MEDICAID IMPROVEMENT RECOMMENDATIONS FROM CONSUMER-ADVOCATE MEMBERS OF THE MEDICAL ASSISTANCE PROGRAM OVERSIGHT COUNCIL PURSUANT TO PA-23-171

October 25, 2024

Executive Summary

Introduction

The 2012 move to managed fee for service with non-risk administrative services organizations (ASOs) rid the CT Medicaid program of capitated or risk-based managed care organizations. Since that time, CT Medicaid is in the top quarter of states in 17 of 28 adult quality measures and 13 of 22 child quality measures. We spend 2.75% of program cost on administration, compared to the U.S. average of 8.5%. Compared to states with MCOs, Connecticut spends 7.7% less of our state budget on Medicaid.

Focus on quality and access to care

We certainly want to protect what is working well and improve upon it and, as previously stated, quality and access have both improved under our ASO managed fee for service model. To ensure this continues, quality and access should be pillars in any model that is used going forward.

Our recommendation:

1. **Quality and access consequences of all policies should be considered in development, implementation, and evaluation.**
2. **Do not return to a system of capitated managed care through MCOs**
3. **Do not pay providers or groups of providers under a system that puts financial risk on providers for the cost of their patients' care, through capitation, downside risk, etc.**

Improve Government Services to Access Medicaid

About 10 years ago, Connecticut dramatically changed how individuals applying for or trying to stay on Medicaid went through the administrative process. We moved from each person applying or recertifying being assigned to an individual worker to a centralized call system in which DSS staff are now tasked with of "pieces of work" belonging to randomly assigned applicants or enrollees each workday. This call center has become understaffed regularly causing tremendous wait times, which in turn has caused access barriers for individuals trying to apply for and stay on critical benefits.

Our recommendation: **While an immediate infusion of hiring is needed to address the immediate crisis, our long-term suggestion is to once and for all address the endemic poor performance of the DSS call center, through at least these steps:**

1. **Require a long-term plan of sufficient staff, signed off on by both the Governor and the legislature, to ensure compliance with an agreed upon level of performance, along the lines of the performance DSS requires of its own contractors which run call centers, including a plan for closely monitoring available staff and automatically beginning an aggressive hiring campaign when the level of staff starts to hit a threshold, with no additional approval needed.**
2. **Publicly report all call center data, for both tier I and tier II (if there is one), and without any interruptions, to help identify a developing trend of longer waits which would trigger the automatic hiring set forth above.**
3. **Explore a return to individually-assigned workers for both Medicaid applicants and enrollees, as currently used for long-term care Medicaid applications, so that the work of being an eligibility worker is more satisfying and attrition can be reduced, including canvassing current workers (in an anonymous survey) about likely job satisfaction if they could have a continuing relationship with Medicaid enrollees.**

Better Access to Office Visits for People with Cognitive and Communication Disabilities

Individuals with certain kinds of disabilities, particularly developmental, cognitive and communication disabilities, often require more time with a provider in order to understand, and respond to, the questions being asked and the advice being provided. Accommodations in the way of additional time are needed to ensure meaningful interaction between patient and provider. There are codes available for such longer visits, but they are not widely used.

Our recommendation:

1. **Work with provider groups to educate individual Medicaid providers about the availability of codes for longer office visits and their applicability for individuals with disabilities requiring additional time to interact with their providers.**
2. **Work with advocacy groups to educate individuals with disabilities, and their family members, about the availability of these codes and how to advocate for more time with providers, including by specifically asking for these codes to be applied.**
3. **Audit records of providers who use these codes to ensure that longer visits are in fact being provided.**

Improve Access to Community-Based Long-Term Care

CT has been slipping with a higher percentage of our long-term care (LTC) clients receiving skilled nursing facility care than in the past. Not surprisingly, this backtracking has been associated with a higher percentage of CT's overall Medicaid budget going to LTC services.

