Id. at 123.
\item \textsuperscript{273} Id. (quotation marks omitted).
\item \textsuperscript{274} Id.
\item \textsuperscript{275} Id. at 125.
\item \textsuperscript{276} Id.
\item \textsuperscript{277} Id. (emphasis omitted).
\item \textsuperscript{278} Id.
\item \textsuperscript{279} See David Frydlinger & Oliver Hart, Overcoming Contractual Incompleteness: The Role of Guiding Principles 8 (Jan. 2022) (unpublished manuscript) (on file with author), https://scholar.harvard.edu/hart/publications/overcoming-contractual-incompleteness-role-guiding-principals [https://perma.cc/3U8Q-ND7U] (quoting a cohead of a contracting team who noted relationship-building took place at all levels).
\item \textsuperscript{280} Id.
\end{itemize}
2018, New York MCOs reduced personal care services for eighty-eight percent of cases reviewed without an adequate change in the beneficiaries’ conditions or circumstances. These reductions could not strictly be considered shading because the cutbacks—without showing of a change in condition—could be readily adjudicated. In fact, this is the exact scenario the constitutional due process protections discussed above could prevent against. Other problems unrelated to shading might include a failure to carry out important tasks for beneficiaries in a timely manner. To prevent these problems, the state could include contractual incentives. For instance, Florida has a schedule of damages for MCOs that fail to provide services at specified levels. And New York has implemented a program that financially rewards quality and improvement.

Although these tactics can be helpful, formal relational contracting, designed to prevent shading, also prevents non-shading related issues. It stands to reason that the best safeguard for accountability and performance is motivation, not monitoring. Within an organization, a motivated employee is worth far more than one subject to rigorous supervision. And between organizations, it is intuitive that a motivated partner is worth far more than a partner that does just enough to avoid consequences. Building motivation toward shared goals is the purpose of the formal relational contract. When an MCO pursues the goals of the managed care program along with the state,

281 LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 18.
282 For a discussion of the impact of constitutional due process protections, see supra Part II.
283 LTSS ACCESS & QUALITY REPORT (GAO-21-49), supra note 1, at 21.
284 See Model Health Plan Contract, Exhibit II-B – Long-Term Care (LTC) Managed Care Program, AGENCY FOR HEALTH CARE ADMIN. at 71 (Oct. 1, 2021) [hereinafter Model Health Plan Contract – LTC Managed Care], https://abca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2021-10-01/Exhibit_Il_B_LTC_2021-10-01.pdf#page=71 [https://perma.cc/U983-RTHR] (describing financial penalties for failures such as neglecting to follow up and ensure in-home home and community-based services are in place). Signed model ACHA contracts are not always publicly available.
286 See Frydlinger et al., supra note 199, at 120-21 (discussing how formal relational contracting can decrease hold-ups, incomplete contracts, and shading).
287 John Bohannon, One Type of Motivation May Be Key to Success, SCI. (July 1, 2014), https://www.science.org/content/article/one-type-motivation-may-be-key-success [https://perma.cc/N3Q7-YVWD] (attributing the success of military officers to internal motivation as opposed to external drivers or incentives, and suggesting that the finding is robust in other contexts).
288 Frydlinger et al., supra note 199, at 119.
it seems a natural consequence that it will prevent the infringement of rights, an outcome that is paramount for the contract. In addition, the specter of litigation looms if a party cuts back in its pursuit of the contract’s aspirations or grounding principles, deterring underperformance.289

Formal relational contracting motivates toward partnership. Of course, motivation toward more specific ends is possible, as the contract with the MCO can set particular performance standards, which trigger legal action or financial damages if not met, or provide additional incentives if the MCO performs particularly well.290 So, why motivate toward partnership through formal relational contracting, in addition to performance through specific standards?

One of the observations of the keiretsu business relationship in the auto industry, which relies on obligations linked to trust, is that a primary source of hidden costs in a standard supplier relationship is the use of unproductive finger-pointing and blame-shifting to obscure the root causes of problems.291 Under a keiretsu relationship, however, car manufacturers and car suppliers have incentives to work together to find solutions.292 Thus, in light of similarities between the keiretsu relationship and formal relational contracting, it follows that when problems arise between a state and MCO with a formal relational contract between them, both entities would likely engage in problem-solving rather than claiming the other is at fault, an adversarial reaction that obscures the root causes—and potentially the solutions.

