How Connecticut Eliminated Managed Care in Medicaid

A talk presented by Sheldon Toubman, New Haven Legal Assistance Corporation (slightly) edited Transcript – February 2019

In 2012, Connecticut replaced managed care organizations (MCOs) in its Medicaid program with a program of "managed fee for service". Enhanced care coordination for all Medicaid recipients became an important part of this program, which has reduced Medicaid spending and provided better service to patients. Toubman, along with Ellen Andrews of the Connecticut Health Policy Center, was instrumental in bringing about this reform. In this talk, presented to the PNHP-NYMetro Research/Study Group, he describes the process by which it happened.

I have been a legal aid lawyer with New Haven Legal Assistance for almost 28 years and other programs for three years beyond that. For most of that time, I have been focusing on the Medicaid Program.

In that role, I came of age in Medicaid advocacy in Connecticut in 1995 as the state was moving from the traditional Medicaid fee for service program, where the provider provides the service and they bill for service, to what other states were doing at the time, a capitated managed care system in which the state pays a fixed amount of money per member per month for health care services.

I will give you the background of what we had in Connecticut, the strategy we came up with, and then where we are today. It was seven years ago, January 2012, that Connecticut made the transition to what I call "managed fee for service", or single payer. We've now had seven years of experience and I can tell you exactly what we've gotten for our money. Recognize that Connecticut is rather unusual. There are only four states that don't have capitated managed care running their Medicaid program as you do in New York.

So, when the capitated managed care model rolled out, there were eleven MCOs, Managed Care Organizations. We were told that the state was going to save money by paying them 95% of what we would otherwise have paid them. You won't be surprised that the managed care industry managed to convince the state not to reduce its fees, but to pay it 100% of current spending. And you'll not be surprised to hear the industry say that actually it's not getting enough, so it needs more money, even though the whole premise was that it's going to save money. (I should say that this is for our family and children population, not the elderly and disabled population, which is a sicker population, but generally family, kids and pregnant women is a healthier population. And so that is the group that was in the managed care system.)

This dynamic started right away -- they were always demanding more money, but the state had become dependent on them.

The MCOs also argued that they were going to improve care because they are uniquely in a position to coordinate care. This is especially noteworthy because there is always a complaint

from Medicaid recipients that their care is uncoordinated, that they see a lot of different doctors and nobody is watching out for them.

So MCOs would say they're going to coordinate care so that the state saves money, improves access to care, and thus improves the quality of care.

However, in practice, what we saw constantly was routine lack of access to services. It was horrendous in the case of behavioral health, where kids who had been abused would be told they get a limited number of sessions and, if their provider was willing, they could beg for more. These abusive practices were partly a function of the fact that the MCOs subcontracted with other capitated insurance companies, so if the MCO was getting $200 a month for all health care, they could contract for $11 a head to a specialized for-profit company to provide behavioral health, and those companies were even worse in restricting access to care.

The basic problem with capitated MCOs is the same as with commercial insurance: every dollar of health care they provide comes out of their pocket. So the incentives were pretty obvious. Their messaging in response was always, "Don't worry about that. Yes, it seems that way, but if they get sick, it's on our dime. If somebody's not taken care of and they end up in the hospital, we have to pay for that. So we have a real incentive to coordinate care and make sure that bad things like that don't happen. We're going to keep people healthy."

The reason that was garbage is, first of all, these are mostly for-profit, publicly-traded companies. All they care about is how well they're doing this quarter. So if they can keep someone's diabetes under control and keep them out of the hospital next year or the year after, that's interesting but it's not relevant to what they're trying to do. They're trying to profit right now.

Second, people move from one plan to another, and so it may save money for another plan, so they don't see the benefit. The consequence is that they never did the things they said they would do. They never coordinated care. They never did the kinds of things that were necessary to prevent complex conditions from developing. And even on basic measures, like the Early and Periodic Screening, Diagnostic and Treatment requirements of federal Medicaid law, they were doing abysmally.

