Overview of Connecticut Medicaid

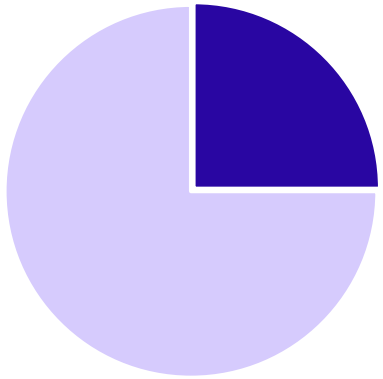
Presentation for colleagues in Idaho

Agenda

1. Overview of Connecticut's model + brief history
2. Comparing "Managed Fee For Service" and Managed Care models
3. How is Connecticut doing?
4. Additional thoughts on the "Managed Fee For Service" model
5. Conclusion

CT Medicaid / HUSKY: By the numbers

3.5 million
total CT population



1 in 4
CT residents are covered by Husky (Medicaid + CHIP)

Currently covering ~1 million people

In CT, Husky Covers


1 in 6 adults, ages 19-64

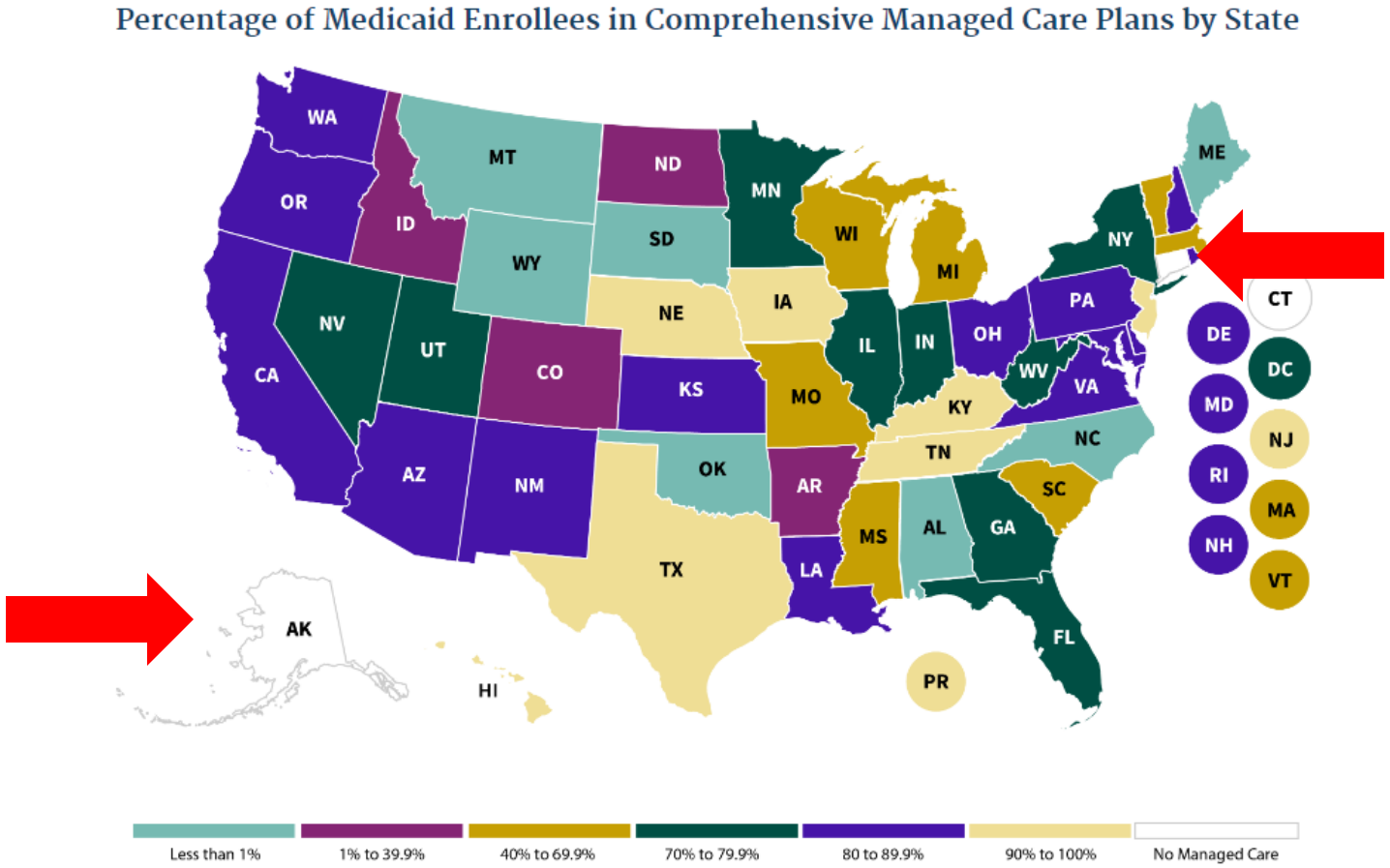

1 in 3 children


2 in 3 nursing home residents


3 in 8 individuals with disabilities


1 in 4 Medicare beneficiaries

Connecticut is one of only two states to have no comprehensive managed care plans…but many other states have little comprehensive managed care plans.



Source: https://www.medicaid.gov/state-overviews/scorecard/how-states-deliver-care-medicaid/index.html

More details on Connecticut's model

Connecticut Department of Social Services (DSS) is the **single state Medicaid agency** for Connecticut

DSS partners with **several sister state agencies** (DMHAS, DCF, DDS, DOH) that have roles in managing Medicaid benefits and related services

DSS works with DPH (Department of Public Health), state healthcare licensing agency and the federally identified state survey and certification agency, to ensure quality

