Actions to protect Medicaid success long-term

Connecticut Medicaid Study Group
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Since moving away from capitated managed care plans in 2012, Connecticut's Medicaid program has enjoyed enormous success. Per capita spending is actually down, saving hundreds of millions of tax dollars every year, and making Connecticut the best performing state in the US at controlling costs. Even better, those savings were achieved while Connecticut also made enormous strides in expanding provider participation in the program, access to care, and quality improvement to levels similar to private coverage.

However, this progress is fragile. Ongoing state budget pressures and uncertainty at the federal level threaten achievements. A new state administration next year offers both concerns and opportunities to continue and expand our progress into the future.

The Medicaid Study Group is a collaboration of independent consumer advocates dedicated to protecting and expanding on Connecticut Medicaid's recent success. In the past, we have worked with the administration providing input and information on Medicaid best practices from other states and how they might be successfully implemented in Connecticut. We offer state policymakers these recommendations to both protect the progress we've made to date and to build on those efforts to benefit both consumers and taxpayers.

- The General Assembly should pass legislation to prohibit move to capitated managed care, in any form including Accountable Care Organizations (ACOs) or Managed Care Organizations (MCOs)
    - There is growing evidence that the shift away from financial risk in Connecticut's Medicaid program resulted in significant savings to the state as well as improvements in care for members (see above).
    - The current provision requiring, at most, approval by the legislative committees of cognizance does not allow all legislators, all of whom represent Medicaid beneficiaries and taxpayers, to have a voice in changes to an improving program that covers one in five state residents and a significant share of the state's budget.
- The General Assembly should pass legislation to prohibit downside risk in the Medicaid program.
    - Downside risk refers to payment models in which, if health costs for a provider network's assigned members rise rather than fall, funds would be clawed back or returned to the state. This would cause a potentially large loss to Medicaid providers of care, already paid less for their services by Medicaid than other payers. In virtually all downside risk models, improvements in quality or access to care that may provide long term savings but short term increases are not considered or accounted for.
    - The experimental downside risk payment model amplifies very dangerous incentives to stint on necessary care and to select lucrative patients/practices, as