And then there was dental access, which was terrible. There was pharmaceutical access, which was terrible At some point, we decided that the basic financial model, where they make money by denying care, was just not going to work. There was no way we were going to reform that basic economic model and make it work for our clients.

We started with a lawsuit. In 1999 we filed a class action suit against HealthNet and the state, which is ultimately responsible. Our specific allegation was that they were not compliant with due process. They were constantly denying services, but patients were not getting written notice of it. They learned about it because their doctor would say, "I tried to get approval, but they wouldn't grant it." There was no written notice to the patient of what the decision was, why it was decided and, more importantly, their right to appeal. These basic rights apply to all state, and federal government programs.

So we brought a lawsuit saying they weren't providing written notices and in the few cases where they did, the notices were grossly defective. For example, in one case the reason given for being denied was you don't meet our company's criteria, unspecified.

One of the things we uncovered is that, routinely, people would be denied drugs which were covered under Medicaid and therefore covered under these contracts with MCOs. When they were denied, even when they were sent the written notice, it said the drug is not covered for you, which was not true. The drug was simply not on their formulary, which means they had to go through prior authorization, but it didn't say that. It was basically a substantive access issue created by misrepresentation of the rules. So, we brought a lawsuit about that.

One of the things we did with the lawsuit was to get a lot of press. This was the first class action suit ever brought in this country against the Medicaid-agent model insurance company. (Most of the time, people just sue the state; they don't sue the insurance companies.) We did get a lot of press, and that's really important because insurers really care about bad publicity. They are in a competitive marketplace, especially if they're in the commercial sphere as well as the Medicaid world. They worry about their name, and their brand. They don't want to be associated with problems. So we did a lot of press focusing on one MCO, but we also talked about problems with other MCOs as well.

One of the things we emphasized is that this system is a black box. No one can tell what they are doing. We know people are routinely being denied service, because they come to our office and tell us that. Getting data on dollars and numbers of denials was really difficult, and the state couldn't even get the information. So, one of the things that happened that we were responsible for is that some other avenue had to be found.

We started focusing on recipients' lack of access to providers, meaning that they just couldn't find one. They couldn't find a cardiologist, a neurologist. Various specialties just didn't take Medicaid under any plan. This was a huge issue, related to low payment rates, because the specialists were being paid too little by the MCOs. So we wanted to get the rates. We filed a request under the state's Freedom of Information Act, the open records law. We asked for the payment rate for each of the specialists, for each of a set of codes, for each of the MCOs.

What happened is the state said, "We don't have that data because Freedom of Information Act is on what's in the possession of the state." And the state correctly said, "We don't have that. We don't have the rate that the docs are being paid." So I helped draft a Freedom of Information Act request which went beyond that. We have in state law, special to Connecticut and maybe Pennsylvania, that a large, privately-owned contractor who is providing at least $2.5 million a year in services is essentially performing a governmental function, It is taking over a role of government. And that was really easy to show because the elderly and disabled population in Medicaid were not in managed care, all the things that the insurance companies were doing for the family population, the state was doing for the elderly and disabled. So I helped craft a Freedom of Information Act request asking for the provider rates from the MCOs.

In addition, I got involved in trying to get information about the numbers of pharmacy denials for lack of prior authorization. One of the ways insurances companies block access to

drugs is they impose extra burdens and quantity limits for medication requests. We wanted to know how often does that happen. So we made a FOIA request saying to the state, "If you don't have the data, please get it from the MCOs. They have to provide it because they're performing a governmental function in running a portion of the Medicaid program in general, and providing prescription drugs in particular."

This caused a firestorm. Initially, the state denied that the MCOs were performing governmental functions. We appealed it to the Freedom of Information Commission which enforces our open records law. It was a standing room-only hearing because the entire industry was really worried that we were going to have a situation where private parties would be subject to the law, and a Freedom of Information Act request could be submitted by anyone. That's a scary thought if you're a corporate entity

We got great media coverage about this, because our messaging was that these entities didn't want to accountable for taxpayers' money. They just want to take the money and not be accountable. And we said the state officials don't want to hold them accountable either.