To be sure, states should design contracts that set better performance standards. States can also pursue systems of incentives, coupled with oversight.293 But the wellbeing of managed LTSS beneficiaries will be in danger if the MCO does just the bare minimum—as anything short of attentive vigilance and cooperation by an MCO at any stage of service

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289 Id. at 122-23.
290 See e.g., Model Health Plan Contract – LTC Managed Care, supra note 284, at 71 (describing financial penalties for failures such as following up to ensure in-home HCBS services are in place); N.Y. DEPT OF HEALTH, 2019 QUALITY INCENTIVE REPORT 3 (2019), https://www.health.ny.gov/health_care/managed_care/reports/docs/quality_incentive/quality_incentive_2019.pdf [https://perma.cc/P5V2-L2YZ] (outlining the incentive program used to encourage higher quality care and patient satisfaction from New York managed care plans).
291 Aoki & Lennerfors, supra note 60, at 110-12.
292 Id. at 112.
293 See e.g., Model Health Plan Contract – LTC Managed Care, supra note 284, at 71 (describing financial penalties for failures such as following up to ensure in-home HCBS services are in place); MINN. DEPT OF HUM. SERVS., CONTRACT FOR MINNESOTA SENIOR HEALTH OPTIONS AND MINNESOTA SENIOR CARE PLUS SERVICES 102 (Jan. 1, 2022), https://mn.gov/dhs/assets/2022-seniors-contract-bp_tcm1053-514949.pdf?false [https://perma.cc/3YK4-HYQV] (describing remedies or sanctions the state may impose for a determination of noncompliance with sections of the contract).
authorization, coordination, and care delivery risks a bad outcome for beneficiaries in a vulnerable state. Formal relational contracting is a simple approach that covers accountability and performance problems—shading or otherwise. In the end, the state must rely on the MCO as a partner in surfacing and addressing issues in complex care management. This partnership approach is what formal relational contracting achieves.

4. Why Formal Relational Contracting Is Particularly Well-Suited to Managed Long-Term Care

Formal relational contracting also has substantial upsides in the LTSS context. Populations receiving LTSS have significant health needs. States frequently look to MCOs to help address social determinants of health (SDOH), such as housing needs and food insecurity, which can affect these populations in LTSS programs. Tight relationships with MCOs would allow states to effectively enable access to resources for their beneficiaries. The shared vision associated with the formal relational approach would allow the state–MCO contract to set out goals for population health that drive SDOH programs. And the governance structures built into the contract would provide a mechanism for the parties to monitor any ongoing pilots or benefit programs.

The formal relational contract also enables adaptability. When unforeseen issues arise, and the state and MCO must work together to resolve them, the formal relational contract lays the basis for doing so while leaving room to accommodate ever-changing regulatory and legal environments. The state must have MCO partners that can adapt to these changing circumstances to continue delivering on the goals of the contract. The formal relational contract enables adaptability by garnering a commitment toward shared goals and by laying out a governance structure in which the parties can collaborate to achieve those ends. The goal-based framework of the formal relational contract gives both the state and the MCO a shared vision, fostering creativity by establishing clear ends but leaving means moldable. The guiding

294 For a discussion on how small operational shortcomings may lead to issues for beneficiaries, see supra subsection III.A.2.

295 HHS 2018 LTSS MEDICAID REPORT, supra note 2, at 1 (“Long-term services and supports (LTSS) encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities.”).

296 See Hinton & Stolyar, supra note 21 (“Many states are leveraging MCO contracts to promote strategies to address social determinants of health (SDOH) . . . . Social determinants of health (SDOH) are the conditions in which people are born, grown, live, work, and age that shape health.”).

297 See Frydlinger et al., supra note 199, at 125 (commenting on how formal relational contracting’s governance structure helps parties deal with scope creep).
principles approach, focusing on fairness and equity, gives the parties confidence that the other “has its back” when it undergoes novel costs or efforts to adapt, trusting that the other party sees that effort and will reward it accordingly. The governance structures built into the contract allow the parties to both exchange up-to-date information about what is happening on the ground and create solutions. Shared goals, principles, and governance—all key aspects of the formal relational contract—allow for effective contract evolution.