has happened in other states, to generate false "savings" payments and avoid clawback payments.
    - Downside risk models are very new and have not been successful where they've been tried and leading Medicaid states are moving away from the model. It has not been attractive in Medicare, serving as a significant barrier to provider participation in more successful reform efforts. Some early-adopter state Medicaid programs are moving away from ACO financial risk models.
    - Implementation of a downside risk model in Medicaid violates a promise made repeatedly by this administration. That commitment should be codified in law as are most others.
- Legislation to wait at least a year after completion of a full evaluation of Medicaid PCMH+ Wave 1 experiment before expansion to place hundreds of thousands more people at risk
    - Also require disclosure to the public of all available performance data – including evaluation, quality metrics, and financials, etc. It is critical that disclosure be of raw data and not limited to a small number of carefully selected bullet points.
    - Any PCMH+ evaluation of this risky and controversial experiment must be conducted by an independent entity with no conflicted interests or expectation of ongoing contracts. We understand that researchers at UConn have the capacity to do the job and significant experience in other states. In fact, personnel were recruited to the state for this purpose, but access to the data was rescinded abruptly. Current evaluation plans are meager and unlikely to detect any issues that could harm consumers and/or raise costs to the state.
    - There must be a robust, sincere public input process regarding how/whether to expand the program after the evaluation is complete to help the state identify critical missing issues and help ensure success of the program.
- Ensure meaningful information for PCMH+ members about their right to opt-out of the program
    - Real survey of opt-outs for why they did so, if anyone encouraged them
    - Policymakers must require clear, readable consumer notices that accurately convey both the potential risks and benefits of remaining in the program, and a clear process to opt-out. The state could return to the balanced, understandable notice drafted in a transparent, collaborative with providers and independent advocates. Opt-out notices should be delivered to consumers on a regular basis, possibly along with HIPAA notices to reduce any administrative burden.
    - There must be a robust consumer survey of the program including awareness of the program, potential risks and benefits, knowledge of right to opt-out and access to the process to exercise that right.
    - In addition, the state must survey every member who opts-out, not a sample, to determine why and if anyone "encouraged" them to opt-out, possibly to game "shared savings" payments, as has happened in other states.
- The state must create a process to regulate ACOs
    - Creates incentives and opportunities to stint on needed care, as happened with managed care in the 1990s *SIM equity and Access
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    - ACOs and other provider networks are taking on financial risk and should be regulated as are insurers. New payment models funding ACOs create incentives to stint on needed care, as happened with managed care plans in the 1990s. The state then stepped in to protect consumers from those risks. Even those taking on only "upside risk" are susceptible to problems that could seriously harm consumers and the state. The state has a responsibility to ensure the public's safety and best interests in this new health model.
    - Connecticut should learn from other states moving forward in regulating ACOs, especially for definitions of what entities and functions must be regulated.
- Release non-identifiable cost, quality and performance data for independent analysis
    - By allowing others to analyze Medicaid's claims and quality data, the state could access expertise that we could never afford to purchase. Leaders from Massachusetts's Health Policy Commission reports great benefits from allowing others access to their data. They have learned lessons and identified issues that they never would have found, benefitting health outcomes and saving money.[1]
    - Allowing independent analysis and reporting of findings from Medicaid data would significantly improve public trust in the program and in the department's commitment to improving the program.
    - It is critical to remove any possibility of attaching any person's identity with their information. Academic institutions and other state All Payer Claims Database programs are a good model.
    - Have an advisory committee of independent consumers, advocates, and providers to review all requests, ensuring only appropriate use of the data that benefits consumers and the state.
- The state needs to strengthen Conflict of Interest rules, for Medicaid and all health policymaking
    - Ensuring that policymaking is free of incentives for personal/professional gain over the best interests of the state and Medicaid members is foundational to building a program that deserves our trust.
    - The General Assembly should immediately pass legislation to close the ethics loophole in state law regarding definition of "public officials".
    - Strong, enforceable COI rules on membership on critical policymaking committees – the FDA's conflict of interest rules for advisory committees is a good model
    - There need to be strong, clear and enforceable rules to prevent members of important committees from benefiting financially from their membership.
- Remove premium assistance legislative authority
    - Premium assistance in Medicaid requires that consumers with an employer offer of benefits must accept that offer and reject traditional Medicaid and/or require some Medicaid members to purchase coverage in the health insurance exchange. Private coverage premium assistance failed badly in states where it was tried before the ACA, raising costs to the state, denying people needed care, and creating massive administrative burdens on providers and the state. Since the ACA, premium assistance for Medicaid expansion populations through health

[1] Personal communication

insurance exchanges have been implemented to overcome political resistance to expanding any public program. These programs are new but are likely to cost far more than traditional Medicaid. The Congressional Budget Office (CBO) estimates that it will cost the federal government $3,000 more for every American who enrolls in a health insurance exchange rather than Medicaid. Estimates of increased state costs were not available.
    - Elimination of the language was part of negotiated budget agreement in 2007, but the language remained due to a legislative drafting error
- Support state legislation imposing individual mandate
    - Many Connecticut residents will lose Medicaid if the individual mandate ends because the eligibility systems are linked
- Strengthen Medical Assistance Program Oversight Council (MAPOC) leadership to support independent oversight, advice and monitoring
    - MAPOC should pair a legislator and an independent advocate/provider as Co-Chairs of the council and all committees
    - Co-Chairs must have discretion to set the agendas for their committees, in consultation with others to reduce burden on Council staff and to avoid overlap and duplicated efforts
    - MAPOC committees should consider DSS input into agenda items and scope but decisions must be independent and in the best interests of members and the state
- The General Assembly should prohibit Medicaid eligibility and coverage changes that will undermine current progress and raise the number of uninsured in Connecticut
    - No work or "community engagement" requirements
    - No drug testing requirements or limitations
    - Codify current retroactive eligibility
    - No premiums or shut-outs for not paying them
    - No waivers of mandated coverage (e.g., NEMT)
    - No waivers of federal pharmacy coverage rules