November 1, 2024

The Honorable Ned Lamont
Governor, State of Connecticut
Capitol Avenue
Hartford, CT 06106

Re: Concern with Selection of Insurance Industry Consultant to Review Medicaid Options

Dear Governor Lamont:

As advocates who serve the interests of Medicaid enrollees, and enrollees themselves, we are very concerned that DSS selected a law firm/consulting firm which represents the interests of the Medicaid managed care industry to do what should be an independent, unbiased evaluation of whether there is any possible benefit to be gained from jettisoning our successful managed fee for service Medicaid program and contracting with unsuccessful Medicaid managed care organizations (MCOs) once again. As explained below, while CT's managed fee for service program is indeed a success story in both quality/access and cost control, the primary interest of this selected firm presents a significant conflict of interest. It is impossible for such an organization to provide an independent, evidence-based assessment of our current nation-leading, efficient managed fee for service Medicaid program, and possible improvements based on that successful structure. Instead, it will almost certainly recommend a return to the failed MCO system because of its obvious bias.

First, we note that the 2012 move away from capitated MCOs to managed fee for service with non-risk administrative services organizations (ASOs), as decided by Governor Malloy shortly after taking office in 2011, with the full support of the legislature, was the beginning of CT Medicaid's success story, as it shifted the program's focus very intentionally to patient care, higher efficiency and transparency. The non-risk ASOs took on certain functions which the MCOs previously provided, but also newly provided intensive case management, while DSS implemented the broad use of patient-centered medical homes (PCMHs) to coordinate care.

CT Medicaid is now in the top quarter of states in 17 of 28 adult quality measures and 13 of 22 child quality measures. Connecticut | Medicaid.gov In addition, provider access has dramatically improved from MCO administration days, when the results of a secret shopper survey indicated appointments were only obtained about 25% of the time requested, across several provider types. Providing better access and better-quality care has also resulted in significant cost savings for taxpayers. We spend only 2.75% of program cost on administration, compared to the U.S. average of 8.5% reported by DSS. *See* 2/10/23 DSS presentation to Medical Assistance Program Oversight Council (MAPOC), at slides 9-16 (2906a2). Compared to states with MCOs, Connecticut spends 7.7% less of our state budget on Medicaid. Indeed, CT's taxpayers have literally saved billions of dollars since the shift away from capitated managed

care to paying entities that actually manage care, *see, e.g.,* [Medicaid switch from MCOs saving taxpayers billions - CT Health Policy].[1]

Second, we of course recognize that our Medicaid program is not perfect. While ours is the only state Medicaid program that has adopted every innovation option analyzed by Kaiser Family Foundation, many of us are working collaboratively with other stakeholders, under the auspices of the MAPOC and the Behavioral Health Partnership Oversight Council among other oversight entities, to improve the program. The further innovations on the table are all premised on the state maintaining active control over all basic policy decisions, such as provider payment rates, breadth of services and the determination when prior authorization is applied – policies which, as a practical matter, in CT in the past and currently in other states, are handed over to the MCOs under managed care. Comments were submitted by some of us pursuant to PA 23-171, Section 17 (attached), recommending a further broad set of such improvements, all built on the successful managed fee for service foundation.

Third, we also recognize that our long-term care (LTC) costs are somewhat higher than other states as a percentage of the state's Medicaid budget. This is readily explained by a failure to take advantage of existing programs to rebalance long-term care away from nursing homes toward community-based services, which overall are less expensive than nursing home care. As the Long-Term Care Planning Committee's 2021 report notes, at page 49, research demonstrates that services in the community cost less than institutional care overall, even if a few care plans exceed the cost of nursing home care. *See* 2 Julie Robison, Ph.D., et al., Transition from Home Care to Nursing Home: Unmet Needs in a Home- and Community-Based Program for Older Adults, Journal of Aging & Social Policy, 24:251-270, 2012, pages 252-253.

