Disability Rights Connecticut

Connecticut's Protection and Advocacy System

75 Charter Oak Avenue
Suite 1-101
Hartford, CT 06106

July 22, 2024

By electronic mail
William Halsey
Acting Medicaid Director
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Re: Opposition to Managed Care Organizations Returning to Run Medicaid/HUSKY, Suggested Criteria for DSS Review of Alternative Medicaid Models

Dear Mr. Halsey:

This letter is in part a follow-up to the June 27th letter (attached) written to Governor Lamont from dozens of advocacy organizations and individuals respectfully urging him not to move our successful managed fee for service Medicaid program back into the harmful, expensive and wasteful capitated managed care model. It also is a follow-up to your presentation to the Medical Assistance Program Oversight Council (MAPOC) on July 12th in which you presented criteria which you stated would be applied by your agency in reviewing various options for the Medicaid program, including but not limited to returning to capitated managed care, through the inclusion of additional recommended criteria.

As noted in the advocates' June 27th letter, since removing capitated Managed Care Organizations (MCOs) from the program in 2012, CT is a leader among states in cost control, access to care, and quality. Since 2012, we have saved billions of taxpayer dollars. Our care management-centered program has adopted more innovations than any other state. We are in the top quartile for two-thirds of federal Medicaid quality measures. And improvements are debated and adopted pursuant to a generally open, collaborative process. While there of course is always room for improvement, MCOs will erase CT Medicaid's progress to date and make matters far *worse*, not only for Medicaid enrollees and their providers, but also for Connecticut's taxpayers as they would be a fiscally irresponsible choice.

Arbitrary denials by MCO reviewers under pressure from their bosses to save money on Medicaid patient care would again become routine, as they were until January 2012. Providers will depart from the program over this deliberate obstruction interfering with access to care (and delayed provider payments, even when services are approved). The consequences for Medicaid enrollees will again be severe. For example, as noted in the June 27th sign-on letter, a study published just this year found that the rates of early-stage cancer diagnosis and survival among Medicaid members were substantially better in Connecticut, without MCOs, than in New Jersey, a demographically comparable state that still

has MCOs, after they left our state in 2012. In sum, their return would violate the health policy maxim to "do no harm."

Given all of these problems presented by a return or partial return to capitated managed care, advocates were pleased to hear at the MAPOC meeting that DSS is looking beyond capitated managed care to other models as well, and also will be assessing the maintenance of our current successful, innovative and efficient managed fee for service program as one of the options. However, the criteria laid out in your powerpoint presentation, at slide 14 (PowerPoint Presentation (ct.gov)) are not sufficient. They are inadequate to allow for a fair consideration of the downsides of MCOs in states which rely upon them.

Accordingly, per the invitation for input from advocates and others, as stated in slide 13 of the MAPOC presentation, I am providing some additional criteria, developed after consulting with other advocates, which I believe must be applied to the extent your agency is in fact looking to a possible return to capitated managed care or, for that matter, to adopting provider risk models with similar downsides. I urge you to include at least these additional criteria in your review, based on data collected by your consultant:

1. Administrative load (percentage of total costs which go not to health care but to administrative costs and profits, if applicable) for each option, including reported medical loss ratios in the case of MCOs and whether the MCO states have done any auditing to assess the reliability of those reported MLRs.
2. Ease of the state obtaining reporting on cost and performance data from the MCO or other entity contracted with the state (compared with the ease of obtaining such data when the state is directly responsible for the provision of health services).
3. Annual rates of increase for the state's capitated MCO payments, and how this compares with the inflation and medical inflation rates in the state.
4. Ability of the state to set provider rates under each of the options and, in the case of MCOs, whether the state is able to *know* what those rates are.
5. Extent of use of prior authorization (PA) under each model and who decides when to impose PA and what criteria are applied in conducting PA.
6. Where MCOs are involved, ability of policy-makers and Medicaid enrollees to obtain access to the criteria applied by MCOs in reviewing PA requests.
7. Rates of reversal of denials where the enrollee appeals to an administrative hearing, under MCO v. non-MCO models.
8. Average times, and maximum times, for providers receiving payment for services rendered (and, where applicable, prior authorized) after submitting claims, in MCO vs non-MCO models.
9. Annual rates of provider loss, where this is captured, under various models.
10. Results of any secret shopper surveys conducted under various models.
11. Complaint rates from both Medicaid enrollees and Medicaid providers, the nature of those complaints and the state's response to the complaints, under various models.

Thank you for incorporating these criteria into your review.

Sincerely,

Sheldon V. Toubman
Litigation Attorney

Att.
cc:
Commissioner Andrea Barton Reeves
Senator Martin Looney
Speaker Matt Ritter
Senate Minority Leader Stephen Harding
House Minority Leader Vincent Candelora
Rep. Jillian Gilchrest
Sen. Matt Lesser
Sen. Saud Anwar
Rep. Toni Walker
Sen. Catherine Osten
Rep. Lucy Dathan
Rep. Susan Johnson
Rep. Anne Hughes
Sean King, Office of the Healthcare Advocate