Our recommendation:

1. **Remove all waiting lists for the ABI II, PCA, DMHAS, Autism and Katie Beckett waivers, as already was done years ago for the CHCPE waiver program, and provide sufficient funding to make this possible.**
2. **DSS should educate all individuals potentially needing long term care under Medicaid, family members, providers and access agency and DSS staff, about the broad coverage available under CFC and the obligation of DSS to consider and grant exceptions to the amount of services authorized under its CFC level of need budget chart for a given level of need whenever a greater actual need exists, reevaluate its processes for reviewing requests for such additional services as submitted by access agency reviewers, and audit with outside assistance the cases in which exceptions are denied by DSS staff.**
3. **DSS should assist low income clients through the home care waiver application process proactively.**
4. **Hire as many federally-funded staff as possible to administer and grow the MFP program.**
5. **DSS needs to grant MFP services to anyone who meets the eligibility criteria of being in a nursing home at Medicaid expense for two months or more and desiring community-based services so as to explore all options with MFP services.**
6. **DSS needs to publish regulations for MFP and CFC, including a clear notice and appeals process, and require all the different layers of contractors actually running the program to have a grievance official policy and written grievance procedure.**

Community Health Workers

Ensuring payment for CHWs, and other trusted nonmedical community patient support workers, will improve health outcomes, engagement with medical care, and free up time for primary care clinicians. It is critical for doulas, peer support specialists, and recovery coaches to be independent of but connected to clinical care.

Our recommendation:

1. **Following the lead of other states, establish a Medicaid fee schedule for paying CHWs and other trusted nonmedical community patient support workers not employed by medical practices, on a fee for service basis.**

Nonmedical Interventions

While there are federal restraints on state Medicaid spending for non-medical interventions, Connecticut should continue to explore opportunities to support community resources to address the social drivers of health. CT Medicaid's support for housing and justice-involved services are excellent examples. Our recommendation:

1. **Invest in proven upstream preventive solutions.**

Improvements in Access to Behavioral Health Services

It is now well accepted that the reimbursement rates paid to non-institutional behavioral health providers, many of whom are nonprofits, are inadequate. This has led to a lack of community-based services. This shortfall results in avoidable emergency services, hospitalizations, and even intervention by the criminal justice system.

Our recommendation:

1. **Community-based behavioral health per visit reimbursement rates should be increased to match the Medicare rates for the same services and, where this is not available under Medicare, the average Medicaid rates of our neighboring states.**

Transparency and data reporting

Public performance reporting on Medicaid has lapsed. Regularly sharing this information allows for input on context unavailable to DSS, leading to better solutions.

Our recommendation:

1. **Provide more timely information, with more detail.**
2. **Share information that can help lead to solutions, for example: There have been concerns that Long-term Services and Supports spending is up. Sharing information on that concern will lead to development of better options to both improve care and control costs while minimizing unintended consequences.**

Thank you for taking our comments and recommendations into consideration. We are available to discuss any of them with you in more depth.

Sincerely,

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Introduction

As advocates who serve the interests of Medicaid enrollees and individuals applying for Medicaid, several of us for multiple decades, we greatly appreciate the opportunity to provide suggestions for improvements in the Medicaid program. Before we do, we agreed that it is extremely important to recognize that the CT

Medicaid program has achieved an enormous amount of success. When compared to programs across the country, CT Medicaid may well be the best in terms of efficiency, cost control, quality, and accountability.[1]

The 2012 move to managed fee for service with non-risk administrative services organizations (ASOs) rid the CT Medicaid program of capitated or risk-based managed care organizations. This move was the beginning of CT Medicaid's success story, as it shifted the program's focus very intentionally to patient care. The ASOs took on certain functions which the MCOs previously provided, but also provided intensive case management, while DSS implemented the broad use of patient-centered medical homes 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. In addition, access has 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 resulted in significant cost savings for taxpayers. We spend 2.75% of program cost on administration, compared to the U.S. average of 8.5%. Then administration is performed by non-risk ASOs, and particularly not for profit entities, the costs are inherently lower. Compared to states with MCOs, Connecticut spends 7.7% less of our state budget on Medicaid.

Given the success in both quality and access, and the lessons learned from other states and our state's history with MCOs, there is no reason to go back to a failed capitated insurer system or to adopt a newly-titled capitated system (i.e. "value-based payment") which creates a direct financial incentive for others- this time providers - to deny care, with no failproof way to detect when this might be happening, unconsciously or otherwise.