In the past, CT has been in the middle of the pack of states in terms of rebalancing LTC costs away from nursing facilities and toward more innovative home and community-based services. However, recently, CT has been slipping. The last Long-Term Care Planning Committee report (from 2021) stated that 60% of Medicaid funds for long-term care services at that point went to community-based services instead of institutional care. But the LTC Committee's latest statutorily-required annual report on CT Rebalancing, for SFY 2023, states that the proportion of CT Medicaid long-care clients receiving community-based services *decreased* from 70% in SFY 2021 to 69% in the following two fiscal years, and that "[i]n SFY 2023, Medicaid long-term care expenditures for individuals in the community versus in an institution ***decreased by 3%*** from SFY 202[1]." Page 3 (emphasis added). Not surprisingly, this backtracking has been associated with a higher percentage of CT's overall Medicaid budget going to LTC services.

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[1] We note that much has been said by some legislators and in the media about supposed DSS Medicaid budget cost overruns. *See, e.g.,* [Could CT budget face emergency cuts despite plan to save $1.2B?] In fact, those apparent cost overruns are really a result of intentionally under-budgeting the agency for fully expected Medicaid costs in the second year of the biennium, because of a choice not to reopen the biennial budget passed in 2023. If, as routinely is done every other year, the budget were adjusted in the legislative session which ended in May to reflect the expected Medicaid costs in the 2024-2025 fiscal year, there would be no (or little) "cost overruns."

A major cause of this backtracking affecting the LTC budget is the long and growing wait lists for most of the LTC waivers, coupled with a lack of resources and support for the critical Money Follows the Person (MFP) program which gets people out of nursing facilities, lack of education of applicants about community-based options, as well as cumbersome application procedures for the long-term care waivers. In their 10/25/24 joint comments with suggested Medicaid improvements (attached), advocates from Conn. Legal Services, Disability Rights CT, Conn. Legal Rights Project and the CT Health Policy Project laid out detailed suggestions for addressing this particular imbalance (as well as deficiencies in the delivery of behavioral health services and in addressing health equity concerns, among other areas). These improvements would allow more people to get out or stay out of expensive nursing homes, and in the process address the current relatively high LTC costs within the Medicaid budget -- all while preserving our overall very efficient and accountable managed fee for service structure.

The proposal to bring back MCOs directly threatens all of this progress. As word broke through public reporting that you were considering a return to the MCO system of Medicaid delivery, and concerns therefore were raised broadly with returning to this failed approach -- by legislators, providers, advocates and other stakeholders -- DSS officials assured members of the MAPOC at its July 12th meeting that it would be conducting a review of <u>various</u> options for the Medicaid program under a "Managed Care/Medicaid Landscape Analysis." We were expressly told that the review would <u>not</u> be limited to a return to capitated managed care, and that the review would be assisted by a consultant providing an *independent, unbiased, data-driven review of options*, with broad stakeholder input. *See* PowerPoint Presentation, slides 11-14.

We were very disappointed to see this is not the case. We recently learned, in a message DSS sent out widely on 10/23/24: "[DSS] has contracted with Accenture and **Manatt** to assist the Department in conducting a Medicaid Landscape Analysis. This analysis will look at the current Medicaid program, including what is working well and where there are opportunities for improvement. *The analysis will include whether there are opportunities to explore managed care options to improve the Medicaid program*." (emphasis added).

While no other option besides a return to capitated managed care was mentioned, this might still sound like some kind of independent review. However, it is anything but: Manatt Health, which is going to do most of the analysis, is actually a well-known law/consulting firm whose principal clients include not only individual insurance companies which run Medicaid managed care plans but also the **association** of such MCOs. This outfit chosen to do the "independent" analysis is serving the economic interests of the Medicaid managed care industry and individual managed care entities. As just a few readily available examples from Manatt's own issuances:

1. On its website, Manatt prominently proclaims as among its key clients Humana, Blue Shield of CA, Aetna, and Kaiser, all of which run Medicaid managed care plans, see Manatt Health - Manatt, Phelps & Phillips, LLP

