

## **How Connecticut Eliminated Capitated Managed Care in Medicaid**

**A talk presented by Sheldon Toubman, then with New Haven Legal Assistance Association  
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. In this talk, presented to the PNHP-NYMetro Research/Study Group, Sheldon Toubman, then at New Haven Legal Assistance, 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 [since August 2021, Toubman moved to Disability Rights Connecticut]. 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 then bill for the service, to what other states were increasingly 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 that advocates 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 for the same health services under Medicaid. 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 said 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 was for our family and children population, not the elderly and disabled population, which is a sicker population; generally, family, kids and pregnant women are healthier populations. 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, say, \$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, along the lines of: "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 false 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 only 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, advocates 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 for all Medicaid services even if contracting with MCOs. 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 benefit 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 the prescriber 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 our lawsuit included this issue.

One of the things we did with the lawsuit was to get a lot of media attention. This was the first class action suit ever brought in this country against a Medicaid-contracted insurance company. (Most of the time, people just sue the state; they don't sue the insurance companies.) Press was 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.

Advocates emphasized 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 involved in was finding some other avenue.

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, i.e., specialists were being paid too little by the MCOs. So we wanted to get information about the rates paid. Someone filed a request under the state's Freedom of Information Act, the open records law, asking for the payment rates for each of certain kinds of specialists, for each of a set of codes, for each of the MCOs.

The state responded saying, essentially, "We don't have that data and the Freedom of Information Act applies only to what's in the possession of the state." The state correctly said, "We don't have the rates that the docs are being paid." But we have in our state law, special to Connecticut and maybe to Pennsylvania, that a large, privately-owned contractor which is providing at least \$2.5 million a year in services and is essentially performing a "governmental function," that is, it taking on a role of government, is subject to that law. And that was really easy to show because the elderly and disabled populations in Medicaid were not in managed care, so all the things that the insurance companies were doing for the family population, the state itself was doing for the elderly and disabled populations, i.e., MCOs were performing that same governmental role. So advocates crafted a second Freedom of Information Act asking for the provider rates directly from the MCOs.

In addition, parallel to the request for MCO provider rate information, advocates 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 essentially saying to the state, "If you don't have the data, please get it from the MCOs. They have to provide it under the FOIA 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 a governmental function. We appealed that denial 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

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

We won before the Freedom of Information Commission, but it was appealed to the superior court by some of the MCOs. The state Attorney General then joined the side that was going after managed care organizations, which really annoyed the state agency. 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, essentially, 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 administrative service organization contractors, not insurance companies taking financial risk. This was really important because this is what advocates wanted, and ultimately what they got, but not at this point. It was just temporary.

The governor also said she was going to find other insurers which would accept this FOIA requirement. At about the same time, she decided to create a new subsidized program for lower income but non-Medicaid recipients called Charter Oak Health Plan, and she needed insurance companies to run it despite the uncertain costs of this new population. She went to the insurance companies and said, basically: 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 the insurers would be accountable under the Freedom of Information Act and they got three bidders. So, the three bidders agreed to contract on a risk basis, and advocates were back to square one, after they thought they had won.

Advocates then started exploring how much the new companies were being paid. Whatever capitated rate the state pays a Managed Care Organization has to be approved by the federal Medicaid agency, and so they have to be audited. (Half or more of the state money paid to MCOs is actually federal money.) Advocates felt that the rate that the auditors found was acceptable was actually excessive. The state Comptroller then contracted with an accounting firm to come in to audit the auditors. They found the payments to the MCOs were at least \$50 million/year too high. Advocates concluded they were being paid excessively through what was essentially a legal bribe from the Governor, to get them to run the Charter Oak business, which was her priority.

Another thing that was happening under the earlier set of MCOs was that a group of pediatricians was focusing on the Medicaid provider network and the fact that it appeared to be bogus. That is, the list of doctors and other providers listed by the plans on their websites were not real, practicing providers or they were real people but were not really participating in the plans which listed them. So, these folks pushed to get 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. The results were 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 lists were bogus.

This was really important because, about the same time this study came out, we finally received through the FOIA effort the provider rates that the MCOs were paying. Though they always claimed that they paid generously, it turned out they were mostly just paying the same low Medicaid rates already paid by the state under the rest of the Medicaid program. So the suspicions appeared to be correct that the reason specialists wouldn't see these folks was because of the low rates.