DSS oversees contracts with **three Administrative Services Organizations (ASOs)** (for medical, behavioral health, dental) and a non-emergency medical transportation broker

Brief overview of HUSKY's model: managed Fee For Service

	(A). Traditional Fee For Service	(B). Managed Fee For Service	(C). Capitated managed care organizations
Example			
Overview			

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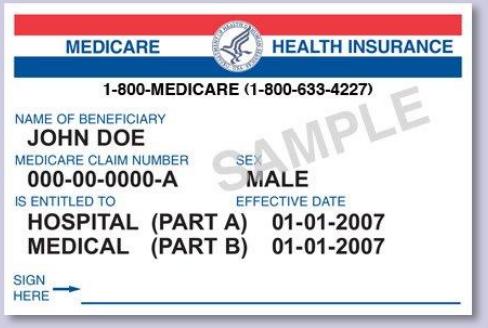
Example	Traditional Medicare 		
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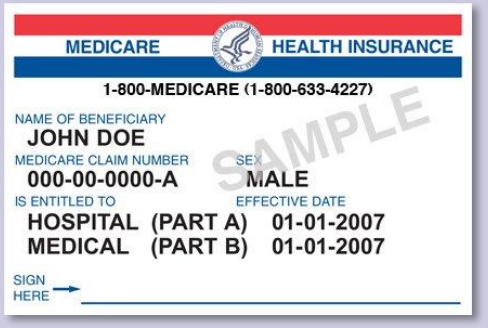
Example	Traditional Medicare 	Most large employers ("self-insured") 	
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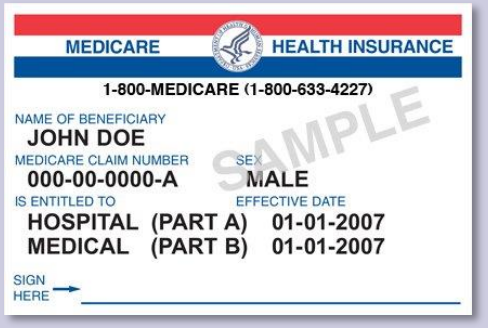
Example	Traditional Medicare 	Most large employers ("self-insured") 	Medicaid Managed Care 
Overview	Payer sets rates and determines benefits Generally little care management (CM) or utilization management (UM)	Payer sets rates and determines benefits Payer hires ASO, who conducts CM, UM, and other functions	Payer sets broad regulatory framework and pays capitation payment to managed care plans Managed care plans sets rates, network, UM, CM and other policies

More details on managed Fee For Service versus capitated managed care

Connecticut Medicaid does not contract with capitated managed care organizations. Instead, like most large employers, the program is self-insured and uses a managed Fee For Service approach.