C. Avoiding Practical Barriers & Pitfalls

There are several key concerns about the practicality of formal relational contracting in the government setting. First, whether procurement laws prevent the tight relationship between states and MCOs that formal relational contracting requires. Second, whether states have the institutional capacity to engage in a labor-intensive contracting process with MCOs, given that states may hold many contracts and have many other duties. Third, whether a tighter relationship between states and MCOs will shut out third parties, such as advocacy organizations, from the conversation. Finally, whether the realities of the contracting marketplace—such as available profit margins or underfunded programs—undermine productive state–MCO relationships. As set forth below, however, several state experiments with initiatives across relationship management, procurement choices, and contract design bode well for the success of formal relational contracting.

1. Maintaining Compliance with Procurement Laws

Despite the fact that the formal relational contracting approach developed from government procurement, some may argue that state procurement rules, which differ state-to-state, limit how state officials can interact with private vendors, imposing constraints on relationship-based contracting. Agencies, however, generally have tools that allow them to pursue tight collaboration with MCOs. One tool, if available, is an ongoing relationship, such as an existing managed care contract. A current partner could be a future partner, and the state can use an ongoing relationship with an MCO to build trust, understand objectives, surface pain points, and align expectations and interests.

298 See id. at 122 (explaining that guiding principles, including loyalty and equity, encourage mutually beneficial activities).

299 See Vitasek et al., supra note 251, at 129 (describing how formal relational contracting grew out of an Air Force research contract).

300 See GEORGETOWN UNIV. HEALTH POL’Y INST., supra note 122, at 2 (describing significant state variation in the managing of MCO procurement).
Other tools also set a foundation for formal relational contracting. States can use both Requests for Information (RFIs) and procurement documents to attract collaborative partnerships. The RFI is a mechanism for the government to solicit engagement from private parties in response to public questions issues by the agency.\footnote{See \textit{RESULTS FOR AMERICA, AN RFI GUIDE: HOW REQUESTS FOR INFORMATION CAN IMPROVE GOVERNMENT HUMAN SERVICES CONTRACTING}, 3, 5 n.1 (2019), \url{https://results4america.org/wp-content/uploads/2019/02/RFIGuide_FINAL.pdf} \[https://perma.cc/PZ77-G9E6\] (explaining the benefits of an RFI and noting that it may be referred to by a variety of names).} At least one policy organization has championed the use of RFIs for better contracting, describing the RFI as a means for government and private organizations to “identify relevant community challenges, co-create strategies to solve those challenges, and design the best procurement structures to achieve the desired outcomes.”\footnote{Id. at 3.} The RFI can allow many of the initial steps of formal relational contracting to proceed while honoring procurement rules. Finally, a pathway to setting shared objectives is the procurement document, formally known as the Request for Proposal (RFP), which sets forth state expectations for MCOs under the contract\footnote{See \textit{GEORGETOWN UNIV. HEALTH POL’Y INST.}, supra note 122, at 8 (describing the role of the RFP in the procurement process).}—and which can incorporate the goals and guiding principles for the desired relationship between the state and the MCO.

2. Ensuring Institutional Capacity

Another potential concern is that the state or the MCO may lack the institutional capacity needed to dedicate sufficient resources to what could be a time-consuming task.\footnote{See Frydlinger & Hart, supra note 279, at 5 (“First, we do not want to suggest that a formal relational contract should be used in all situations. As will become clear such a contract requires a great deal of communication and discussion both ex ante and ex post, and this is undoubtedly time-consuming and costly.”).} The state has a myriad of other legal and administrative obligations, and the MCO has many other assets and populations to manage. Two approaches can help manage institutional capacity for the state: investment in high-quality contract management talent and limiting the number of MCO relationships to manage. For the MCO to invest in relationship management, structural incentives must be aligned, as discussed in subsection III.C.4, \textit{infra}.