Some innovations are appropriate. While Husky is the only state Medicaid program that has adopted every innovation option analyzed by Kaiser Family Foundation and despite our success, we fully recognize significant shortcomings like access to behavioral health services, long-term care, and health equity across the board.

[1] Link to sources for Medicaid's high performance statistics is here -- https://cthealthpolicy.org/wp-content/uploads/2024/06/CT-state-compare-the-evidence.pdf
Link to more detail on the need for better access to care for people with disabilities -- https://portal.ct.gov/ctcdd/about/about-us/council-products/ctcdd-access-to-healthcare

Focus on quality and access to care

We certainly want to protect what is working well and improve upon it and, as previously stated, quality and access have both improved under our ASO managed fee for service model. To ensure this continues, quality and access should be pillars in any model that is used going forward.

For instance:

- Participation in any new payment or delivery models, such as the maternity bundles, should only be available to providers with the highest level of quality and access performance. These new models might give providers more flexibility to individually customize care according to members' needs. However, they come with great risk of inappropriate denials of necessary care, because the provider generally gets paid the same amount no matter what services are rendered or withheld.
- Flexibility must be earned and should only be entrusted to providers who are already high performers with robust, successful quality and access systems already in place. The traditional fee-for-service system has built-in accountability as payments are tied to members receiving care.
- Quality gates for receiving bonuses are entirely insufficient in protecting members, especially with no recent quality reporting.

Our recommendation:

1. **Quality and access consequences of all policies should be considered in development, implementation, and evaluation.**
2. **Do not return to a system of capitated managed care through MCOs.**
3. **Do not pay providers or groups of providers under a system that puts financial risk on providers for the cost of their patients' care, through capitation, downside risk, etc.**

Improve Government Services to Access Medicaid

About 10 years ago, Connecticut dramatically changed how individuals applying for or trying to stay on Medicaid went through the administrative process. We rejected the previous model of individually-assigned workers and moved to our current system, a combined central processing system. The system uses a statewide call center whose staff are tasked with processing client information that has been scanned. Each worker is given dozens of "pieces of work" belonging to randomly assigned applicants or enrollees each workday. The exception is that long-term care applications are assigned to individual workers to process. About the same time we moved to the current system, we created CT's health insurance exchange, AHCT, for the "MAGI" based Medicaid programs as well as subsidized insurance, with its own call center.

While the AHCT call center has generally performed well, the DSS call center has had very uneven performance, with wait times and call abandonment rates at various times being nothing short of terrible; the call center is in that zone now. In all cases, the overwhelming cause of the long delays is inadequate staff. Historically, when concerns have been raised about the inadequate staffing of the call center, including through negative media reports, DSS has obtained permission to conduct substantial hiring and has done so, bringing down the long wait times, but, inevitably, staffing becomes inadequate and wait times once again climb.

Our recommendation: **While an immediate infusion of hiring is needed to address the immediate crisis, our long-term suggestion is to once and for all address the endemic poor performance of the DSS call center, through at least these steps:**

1. **Require a long-term plan of sufficient staff, signed off on by both the Governor and the legislature, to ensure compliance with an agreed upon level of performance, along the lines of the performance DSS requires of its own contractors which run call centers, including a plan for closely monitoring available staff and automatically beginning an aggressive hiring campaign when the level of staff starts to hit a threshold, with no additional approval needed.**
2. **Publicly report all call center data, for both tier I and tier II (if there is one), and without any interruptions, to help identify a developing trend of longer waits which would trigger the automatic hiring set forth above.**
3. **Explore a return to individually-assigned workers for both Medicaid applicants and enrollees, as currently used for long-term care Medicaid applications, so that the work of being an eligibility worker is more satisfying and attrition can be reduced, including canvassing current workers (in an anonymous survey) about likely job satisfaction if they could have a continuing relationship with Medicaid enrollees.**

Improve Access to Community-Based Long-Term Care

In the past, CT has been in the middle of the pack of states in terms of rebalancing long-term care (LTC) away from nursing facilities and toward more innovative home and community-based services. However, recently, CT has been slipping with a higher percentage of our LTC clients receiving skilled nursing facility care than in the past. Not surprisingly, this backtracking has been associated with a higher percentage of CT's overall Medicaid budget going to LTC services.