We won before the Information Commission, but it was appealed to the superior court. We put a lot of pressure on our Attorney General to join us, which he did. So he was on the side that was going after managed care organizations, which really annoyed the state agency which is supposed to be represented by him. In any event, while this was pending, we put pressure on the governor, and there were op eds and editorials saying, "Yes, you should hold these state contractors accountable." It got to the point where the governor gave up and said to the MCOs, "All right, you're going to be bound by this obligation, no matter what the courts say. You're taking hundreds of millions of dollars in taxpayer money, so you should be accountable and we're going to put it in the contract." Several of the big MCOs balked, so the governor pulled the trigger and basically said, "Okay, fine, you're out of the program, but in the meantime, we're going to turn you into non-risk entities." That is, they would be service contractors, not insurance companies. This was really important because this is what we wanted, and ultimately what we got, but not at this point. We just got it temporarily.

So the governor said, "We're going to find other insurers who will accept this transparency agreement." She decided to create a broader subsidized program including non-Medicaid recipients called Charter Oak Health Plan, and she needed insurance companies to run it. She went to the insurance companies and said, " If you agree to run my Charter Oak plan and take the risk, we'll give you this very lucrative business of Medicaid clients." An RFP went out, and it did include that they would be accountable under the Freedom of Information Act and they got three bidders. So, the three bidders agreed to take it on a risk basis, we were back to square one after we thought we won.

So we started exploring how much the companies were being paid. Whatever capitated rate the state pays a Managed Care Organization has to be approved by the Feds, and so they have to be audited. (Half of the state money is actually Federal money.) We felt the rate that the auditors found was excessive. So my colleague, Ellen Andrews, managed to get an accounting firm to come in to audit the auditors. They found it was at least $50 million too high. They were

being paid excessively (The reason they were being paid excessively was as a bribe, a legal bribe, from the Governor to get them to run the Charter Oak business.)

Another thing that was happening was that a group of pediatricians was focusing on the Medicaid provider network and the fact that it was bogus. That is, the list of doctors and other providers listed by the plans on their websites were not real people or they were real people but were not really participating. So, these folks got a secret shopper survey done, where people got dummy Medicaid ID numbers and called up real providers and tried to set up real appointments for real medical problems. It was fictitious, but it sounded real to the office they were calling. It was really disturbing and eye opening. For all of the MCOs, only about 25% of the time could people get an appointment, and the vast majority of times, the provider said, "I'm not participating in Medicaid" or "I'm not participating in Medicaid under your plan," or "I'm not participating for new patients." So, the vast majority of the time, the list was bogus.

This was really important because, about the same time a study came out with the provider rates that the MCOs were paying. Though they always claimed that they paid generously, it turned out they were just paying the low Medicaid rates So the suspicions were correct that the reason specialists wouldn't see these folks is because of the low rates.

Going back now to the Charter Oak plan, we found they were being paid excessively on the Medicaid side. And, in addition, we started uncovering more misrepresentation of drugs which they claimed were not covered when, in fact, the reason was they just required prior authorization. Two very different reasons. They chose not to use the code which contained information about required prior authorization and, instead, falsely said the drug was not covered. We emphasized that the MCOs were committing fraud, lying about what is covered under the plan. So even though they were now subject to the Freedom of Information Act as a matter of contract, they were still misrepresenting what their coverage was in order to cut corners.

So, at this point we decided to offer an alternative. We needed to say, "You know, this is not working. This capitated managed care for poor people is not working. Maybe we should do what some other states are doing." The Federal Medicaid law offers an alternative type of managed care that doesn't involve capitation at all. It's called Primary Care Case Management. What this means is the state pays primary care providers to manage care. The HMOs always claim to manage care, but we all know they only manage cost.

So, we suggested that Connecticut adopt, at least on a pilot basis, what other states like North Carolina and Oklahoma were doing, which is to actually pay primary care providers directly to coordinate care or manage care, paying them to actually coordinate care in a meaningful way. We got a pilot plan through the legislature. It was very small, and the state agency did not want to implement it, but we made a lot of noise about the fact they were not implementing it.

