Proposed criteria for DSS consultant to evaluate Medicaid program, including MCOs
In no particular order
Response to July 2024 DSS presentation to MAPOC, slide 12 (input welcome)
July 22, 2024

Accountability

How complex/difficult will accountability be? Assess DSS capacity and willingness to evaluate, monitor, and hold venders accountable, including data reporting/analysis, access, quality, spending?

Does option support accountability for different populations e.g. access and sensitivity to underserved communities, people with disabilities, rural areas? Is the benefit limited to a narrow population?

Does the option include evaluation on metrics that are only disclosed by area (e.g. access to care) but not specifically until after measurement closes (e.g. wait times for appointments, average distance to provider)?

Evidence-based Efficiency/Savings

How will the option solve identified problems? Map a direct line to measurable change toward a program goal.

Are options supported by independent evidence? What is the level of the evidence's quality and strength?

Identify strengths and weaknesses of each option – mapped to Connecticut context and history

If the option saves money, where will it be invested? By the vender and by the state

Are the savings likely to be sustained? Does the option invest in the future health of members/communities and provider retention?

Maximize spending on medical care, quality improvement and care management over administrative burden.

For each option, what is the cost in additional DSS staffing, changing job descriptions? What cuts will have to be made to accommodate the change?

How will risk adjustment work? What are the opportunities for gaming?

Can we cap profits and executive salaries, as for nursing homes?

Contracting

How easy will it be to unravel if the option fails? (as they often do) What if the initial funding amounts are not enough for the venders in future years after they are entrenched? What is the exit strategy, resources necessary? (It took 16 years to remove MCOs from the program last time.)

What is the process and timing to update, fix problems, and adopt innovations? Will we have to wait for the next contract, negotiate amendments, and pay more for changes? What are the options to implement changes outside the vender? Avoid a situation where the state is stuck with poor-performing venders and they won't budge, or they charge too much.

Can the state set provider payment rates or minimum? At the very least, the state must monitor the adequacy of payment rates to ensure access.

What is the likelihood of resistance/non-engagement from Connecticut stakeholders including members, patients, individual and organized providers (societies), health systems, advocates, legislators, in-state competitors (especially those not chosen to participate)?

Does the option allow caps for profits and executive pay caps (as for nursing homes)?

Will DSS allow subcontractors? Will they be subject to same process of state approval and standards, including public transparency?

Transparency

Are the venders subject to Freedom of Information laws? What information is protected?

Is it possible to track where dollars go – by provider type, service, population, geography, administration vs. services?

Is timely, actionable, complete (deidentified) data fully available to the public with ability to compare performance across venders on quality, access, and spending?

What are the challenges to getting actionable data for holding venders accountable?

Access

What is the risk of and incentives for underservice and cherry picking members?

Can members opt-out of the option?

Does the option maximize patient choice among all Medicaid-participating providers, especially behavioral health?

How will venders connect to transportation and other companies serving members?

Impact on ICM and PCMH programs that are working – both in viability and member access?

What is the impact of each option on currently participating providers including the need to negotiate payments, administrative burden across multiple payers, payment delays/hassles, especially prior authorization, denials of care, access to independent review?

Quality

Will members hear about ALL treatment options and sources well before treatment? (critical to informed consent)

How will this promote integration of care across all Medicaid-participating providers and systems? Provider communication and collaboration are crucial for members with chronic conditions

How will the option support health-related social needs? Early promises must be kept and continued for the long-term?