The last Long-Term Care Plan 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, and that 70% of individuals on long-term care were receiving community-based services. But we have since lost ground, with

the LTC Committee's latest statutorily-required annual report on CT Rebalancing, for SFY 2023, stating 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 "In 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).

A major cause of this is the long and growing wait lists for all HCBS waivers, except for the CHCPE program, the DMHAS waiver, and DDS-administered waivers, coupled with a lack of resources dedicated to the Money Follows the Person (MFP) program which gets people out of SNFs and denials of access to the MFP program without due process rights, as well as cumbersome application procedures for the long-term care waivers.

In a December 8, 2023 presentation by the DSS Community Options Division, extremely long waits were presented, from 3 years to 10 years. These kinds of delays do not comport with the integration mandate of the Americans with Disabilities Act as articulated in the *Olmstead* decision by the U.S. Supreme Court.

Another problem with CT's rebalancing effort is the inadequate policies and procedures governing the MFP program. First, DSS fails to adequately staff the program, under which positions are 100% federally funded. The MFP staff, as recognized in the 2021 report, at page 11, help move individuals already in expensive nursing homes to less expensive community placements. Accelerating rebalancing progress is an actionable, immediately available means of honoring preferences and needs of older adults and people with disabilities. Second, as of late, DSS is denying critical social work services available under MFP to some individuals desiring to leave nursing homes, despite their meeting all eligibility requirements for MFP services, simply because alternative community-based services may be somewhat difficult to arrange down the road. When these denials occur, there needs to be better due process protections: DSS needs to publish formal regulations for MFP as well as the Community First Choice program, including a clear notice and appeals process.

In addition, CT does not fully utilize the Community First Choice Medicaid state plan option (CFC), which allows for self-directing individuals to hire their own PCAs and without any caps on the number of people participating, allowing more people to stay in the community: (1) it fails to advise all participants or applicants that a federal regulatory exception process is available if they believe they need more hours of care than DSS's budget chart allows (see 42 CFR § 441.560(c), mandating a process for individuals "when the budgeted service amount is insufficient to meet the individual's needs"), and (2) anecdotally, DSS staff

routinely deny these exceptions requested, to such a degree that the access agencies contracted to do annual assessments are demoralized by the brick wall and do not even ask for additional hours which they believe are needed. The resulting inadequate CFC plans also can lead to unnecessary institutionalization at the taxpayers' greater expense.

Finally, the application process for the home care waivers is difficult. DSS should assist low income clients through this process instead of making it so difficult that clients give up and don't apply for the services. Two examples: 1. Clients are expected to come up with bank statements going back 5 years from the date of the application. Some banks charge poor clients for these statements, or the client has difficulty getting them for various reasons (e.g., cannot get to the bank); 2. Getting information from separated spouses is often difficult, and clients will be denied for not providing it.

The consequences of all of these failures go beyond the irreparable harm to individuals forced into nursing homes because of the absence of alternatives, and the legal jeopardy this creates for Connecticut which appears to be out of compliance with the ADA's integration mandate and the *Olmstead* decision implementing it, as well as due process obligations. It also is harmful to CT's taxpayers. As the 2021 report notes at page 49, research demonstrates that services in the community are less than the cost of 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.