In addition, under the last set of MCOs, we started uncovering more misrepresentation of drugs being not covered when, in fact they just required prior authorization. Two very different reasons. When electronically denying drugs, two of the MCOs chose not to use the code which states the drug required prior authorization, which was the case, and, instead, used a code which said the drug was not covered at all. We emphasized that the MCOs were committing a kind of fraud, misrepresenting 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.

At this point, advocates decided to offer an alternative, saying something like, "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 statute 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 extra to manage care. The MCOs always claim to manage care, but we all know they only manage cost.

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

Then, in 2010, we had a governor's race. Advocates 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 advocates lobbied those groups to lay out the PCCM option, emphasizing that capitated managed care wasn't working, and was quite expensive.

So, three weeks into his administration, in early 2011, Governor Malloy 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), as the insurers had temporarily been turned into over the FOIA dispute. 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. Behavioral health and dental services were contracted to different ASOs to manage those services, respectively, also on a non-risk basis.

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 the patient-centered medical home (PCMH) requirements were going to be for the PCCM-like program, because we were really going to 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 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 basic 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 costs under the Medicaid program in part because our program, like that of all the blue states, did a Medicaid expansion and those 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 costs 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 risk-based 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 about 40% at one point for administrative costs for one of the plans, under the CHIP program. Based upon the data that has been available now for a few years, we have done really well on both the total costs and the medical loss ratio, which is now about 96.5% [97% as of 2021]. 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 medical 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, as well as individuals referred to the program. 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 going forward, 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 save money. Again, 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 to point out is 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 (generally larger) provider groups instead of insurance companies.

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 by harming access, denying services, denying referrals. Somehow, they'll do it in the right way. To me, that's frankly religion. It's belief in a system that hasn't been proven, that you can't really prove and has been very controversial. Unfortunately, Connecticut has adopted a shared savings type of ACO program, called PCMH+, that is very different from patient-centered medical homes, PCMH without the "plus". And the primary difference is the use of a shared savings payment model in PCMH+.

If groups of providers respond positively to an RFP, they're in a system where any of the money they save on the total cost of care of their own patients, using actuarial data and some risk adjustment, they get to keep half of. Advocates are 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 about our system: under managed fee-for-service, the state maintains the risk, and is using both insurance companies on a non-risk basis to do certain administrative actions in a good way to meet the goals of improving care while keeping costs down, and PCMHs to coordinate care on a regular basis. 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/disabled population as well for families with kids which had been in the capitated MCO system.

At the time of the transition, there were three MCOs, Community Health Network of CT, Aetna, and UnitedHealth (CHNCT, the one non-profit, became the non-risk contracted ASO). For-profit entities have lobbied hard with successive governors to come back into the program on a risk basis, but we've managed to hold them off. It's saving money, so that's a strong argument for keeping what we have, and we're also pointing out access and quality gains, as well as the high medical loss ratios. 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 overall that advocates 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 requests, essentially committing a form of fraud in terms of

misrepresenting pharmacy coverage, etc. These were important in discrediting them as part of the story. Advocates never would have gotten what they got from the governor if they hadn't done that. Although advocates could produce white papers saying to the candidates that they should do this or that, the reality is that the climate was what really mattered. They worked really hard at getting media to expose the shortcomings in the system, which changed that climate.

Advocates 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. Advocates basically said that state officials don't want to hold huge state contractors accountable with our taxpayer money, so that is why we don't have the necessary data, even as they had a lot of anecdotal stories of harm.

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 advocates made the case that we should do an alternative, the non-risk form of managed care known as PCCM, saying essentially "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."

You can't win this battle on the basis of the money wasted on risk-based insurers alone. Advocates did a lot of outreach to providers, particularly in the behavioral health area, to develop individual stories of abuse. Advocates learned the techniques the MCOs were using to deny services, the games they played. So they 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. Advocates emphasized these kids' cases, and got media attention which was very sympathetic.

Having providers know we were looking was very important. When advocates met with some of them, they said, "We've been looking for a way out for years. We needed you," or words to that effect, so the advocates' names got around. And providers contacted them, and they worked together to tell their stories.