Even if not yet fully embracing formal relational contracting, some states have adapted to ensure that they have the institutional capacity needed to improve their relationships with MCOs, in recognition of the importance of these relationships. Rhode Island, for example, has raised its focus on investing in talent to manage contracts with plans, with Ben Shaffer, the
former director of Rhode Island Medicaid, stating: “[s]uccessful contract management requires investment in high quality state staff. I regularly had meetings with the governor’s office and legislative branch to make the case for competitive salaries for contract manager jobs.”

The importance of good staff cannot be overstated. MCOs, as private insurance companies, may have skepticism toward government “bureaucrats,” and high-quality staff can help MCOs see their government counterparts as peers and not obstacles. In addition, retaining high-quality staff between administrations provides continuity to the state–MCO relationship, despite the turnover of political appointees that accompanies political administrative transitions.

Another state approach to ensuring institutional capacity is limiting the number of MCO contracts. New York, for instance, has considered requiring Medicaid-managed care providers to compete for a limited number of contracts per region. Among other potential benefits, this approach could give regulators more time to vet and invest in relationships with partners by reducing the number of relationships to manage. More vetting increases the likelihood of finding a strategic partner. And more investment in business relationships limits the possibility of unproductive behaviors forming, such as shading.

3. Involving Third Parties

A third major concern is the impact of formal relational contracting on the ability of third-party stakeholders, such as state-level advocacy and provider organizations, to petition for consumer rights. A possible alternative approach is to first specify contract terms in state regulation, then write the contract to match those requirements. Although beneficiaries in their individual capacities may be able to sue as third parties to the state–MCO contract without a regulatory framework, specification of contract details by regulation would allow parties to enforce the contract more directly through the corresponding regulations. This alternative possibly has the benefit of increasing the transparency of process and performance standards, and third parties would have a say in these standards through notice-and-comment rulemaking. Specification by regulation could increase transparency and elevate the voices of third parties on the margins, but the regulatory

305 Rubel, supra note 195.


process is time-consuming, and third parties still cannot prevent shading without prolonged litigation.

When the state–MCO relationship is founded on a relational contract, however, third parties can engage both the state and the MCO in rapid, effective solutions. The relational contract provides rhetorical leverage for advocacy organizations. If the shared goals and principles of the state and MCO are transparent, then advocates can frame performance failures in terms of where the state and MCO are falling short of their own commitments. This argument can be presented to persuade legislators, translating the rhetoric into direct legislative oversight.

Further, both entities have incentives through the contract to solve the highlighted issue without protracted legal battles. Although this third-party leverage may sound weak, it can be more effective than adversarial legal actions. As discussed above, in Section III.B, supra, the relational approach encourages problem-solving rather than finger-pointing, and it seems likely that identification of problems by third parties would therefore spur action rather than invite dismissal. In addition, states and MCOs could build into the contract a governance structure that responds to third parties, requiring MCOs to proactively respond to concerns.

4. Aligning Structural Supports and Incentives

Contract effectiveness depends not only on the efforts of the parties, but also on characteristics of the contracting market such as competition, consumer choice, and payment mechanisms. These characteristics of the contract market would enable successful relationships between states and MCOs that limit or prevent shading. They also serve as enablers of the formal relational approach, giving parties space to collaborate.

Many factors are at play in ensuring a contract’s effectiveness, such as term length, market complexity, and payment mechanisms. Contract term length matters because of the incentives it creates for the relationship. If a

\[\text{108} \text{ States vary in how transparent their procurement process is, with some like California making all proposal materials available to the public upon request once a tentative winner is announced. GEORGETOWN UNIV. HEALTH POL’Y INST., supra note 122, at 13.} \]

\[\text{109} \text{ See id. at 13 (citing state legislative oversight as a key tool for advocates to improve MCO performance).} \]

\[\text{110} \text{ See Frydlinger et al., supra note 199, at 123 (“Few companies will want to risk an expensive court case for breaching the guiding principles; thus the contract becomes a deterrent against counterproductive behavior.”).} \]

\[\text{111} \text{ See e.g., id. at 122 (noting that a formal relational contract for patient care in British Columbia included patient care metrics as part of its shared vision and objectives, and that such guiding principles would have been considered should a legal dispute arise between the parties).} \]

\[\text{112} \text{ See Metzger, supra note 37, at 1851-52 (explaining the importance of factors beyond the terms of a contract in holding parties accountable).} \]
contract is too long, for instance, the risk of shading increases because the contract may not remain favorable to both parties,313 and a state may be locked in to an underperforming partner.314 Additionally, fewer contracts would simplify relationship management but reduce concurrent competition and limit an MCO’s incentive to attract and retain members. Risk-sharing payment schemes, meanwhile, can help both the state and the MCO align financial incentives and quality goals, as the size of the profit pool available to the MCO would increase the financial incentive to collaborate.