Our recommendation:

1. **Remove all waiting lists for the ABI II, PCA, DMHAS, Autism and Katie Beckett waivers, as already was done years ago for the CHCPE waiver program, and provide sufficient funding to make this possible.**
2. **DSS should educate all individuals potentially needing long term care under Medicaid, their family members, providers and access agency and DSS staff, about the broad coverage available under CFC and the obligation of DSS to grant exceptions to the amount of services authorized under its CFC level of need budget chart for a given level of need when a greater actual need exists, reevaluate its processes for reviewing requests for such additional services as submitted by access agency reviewers, and audit with outside assistance the cases in which exceptions are denied by DSS staff.**

3. **DSS should assist low income clients through the home care waiver application process proactively.**
4. **Hire as many federally-funded staff as possible to administer and grow the MFP program.**
5. **DSS needs to grant MFP services to anyone who meets the eligibility criteria of being in a nursing home at Medicaid expense for two months or more and desiring community-based services so as to explore all options with MFP services.**
6. **DSS needs to publish regulations for MFP and CFC, including a clear notice and appeals process, and require all the different layers of contractors actually running the program to have a grievance official policy and written grievance procedure.**

Better Access to Office Visits for People with Cognitive and Communication Disabilities

Unlike under a capitated payment system, providers under CT Medicaid's managed fee for service system are assured of payment for each office visit so, in general, they do not have a disincentive to see patients. However, individuals with certain kinds of disabilities, particularly developmental, cognitive and communication disabilities, often require more time with a provider in order to understand, and respond to, the questions being asked and the advice being provided. Under a set fee for the visit, providers are disinclined to spend that extra time. Accommodations in the way of additional time are needed to ensure meaningful interaction between patient and provider. There are codes available for such longer visits, but they are not widely used and there is the possibility of the code being used to gain higher reimbursement *without* the extra time actually being offered. We recommend this be addressed through an education and monitoring system. Our recommendation:

1. **Work with provider groups to educate individual Medicaid providers about the availability of codes for longer office visits and their applicability for individuals with disabilities requiring additional time to interact with their providers.**
2. **Work with advocacy groups to educate individuals with disabilities, and their family members, about the availability of these codes and how to advocate for more time with providers, including by specifically asking for these codes to be applied.**
3. **Audit records of providers who use these codes to ensure that longer visits are in fact being provided.**

Community Health Workers

Connecticut, along with much of the country, has recognized the important role that community health care workers can play by meeting fellow members of their community where they are. Because the CHW and the individual both hale from the same community, they are able to establish a level of trust impossible for an outsider to achieve. The CHW is able to provide important information regarding such things as disease prevention, asthma inhaler instruction, insulin testing, but, most importantly, vouch for a provider in the community or nearby and help build a connection between the two. Once solidified, the CHW and the provider can work with the individual to ensure they receive important care. CHWs reduce racial, ethnic health disparities by addressing cultural bias, social determinants, and building trust and/or understanding where it is lacking.

We should move forward on the statutory mandate to obtain approval for federal Medicaid reimbursement for CHWs with stakeholder input throughout the process. BIPOC individuals with comorbidities have been shown to especially benefit from CHWs, so when bringing stakeholders to the table to discuss the best way for Medicaid to serve their BIPOC communities, individuals representing these groups should also be at the table. As the statute mandates,

> (a) ….The Commissioner of Social Services shall design and implement a program to provide Medicaid reimbursement to certified community health workers for services provided to HUSKY Health program members, including, but not limited to: (1) Coordination of medical, oral and behavioral health care services and social supports; (2) connection to and navigation of health systems and services; (3) prenatal, birth, lactation and postpartum supports; and (4) health promotion, coaching and self-management education.
>
> (b) The Commissioner of Social Services and the commissioner's designees shall consult with certified community health workers, Medicaid beneficiaries and advocates, including, but not limited to, advocates for persons with physical, mental and developmental disabilities, and others throughout the design and implementation of the certified community health worker reimbursement program in a manner that is inclusive of community-based and clinic-based certified community health workers; is representative of medical assistance program member demographics; and (3) helps shape the reimbursement program's design and implementation. *The commissioner, in consultation with community health workers, Medicaid beneficiaries and such advocates, shall explore options for the reimbursement program's design that ensures access to such community health workers, encourages workforce growth to support such access and averts the risk of creating financial incentives for other providers to limit access to such community health workers*. CHWs should not be paid solely through a practice group. PA 23-186 (Section 4) (emphasis added)

Access and Capacity

Giving responsibility, and funding, to health care provider groups to connect patients with social services has a long history of failures. While there is very good evidence that the social and environmental circumstances of people's lives are critical to their health, the evidence is overwhelming that connecting

people to community services through primary care doesn't work. It is another burden on primary care practices that they are not trained or positioned to succeed at. Evaluations of both large and small scale programs find little or no impact on health status or community needs met. No evaluations found any net savings and most programs were very costly.