What then happened then, in 2010, we had a governor's race. We educated all of the candidates about the problems of managed care and we pointed out that this Primary Care Case Management (PCCM) model seemed to be working well in other states. We think that we should

basically ditch this whole experiment with insurance companies. When Governor Malloy won in 2010, he set up various committees to develop issue briefs, and we lobbied those groups to lay out the PCCM option, emphasizing that capitated managed care wasn't working.

So, three weeks into his administration, in early 2011, he announced that he was going to show the door to the MCOs and adopt some form of Primary Case Care Management, using primary care providers to coordinate care, and also contract with an Administrative Service Organization (ASO). The ASO would take on some of the role that insurance companies play, but not on a risk basis, handling things like prior authorizations, recruiting providers, and so on.

That announcement was made in February 2011, and an RFP was issued not too long thereafter. Connecticut chose a non-profit entity, Community Health Network of Connecticut, to take on that role. It used to be a not-for-profit, capitated MCO, and it was now being turned into an ASO.

We then got involved in advocating for what patient-centered medical home (PCMH) requirements were going to be, because we're going to really use those to manage or coordinate care. We had to beef up the requirements on primary care providers and went with National Committee for Quality Assurance (NCQA) accreditation of PCMHs as the standard. They you had to be accredited as a patient-centered medical home in order to participate and get paid extra for doing care coordination.

That's the history. Now, I want to fast forward to where we are today. It has not been absolutely perfect. There have been problems. But, overall, it has been a dramatic improvement, and the materials that have been distributed tell the story. Just in the hard dollars, in per member per month cost. (You don't look at total cost with Medicaid program because our program, like all the blue states, did a Medicaid expansion and their total costs have gone up substantially because there are a lot more people covered. Connecticut Medicaid member per month costs are down 14% from $706 in the first quarter of 2012 to $610 in the first quarter of 2018. So, that's six years, and the costs went down. As a result, Connecticut, which is one of the highest health care cost states in the country -- our per-enrollment costs had been the 9th highest, now they're 22nd. So, we've actually done very well through this model in terms of total per member per month costs. To have them go down when, in every state that has managed care, they always demand more money. To not have that hanging over you, if you're a state agency, it's pretty nice that you actually have control of the cost.

The other question is, how much of those total costs are actually going to health care? As we all know, there are huge administrative costs that go into the private insurance system. When we had managed care companies, it was hard to get the data, but we found routinely 20%, even 25% or higher administrative overhead. We actually saw 40% at one point for administrative costs among plans. Based upon the data that has been available now for a few years, we have done really well on both the total cost and the medical loss ratio, which is now about 96.5%. Only 3.5 cents on the dollar goes to administrative costs, paying for the ASO and the state's own administrative costs. The rest is all going to health care. So it's a win-win in terms of the cost and where the money goes.

We really care about quality, about access to care. The data there is pretty good as well. Some really basic stuff like significant increases in preventive care, 16.3% from 2015 to 2017, hospital admissions per thousand down 6.29%, readmissions down 3.52%.

There are several reasons, but one of them is the use of patient-centered medical homes. Close to half of our Medicaid population is now attributed to accredited patient-centered medical homes. They have the infrastructure for adequately coordinating care so people don't end up in the hospital, and they provide routine care and the child visits and screenings and so on. Under the new system, the state has the data on what is being done and doesn't have to beg an insurance company to give them the data.

Though the primary responsibility for coordinating care lies with the primary care providers, the ASO (CHNCT) has done extra things to coordinate care. Their major program is called Intensive Care Management. This involves identifying people who are the frequent flyers, who go in and out of the ER frequently and need special attention. They have an aggressive outreach program where they literally go out to the people where they are in their community and try to get them in contact with their primary care provider. Ideally, it's a patient-centered medical home, to make sure that somebody is actually looking out for the various issues they have -- behavioral health issues, medication access issues, home care, whatever. The result is that, for their Intensive Care Management members, in 2017 the total cost of care dropped 12%.