2. In 2019, Manatt filed an amicus brief on behalf of "Medicaid Health Plans of America (MHPA), a nonprofit trade association of Medicaid managed care organizations (MCOs)," in the Fifth Circuit Court of Appeals in support of an appeal of a district court ruling for several states in their lawsuit challenging their duty to reimburse MCOs for the health insurance provider fee that MCOs pay under the Affordable Care Act, Manatt Represents Medicaid Health Plans in 5th Circuit Health Insurance Fee Case - Manatt, Phelps & Phillips, LLP

3. Last year, Manatt filed an amicus brief with the U.S. Supreme Court on behalf of MHPA specifically to urge the Court to hear an appeal of a Seventh Circuit Court of Appeals decision which held that hospitals facing systematic untimely payments from MCOs (an endemic problem with them) could sue over such practices, which it argues "could destabilize the Medicaid managed care system." And in June of this year, it filed a further amicus brief on behalf of the same association following a remand in the case, *see* Manatt Represents Medicaid Health Plans of America in 7th Circuit Court of Appeals - Manatt, Phelps & Phillips, LLP

Other states are now understandably looking at CT as a way to save money on their Medicaid budgets and provide the low overhead and high accountability which a managed fee for service system makes possible, compared with continuing to be dependent on high-cost capitated MCOs which demand large annual increases in their capitated rates and then routinely deny needed care, as CT Medicaid used to be. *See, e.g.,* Minnesota Medicaid Revisits the Question: Managed Care or Fee-for-Service? – Center For Children and Families (Feb. 2024). This movement is an existential threat to the Medicaid managed care industry. Any supposed "wall" between different parts of the law/lobbying/consulting firm cannot possibly combat the powerful financial interest of Manatt in resisting this movement and preserving the managed care association (MHPA) and its individual members as clients, and thus moving CT in the MCOs' direction.

In sum, it is impossible for Manatt to provide an independent, evidence-based assessment of our current nation-leading, efficient managed fee for service Medicaid program. Notwithstanding Manatt's participation in "stakeholder input" sessions, its report will almost certainly endorse a return to expensive, inefficient and unaccountable Medicaid MCOs. That report will have no credibility with the community of advocates actively working with legislators and other stakeholders to improve on our successful managed fee for service model. We therefore ask that you abandon this review.

Thank you for your attention to our concerns.

Respectfully yours,

Disability Rights CT
CT Health Policy Project
Conn. Legal Services
NAMI-CT

Center for Disability Rights
State Independent Living Council
New Haven Legal Assistance Association
Conn. Legal Rights Project
More Than Walking
The ARC Connecticut
AgingCT
Universal Health Care Foundation of CT
Mental Health Connecticut
Independence Northwest
CT Cross Disability Lifespan Alliance
Citizens Coalition for Equal Access
Disabilities Network of Eastern CT
Greater Hartford Legal Aid
Physicians for a National Healthcare Program, Connecticut Chapter (PNHP-CT)
CCAG
Ministerial Health Fellowship Advocacy Coalition
Medicare for All CT
CT Jobs & Human Rights Task Force
Phil Brewer MD
Rev. Josh Pawelek
Nancy Alisberg
Lisa Nee
Elaine Kolb
Kelly Phenix
Maureen Amirault
Melissa Marshall
David Morgana
Charles Cohen
Mary Moberg
Michelle Johnson

Enc.
cc: Commissioner Andrea Barton Reeves
Medicaid Director William Halsey
Senate President Martin Looney
Senate Majority Leader Bob Duff
Senate Minority Leader Stephen Harding

House Speaker Matthew Ritter
House Majority Leader Jason Rojas
House Minority Leader Vincent Candelora
Sen. Matthew Lesser
Rep. Jillian Gilchrest
Sen. Lisa Seminara
Rep. Jay Case
Sen. Catherine Osten
Rep. Toni Walker
Sen. Eric Berthel
Rep. Tammy Nuccio
Sen. Saud Anwar
Rep. Cristin McCarthey-Vahey
Sen. Heather Somers
Rep. Nicole Klarides-Ditria
Rep. Susan Johnson
Rep. Anne Hughes
Rep. Lucy Dathan
Rep. Michelle Cook
State Healthcare Advocate Kathleen Holt