Expanding primary care team capacity is key to improving access.

- Ensuring payment for CHWs, and other trusted nonmedical community patient support workers, will improve health outcomes, engagement with medical care, and free up time for primary care clinicians. It is critical for doulas, peer support specialists, and recovery coaches to be independent of but connected to clinical care.
- Other proven options include enhanced care management, population health reforms, accountability, patient support and education, primary care practice support, technology, innovative delivery options, targeting resources to areas of need.
- Strategies that are not in the best interest of Medicaid enrollees:
  - Despite decades of expensive experiments in primary care, capitation of providers has failed in both improving care and controlling costs. Connecticut should learn from others' mistakes and move on to strategies with evidence of success.
  - Studies have found that increasing payment rates alone is unlikely to improve either the quality or availability of primary care. Invest resources in more effective solutions.

Our recommendation:

1. **Following the lead of other states, establish a Medicaid fee schedule for paying CHWs and other trusted nonmedical community patient support workers not employed by medical practices, on a fee for service basis.**

Nonmedical Interventions

While there are federal restraints on state Medicaid spending for non-medical interventions, Connecticut should continue to explore opportunities to support community resources to address the social drivers of health. CT Medicaid's support for housing and justice-involved services are excellent examples. Our recommendation:

1. **Invest in proven upstream preventive solutions.**

Improvements in Access to Behavioral Health Services

It is now well accepted that the reimbursement rates paid to non-institutional behavioral health providers, many of which are nonprofits, are inadequate. This has led to a lack of community-based services. This shortfall results in avoidable emergency services, hospitalizations, and even intervention by the criminal justice system. The Department's Phase I rate study found that behavioral health was the clear outlier; it had the lowest percent of benchmark (Medicare and neighboring Medicaid rates). Community behavioral health providers have for years asked for rates that cover their costs. To date, these rates have barely been adjusted, other than token increases this year, not comparable to insurers' rates for the same services in other states.

Unfortunately, these providers, desperate for relief, have turned to unproven financing schemes to address the shortfall. One such model is Community Care Behavioral Health Clinic (CCBHC). Under the CCBHC model, providers accept monthly capitation, putting them at financial risk. The National Council on Well-Being, which is the primary non-governmental group pushing this model, said the following about the CCBHC monthly capitated payment model:

> "Providers experience **substantially more downside risk** than in a daily PPS model. Because rates are set based on anticipated monthly client volume, clinics experience a financial loss [if] costs or intensity of services during a month exceed targets—for example, if a patient experiences a crisis due to a poorly controlled condition."
> CCBHCs_A_New_Type_of_PPS_3-2-20 (1).pdf (page 3)(emphasis added).

The conclusion can reasonably be drawn that, as with any financial risk model, to avoid experiencing financial loss and otherwise to shore up its finances, the provider group might limit service going forward, leaving the clients without needed, often critical care.

Our recommendation:

1. **Community-based behavioral health per visit reimbursement rates should be increased to match the Medicare rates for the same services and, where this is not available under Medicare, the average Medicaid rates of our neighboring states.**

Transparency and data reporting

Public performance reporting on Medicaid has lapsed. It's been well over a year since MAPOC received either the usual financial reports on program spending or reporting on quality measures. Regularly sharing

this information allows for input on context unavailable to DSS, leading to better solutions. These reports are critical to:

- Monitoring resource use and ensuring we maximize every dollar
- Identifying gaps in quality and access to care
- Developing collaborative, feasible solutions to address challenges

Our recommendation:

1. **Provide more timely information, with more detail.**
2. **Share information that can help lead to solutions, for example: There have been concerns that Long-Term Services and Supports spending is up. Sharing information on that concern will lead to development of better options to both improve care and control costs while minimizing unintended consequences.**

Thank you for taking our comments and recommendations into consideration. We are available to discuss any of them with you in more depth.

Sincerely,

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