Topic	Self-Insured	Capitated Managed Care
Payments	Connecticut Medicaid does <u>not</u> make payments to managed care plans. Instead, we are at financial risk…and we pay the costs of health care claims.	Medicaid agency pays monthly premiums to a Medicaid managed care organization (MCO).
Assumption of risk	Connecticut Medicaid assumes financial risk.	The Medicaid MCO assumes at least <u>*some*</u> financial risk. *Note: through risk corridor's, reinsurance, and lobbying some risk frequently transferred back to state*
Plan design	Connecticut Medicaid controls and has standardized coverage, utilization management and provider payment statewide.	Each Medicaid MCO determines its own coverage, utilization management, provider network, and provider payments.
Data	Connecticut Medicaid has a fully integrated, statewide set of claims data.	Each Medicaid MCO produces limited "encounter data" for the Medicaid program.

History and overview of Connecticut's "Managed Fee For Service" model

History

- Medicaid in Connecticut began as Fee For Service program
- 1994: Connecticut legislature began transition to managed care
- 1995 to 2010: Used some form of managed care delivery system in parts of its Medicaid program. Generally, low-income children and their families received Medicaid services through arrangements with MCOs…while remaining Medicaid populations (e.g., the elderly or people living with disabilities) received services on a Fee For Service basis.
- Starting in 2010: Began to transition back to managed Fee For Service. By 2012, contracted with ASO

Key structures

- Connecticut determines: services covered, rates, UM criteria, and CM program definitions
- Connecticut contracts with ASOs (medical, BH, and dental) to administer benefits
- Connecticut directly administers key parts of the program (e.g. LTSS) itself

More details here

Assessing 4 claims about Medicaid managed care

Claim #1. MCOs reduce state spending

- Theoretically, arguments exist both for and against this claim
- Best evidence: MCOs do not lower state spending on Medicaid

Claim #2: Narrow provider networks reduce spending by lowering prices

- MCOs often have narrower provider networks
- Research (link link) suggests that while narrow provider networks do lower cost, they achieve these cost savings primarily by decreasing "quantities" rather than reducing "prices"…and narrow networks decrease utilization of both low and high value services

Claim #3: MCOs take full financial risk from the state to another entity

- In principle, MCOs can transfer risk from state to managed care plan
- In practice, this risk transfer is often incomplete because of factors like carveouts, risk corridors, and the practice of setting capitated rates based on past spending

Claim #4: MCO improve health outcomes

- Evidence on this claim is mixed

Claim #1. MCOs reduce state spending. Theory and evidence

Why MCOs might *increase* state spending

1. Fragmented market power → **higher provider rates**
2. **Higher admin costs**…due to (a) fragmented payer landscape and (b) activities like advertising
3. **MCO profits / markups** (especially if market is not competitive)
4. Patient churn may **under-cut MCO's incentives to invest in care that reduces costs in the medium-run**

Why MCOs might *decrease* state spending

1. MCOs may have stronger **financial incentives to keep their members healthy**…and more flexibility to cover services that help reduce costs (e.g. social determinants of health)
2. MCOs might be able to negotiate **lower provider rates, because they face fewer political pressures**
3. Competition between plans might **improve efficiency overall**

Evidence

- *Can't simply compare managed care and non-managed care states. Correlation ≠ causation*
- Comprehensive national data examines state Medicaid spending, following counties before and after the transition from FFS to Managed care, compared to other, similar, counties (source)
- Study finds no state savings from managed care transition…in part because FFS states already set very low provider rates

Claim #2: Narrow provider networks reduce spending by lowering price. Theory and evidence

Potential promise of managed care

MCOs have greater flexibility to set provider networks. In principle, this could lead to:

→ lower provider rates (due to harder negotiation)

→ less "low-value care": without decreasing use of "high-value care" (since providers who deliver low value care could be excluded)

Research design

Examine a market where members who do not actively select a plan are randomly "auto assigned" to different managed care plans