One example of a payment mechanism that has potential to improve state relationships with managed LTSS providers is the use of “risk corridors.”315 Massachusetts has used risk corridors, which offer plans the ability to make upside or downside while sharing outsized earnings or losses with the state.316 For instance, an MCO might make up to four percent profit or loss on the capitation rate.317 If profits or loss exceed four percent, then the state and MCO may share the gain or the loss.318 This mechanism of risk corridors, coupled with quality controls and incentives, can support positive contractual relationships by rewarding good performance and helping partners in unlucky years, as MCOs that see upside potential are more likely to follow the spirit of the contract rather than just the letter.

Upside potential also ensures that a market continues to exist for the managed LTSS contracts, because if there is no profit, there is a danger that the state will lose leverage with plans since they will be incentivized to exit the market. In this scenario, the state could get stuck with a non-cooperative player, and Medicaid consumers could suffer from counterproductive plan behaviors. The risk corridor enables strong partnership due to a concept acknowledged by early practitioners of relational contracting: “trust takes root only if the suppliers share the rewards, not just the risks.”319

It stands to reason that these factors must be in balance for the formal relational contracting approach to work. For instance, if there is not a large enough profit pool or the contract extends for such a long period that the MCO faces no meaningful competition in the near-term, then the MCO has

313 See Hart & Moore, supra note 198, at 28-29 (discussing the effects of contract length on shading behavior).
314 See GEORGETOWN UNIV. HEALTH POL’Y INST., supra note 122, at 5 (noting that one of the main reasons that a state would engage in reprocurement is to switch out an underperforming MCO).
315 See MATHEMATICA, RATE-SETTING, supra note 209, at 10-11 (noting that risk mitigation can protect both the state and health plans and reduce incentives which would be harmful to patients).
316 Id. at 11.
317 Id.
318 Id.
319 Dyer, supra note 256, at 43.
every incentive to shade and engage in perfunctory performance. Or, if the
MCO bears all the risk, it may cut corners to hedge losses. Alternatively, if
the state has too many competing vendors, it may see each as disposable—
and the MCO may recognize that disposability—in ways that erodes the
business relationship. Because of the unobservable nature of shading, states
must be particularly worried about how these structural factors drive behavior
and should account for their predictability. The good news is that, if the state
pursues a formal relational approach, its current vendor may have the trust to
express their concerns about these structural conditions in a way that gives
the state warning before this delicate balance is destroyed.

CONCLUSION

The lack of a solid statutory, constitutional, and regulatory framework to
promote the accountability of MCOs administering long-term care amounts
to a crisis. Even if states have the most leverage in ensuring MCO
performance, courts and the federal government must also do their part to
keep managed long-term care plans accountable. Courts can fill a major gap
in accountability simply by requiring MCOs to show a change of condition
to reduce services, which would both serve as a check against systemic
reductions and ensure transparency in how MCOs make service
authorizations. Although this approach is limited and does not guarantee the
quality of services, it is an important start. Advocates, providers,
beneficiaries, federal officials, and judges should all work to require more out
of the law to protect our families, friends, and neighbors.

The greatest levers for managed LTSS accountability and performance,
however, remain with state agencies and their contracts with MCOs. To
ensure great care for beneficiaries, state officials should focus on fostering
productive business relationships with MCOs, along with strengthening a
contracting marketplace that enables these tight collaborations. State
agencies can build solid MCO relationships by pursuing a formal relational
contracting approach—prioritizing shared goals, principles, and
governance—all within a trusting foundation. This contracting approach has
the potential to limit shading and encourage consummate performance of
contracts, resulting in a win for states, a win for MCOs, and a win for citizens.
States have the tools to make managed long-term care a bright spot in U.S.
healthcare. They should use them.