**Medicaid Comments Pursuant to PA 23-171**

As a Department of Social Service’s employee for over 31 years – 10 of which were in the Medicaid Division – I have the following comments regarding improving CT’s Medicaid Program.

**Quality Measuring**

* While the Division of Health Service’s requires some of its Administrative Service Organizations to run robust quality measure sets such as the HEDIS Measure Set and the CMS Child and Adult Core Sets, CT is still lagging behind in implementing the newer measures that require electronic data feeds. These measures are critical to being able to analyze what is actually happening at a provider visit rather than just knowing a claim was paid for a procedure code.
* CMS has been urging states (for the last 3+ years) to measure the health outcomes of Dually Eligible Medicaid Members (those on Medicaid and Medicare). CT has yet to meet this goal, while states like Massachusetts have. As stated by DSS in many reports, Dually Eligible members are, by far, the most expensive members served and have the most complex health issues. It would behoove the Department to know if good care is being provided and whether the money being spent is being targeted for the maximum benefit to the clients.
* If, due to budget constraints, there aren’t the resources to run every measure, the measures that actually evaluate health outcomes (vs. service volume such as number of doctor visits, etc.) should be prioritized.
* Data sharing agreements with the CT Department of Public Health should be expedited to improve the Department’s ability to measure certain health conditions. One long standing deficit is birth data. DSS struggles to do quality improvement projects regarding C-Sections (CT has one of the highest rates in the Nation) and other birth outcomes due to the lack of timely data from DPH. Other states have been able to get birth data monthly from their sister state agencies to due rapid PDSA (Plan, Do, Study, Act) cycle quality improvement initiatives. With this rapid cycle approach, these states have moved the quality needle dramatically.

**Transparency**

* All measures run by the Department and its vendors should be posted publicly in a timely manner. External partners of the Department would benefit from knowing how various initiatives have been successful. Again, timely data is the only way to improve outcomes above a glacial pace. There should be no need for outside entities to file Freedom of Information Requests for data that has been de-identified.
* The Medicaid Transparency site should be updated as soon the data has been verified. It is often easier to find the data on the MAPOC site than the DSS site.

**Compliance**

* A Certified External Quality Review Organization (EQRO) should be retained to ensure the Department, and its Health Service vendors are in compliance with Federal Regulations and are using best practices. The Department retained an EQRO until the State switched to fee for service. CMS allows fee for service states to forgo hiring an EQRO. However, without an EQRO (which are certified independent entities which are bound to be neutral per CMS) DSS, and the public, do not have a clear sense of the quality, safety, and ethics of its vendors.

**Value/Quality/Performance Based Standards**

I strongly believe that all value/quality or performance-based payments, whether in a vendor’s contract or in a Value Based Program, should have a clause that any provider or entity that is cited by the Department’s Fraud and Recovery Unit, The State Prosecutor’s Office, or CMS for financial malfeasance should be disallowed any financial “bonus” payments in any program DSS manages. Also, health quality citations by the State Department of Public Health should also, depending on their severity, disallow payments and/or participation in “bonus” payment programs. Currently, due to some glaring examples reported in state news sources, it is apparent the Department does not disallow “bonus” payments to entities that have been cited for either health or financial violations.

**Care Management**

The full level of care management afforded HUSKY members whose sole medical insurance is HUSKY, should also be provided to HUSKY member who are also on Medicare or have private insurance. Although the Department does not have the entire picture of the health of members with Medicare or private insurance, there is enough claims data (either paid or not paid (zero-dollar claims) to provide the Department’s vendors strong indicators as to the disease states these clients have. Disease management programs should be offered to these clients as well as “HUSKY Only” clients, especially because many of these members have multiple complex health issues.

**Provider Fraud Reduction**

While most Medicaid providers and entities are law abiding and upstanding, there is a worrisome amount of provider fraud that wastes taxpayer’s dollars as well as undermining the credibility of Medicaid in the eyes of taxpayers.

With the vagaries of the State and Federal Budgets, there will never be enough State staff to monitor and deter provider fraud. The majority of the Department’s fraud efforts are “pay and chase.” Finding out about fraud after the fact and then investigating and “chasing” the accused is time consuming and expensive…and does not serve as a deterrent. Proactive fraud avoidance via strict provider policies and advanced analytics within our medical vendors systems would be much more cost effective and stop fraud at a much more rapid pace. Proper edits in these various computer systems would alert our vendors and the Department, in nearly real time, to unusual medical billing/usage patterns. CMS has issued many white papers giving states guidance on preemptively stopping fraud. Below, is on of the documents.

[HFPP Measuring Value White Paper (cms.gov)](https://www.cms.gov/files/document/measuring-value-healthcare-anti-fraud-efforts.pdf)

**Fee for Service vs. MCO Models**

As someone who worked in the Medicaid Division supporting an MCO model and our newer managed fee for service (FFS) model, I would suggest the state stay with the FFS current mode of operation. Improving, rather than removing the FFS model is, in my opinion the correct path forward.

The MCO years (the last iteration in place in 2008) were marked by chaos, confusion and lack of proper oversight. State staff struggling to monitor the MCOs activities. There were problems with spotty provider networks that were often erroneous, contradictory medical policies, computer files riddled with inconsistencies and a general lack of cohesion to target certain disease states and health equity issues.

Sincerely,

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