So, ER usage has gone down 25% and hospitalization dropped significantly. They actually have developed good programs to do the very thing which the MCOs always claimed they did but never actually did to actually coordinate care. If you do this, you keep people out of the ER and avoid readmissions, you actually save money. It's not perfect, and we've got issues, but we think the system has worked to save money the right way, not by denying services but by providing better service.

The last thing I want to tell you is in the handout "Medicaid's Care Management program is saving lives and money, but savings may be going to PCMH+ ACOs." ACOs, Accountable Care Organizations, are the latest thing that everybody who's anybody in health policy is supposed to believe in as the answer to our problems with health care cost. ACOs put financial risk onto provider groups.

The idea, mostly pushed in Medicare but now in Medicaid as well, is that you put provider groups at financial risk and they'll somehow do the right thing, keep costs down but not in a bad way, not to harm access, deny services, deny referrals. Somehow, they'll do it in the right way. To me, that's frankly religion. It's belief in a system that you can't really prove and has been very controversial. Unfortunately, Connecticut has adopted an ACO program, so that PCMH+ is very different from patient-centered medical homes, PCMH without the "plus". And the difference is the shared savings model.

If groups of providers responded positively to an RFP, they're in a system where any money saved in the total cost of care of their patients, using actuarial data and some risk adjustment, hey get to keep half of the savings. We're very concerned. We have one year of data now, and it suggests that this is not saving money and may be harming access to care. We don't know where that's going at this point.

The basic point: managed fee-for-service, where the state maintains the risk, is using insurance companies to do certain administrative actions in a good way to meet the goals of improving care while keeping costs down. There's still an access problem with specialists because of low reimbursement rates.

About 45% of the Medicaid population is within an accredited PCMH. It's a little hard to know exactly what the PCMHs are doing in terms of care coordination, though we do have numbers that show they are doing better than non-PCMHs on most indicators.

Costs have been relatively flat since we made the transition, suggesting that we are getting some decent care coordination for the elderly population as well for families with kids.

At the time of the transition, there were three MCOs, Community Health Network, Aetna, and UnitedHealth. The latter two for-profit entities have lobbied hard with successive governors to come back into the program, but we've managed to hold them off. It's saving money, so that's a strong argument we're making. And, over time, the State Medicaid agency became very invested in the new program, which was producing good results.

We tried to get consumers involved in designing and then advocating for the new program. However, it was very hard to get them engaged.

It was important politically that we had a period in which the managed care organizations were revealed to have been doing bad things, violating the idea of transparency, resisting the Freedom of Information request, and committing fraud in terms of the pharmacy. These were important in discrediting them as part of the story. We never would have gotten what we got from the governor if we hadn't done that. Although we could produce white papers saying to the candidates that they should do this, but the reality is that the climate was what really mattered. We worked really hard at getting media.

We didn't have great data, because the MCOs kept their cards close to the vest. So it was really hard to produce actual numbers of denials or whatever. It was a challenge. We basically said that state officials don't want to hold huge state contractors accountable with our taxpayer money.

In the absence of data, what do you do? You paint a picture based upon what you do have of an industry that is not capable of being reformed. And so we made the case that we should do an alternative. We said, "Here's another way to do it. It's not radical. Other states are doing it. And it's right in the federal Medicaid Act. It's not a big deal. "

My view is you can't win this battle alone on money. We did it a lot of outreach to providers, particularly with the behavioral health side. We learned the techniques they were using to deny services, the games they played. So we produced a survey which said, "Have you seen this?" We had a one-page referral form and said, don't give us the name of the client, but do you have a client who has experienced this and if so, please tell us what's going on. The horror

stories were just unbelievable. So we definitely emphasized these kids' cases, and we got media attention which was very sympathetic.

Having providers know we were looking was very important. When we met with some of them said, "We've been looking for a way out for years. We needed you," or words to that effect, so our names got around. And providers contacted us.