Some managed care plans have broad networks…others have narrow networks

Compare outcomes

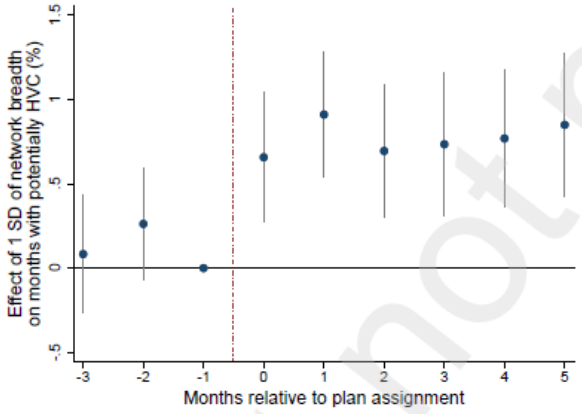
Findings

(1). Narrow networks *do* decrease spending

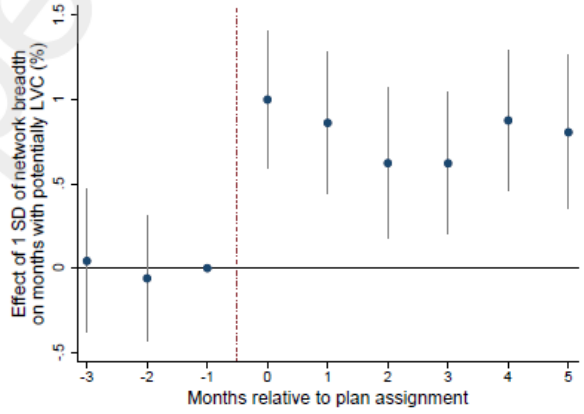
(2). Effect primarily driven by *quantities*, not prices

(3). High Value Care (HVC) and Low Value Care (LVC) are *equally responsive* to narrow networks

Panel C. Impact of network breadth on potentially HVC by month



Panel D. Impact of network breadth on potentially LVC by month



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Claim #4: MCO improve health outcomes	• Evidence on this question is mixed

Claim #4. MCO improve health outcomes
Theory and evidence

Caveat
Understanding how manage care organizations (MCOs) influence health is hard
Here, describe two papers that examine impact of MCOs on health outcomes for pregnant women

Aizer, Currie, Moretti (link)

Empirical approach:

- Examines births in California, which rolled out managed care county-by-county
- Looks at the *same* woman, over time, who experienced both a "FFS" and a "MCO" pregnancy…compared to otherwise similar women who experienced two "FFS" or two "MCO" births

Results: transition to managed care…

- …caused a large (4 – 8 percentage point) *decrease* in prenatal care in first trimester fell [Bad]
- …*increased* incidence of low birth weight, short gestation, and neonatal death [Bad]

Meckel, Rossin-Slater, and Kuziemko (link)

Empirical approach:

- Considers FFS → MCO transition in Texas, which also took place at the county level
- Study how transition from FFS to managed care affects high- and low-cost infants

Results: transition to managed care…

- …widened disparities between high and low cost infants
- e.g., black mortality and pre-term birth rates increased by 15% and 7% respectively

Overall, how is Connecticut Medicaid doing?

Quality

Annual CMS Medicaid and CHIP Scorecard: Connecticut's performance was well above the national median for most of the State Health System Performance Measures, including:

- well-child visits
- immunizations for adolescents
- preventive dental visits
- diabetes short-term complications admission

Costs

The DSS Medicaid account Per Member Per Month (PMPM) has been very stable, reflecting only a 1.35% average annual increase from SFY 2015 to SFY 2020

Administrative expenses of approximately 3.0% are well under Medicaid managed care norms of close to 12%

Connecticut's percentage of Medicaid costs to overall State budget costs compares very favorably to both national averages and "peer" regional states

Additional key advantages…and challenges with the Managed Fee For Service Model

Additional key advantages

1. Simplified **data, formulary, and member experience**
2. Gives state **more control** over strategic levers like provider rate setting, prior authorizations

Some challenges

1. **Less administrative flexibility** from CMS (MCOs can spend their admin dollars on social determinants of health investments, while managed FFS cannot)
2. Some state-performed functions might be able to be **staffed with more flexibility**, if outsourced

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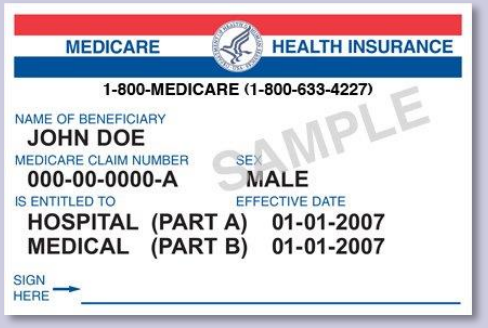
Example	Traditional Medicare 	Most large employers ("self-insured") 	Medicaid Managed Care 
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