November 15, 2024

To Whom It May Concern,

Below are my comments concerning the "Medicaid Landscape" in Connecticut pursuant to the Department's current mission to get a read on whether the Department should move from the current Fee-For-Service (FFS) model back to the capitated Managed Care Organization (MCO) arrangement it once had.

As a former employee of the Department's Medicaid Division from 2008 – 2018, I have experience working with both models. While no model is perfect, in my opinion the current FFS model, as a whole, is far superior.

The MCO years:

My working memory only pertains to the last two iterations of MCOs (two different RFP periods) the Department retained. Managing the MCOs was difficult with an understaffed Medicaid Division. Both periods of time were rife with litigation, lack of vendor oversight, and much confusion for the Medicaid members.

Some examples:

- Two MCOs from the second to last group of MCOs debated their responsibility under Connecticut's Freedom of Information Act (FOI) laws with the state. Governor Jodi Rell finally ordered the MCOs to comply with the State's FOI laws. She said, *"These companies refuse to abide by our public disclosure law, despite being required to do so, and they were also willing to walk away from providing services to our children if they had to live up to this requirement."* Rell orders termination of HUSKY contracts after FOI dispute | Hartford Business Journal The ongoing dispute caused much confusion for Medicaid members who grew concerned whether they would lose coverage or have to change to a new MCO. Almost daily meetings were held to determine which plans would be allowed as a choice by our MCO broker on that particular day, depending on ongoing negotiations. As the largest MCO exited, the Department needed to rapidly communicate the change to its members and advise them to call our broker to pick a new MCO. This was a major undertaking that required the help of our other MCOs, 211 (who provided HUSKY support), and our broker. The Department's staff focus, for some time, had to be solely on the ongoing negotiations and the final exit of this MCO…not on improving the performance of the program and the health of Medicaid members.

- Also, from the second to last iteration of MCOs, one MCO was accused of cherry-picking Medicaid clients in its marketing efforts. The Department and the U.S. Department of Justice investigated this MCO and found the following,

"WellCare agreed to pay the $137.5 million, plus interest, in four installments over three years. About $3.16 million of the settlement amount is attributable to the Connecticut Medicaid program, of which the state's net share is about $1.56 million. "This is a good result because it sends a clear message," Attorney General Jepsen said. "Abuse of the public trust will not be tolerated and companies that do so will face prosecution." Commissioner Bremby said, "WellCare's unacceptable practices are thankfully in the past with respect to Connecticut. In fact, the Malloy/Wyman administration has moved away from Medicaid managed care organizations altogether, in favor of a single administrative contractor under the Department of Social Services. The Attorney General, the Chief State's Attorney and U.S. Department of Justice deserve credit for their role in bringing a portion of this settlement to Connecticut."

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Again, this long investigation by State and Federal Staff was a poor use of resources that should have been spent on the performance of the program and health of Medicaid members.

- The last iteration of managed care consisted of three MCOs. As a whole, this iteration was ill-managed by the Department. Two of the MCOs were new entrants into the Connecticut Medicaid market and, in my opinion, needed more support than the Department had available. One of the MCOs didn't contract with all of the State's hospitals, including some of the State's largest. The lack of all hospitals being contracted led members to switch MCOs. Monthly reports showed the number of clients that joined each plan and the number leaving each plan. Along with the issue with hospitals being enrolled, some of the MCOs had issues with their provider lists. The Department conducted a formal "Mystery Shopper" with an external vendor, and then did a small in-house survey that showed some of the MCOs had inaccurate provider lists with providers who did not practice in CT, who had retired before the MCO had joined Connecticut Medicaid and even some who had passed away. The issues with the hospitals and inaccurate provider lists appeared to be driving a steady increase in one of the three MCOs membership. Overtime, if improvements were not made, one MCO would have been become overly large.

Due to the issues mentioned above, Medicaid members, either by choice, or by need frequently changed MCOs. The "churn" made quality improvement efforts complicated for the MCOs and the Department. The Department was too busy managing the changing cast

of MCOs, and the MCOs had dramatic inflows and outflows of members that made it difficult to follow a member's health over a period of time.

While our current Fee-For-Service model can use improvement, it has already proven to be making progress in its delivery of service. As shown by Connecticut's Medicaid HEDIS Health Measures, the CMS Child and Adult Core Measure sets and the NCQA CAHPS Survey results, Connecticut Medicaid is outperforming its peer states.

While more work needs to be done, I do not feel turning back to the MCO model will help Connecticut's Medicaid members. Improvements can be made via suggestions from Medicaid members, providers and health experts via forums held by the Department and the Legislature's Medical Program Oversight Council.

Sincerely,

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