Meeting Summary for Complex Care Committee Zoom Meeting

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Quick recap

The team discussed the impact of Medicaid managed care organizations (MCOs) on healthcare in Connecticut, with a focus on their potential to improve quality and access of care, as well as their potential negative impacts. They also explored the challenges faced by providers in dealing with Medicaid, including issues with payment and preauthorization processes, and proposed solutions such as conducting surveys to gather insights and advocating for changes in legislation. The team also addressed concerns about proposed changes to the Medicaid prescription drug prior authorization process and the need for better representation of low-income areas in healthcare improvements.

Next steps

Ellen Andrews will research why 45 other states use MCOS for Medicaid and present the findings to the Governor.
Sheldon will investigate the cost and quality implications of reintroducing MCOS to Connecticut's Medicaid program.
The Complex Care Committee will evaluate the current Medicaid cost control strategies and assess the potential impact of reintroducing MCOS.
Rep. Johnson will put in a request to DSS to initiate a survey or recommendation regarding the impact of Medicaid managed care on complex care patients and long-term care services and supports.
Rep. Johnson will work with the full committee to gain their support for the survey and recommendation.
Michael Taylor will explore the possibility of getting short-term help from the federal government for FQAC reimbursement rates until the state indexes its rates.

Summary

The group discussed the issue of food insecurity in Connecticut, and the structure and scope of the meeting, including the work of the Complex Care Committee. Brenda Buchbinder shared her vision for 2024, focusing on healing and making things more fair and accessible.

Managed Care Organizations in Connecticut

Rep. Susan Johnson introduced the topic of the financial and legal aspects of managed care organizations in Connecticut, specifically highlighting the low medical loss ratio of 2.9%. She then invited Ellen and Sheldon to discuss the history and concerns surrounding the return of these organizations to the state's Medicaid program. Ellen detailed the issues with the previous managed care system, including provider shortages, overpayment, and deceptive practices, and discussed the current efforts to improve transparency and accountability. She also emphasized that the appeals process for managed care is vastly different and less accessible than for fee-for-service plans. The conversation ended without a clear resolution, but with a commitment to continued discussion and analysis of these complex issues.

Medicaid Management Organizations Impact Discussed

Ellen discussed the research on the impact of Medicaid Management Organizations (MCOs) on access and quality of care, concluding that there was no evidence of improvement in these aspects. She highlighted that Connecticut's Medicaid program, without MCOs, offered high-quality care, and the state had saved billions of taxpayer dollars since 2012 due to its cost

control measures. Ellen and Michael emphasized concerns about increased costs and a potential reduction in provider rates if more Medicaid funds went to MCOs. They also countered the notion that only MCOs could innovate, pointing out that Connecticut's program was already implementing many of the innovations claimed by MCOs.

Impact of Medicaid Managed Care Organizations on Cancer Diagnosis and Survivability

Ellen presented a study conducted by Dr. Kramer from Wayne State University in Indiana, which demonstrated that early-stage cancer diagnosis and survivability in Connecticut and New Jersey were comparable until 2012, after which Connecticut's rates increased. This was attributed to the introduction of Medicaid managed care organizations (MCOS), which improved the quality and accessibility of care. However, Ellen also highlighted the potential negative impacts of MCOS, such as increased administrative hurdles, prior authorizations, and denials, and the difficulty in removing them once established. She emphasized that Connecticut was already making progress in improving its Medicaid program, and the reintroduction of MCOS could hinder that progress. The decision to reintroduce MCOS came from the governor, who had questions about why other states had these programs and why Connecticut did not.

Discussing Long-Term Care Challenges and Solutions

Ellen and Rep. Johnson discussed the high costs associated with long-term services and supports, and the use of managed care organizations (MCOs) for this purpose. They acknowledged that MCOs can be more expensive than other options, with a significant portion of funds going towards administrative costs and profits. They also highlighted the challenges of providing adequate care for aging populations, as inadequate investment in long-term care services and supports has shifted the burden onto states like Connecticut. The team agreed to further investigate these issues and develop strategies to address them.

Managing Medicaid and Long-Term Services in Connecticut

Sheldon discussed the complexities of managing care for Medicaid and Long-term Services in Connecticut. She highlighted issues such as high spending on long-term services, a proposed tax increase for insurance companies, and the difficulty of negotiating with Medicaid providers. She also noted that Connecticut is an expensive state with high wages to attract and retain care providers, which contributes to overall costs. Michael pointed out that rate increases did not apply to FQHCs, which have not had rate increases in over 20 years. Sheldon agreed but emphasized the need for transparency and accountability in the system.

Improving Provider Rates in LTS Ss Program

Sheldon, Ellen, and Rep. Johnson discussed the importance of raising provider rates emphasizing its efficiency and the need for better access to care. Ellen highlighted the lack of information provided by the DSS, which often deterred providers from participating due to low rates. Rep. Johnson noted that having control over the administrative service organizations allowed for easier implementation of changes. The State proposed the establishment of an oversight council for evaluating services and costs, suggesting it could aid in advocating for better access to healthcare. Ellen confirmed that no other state has a committee like Connecticut's Medicaid Advisory Council (MAPOC), and the group agreed on the need to amplify these successes.

Medicaid Management and Provider-Patient Impact

The discussion focused on issues surrounding Medicaid management and its impact on healthcare providers and patients. Ellen acknowledged Senator Harp's establishment of a transparent committee for Medicaid before her tenure. Sheldon highlighted various legal cases

against Health Net, DSS, and a pharmacy for denying services, not providing notice, and non-compliance with regulatory requirements, specifically concerning behavioral health services. She also mentioned ongoing issues with provider and drug denial rates and difficulties in accessing related data from the DSS. Finally, a case involving a company receiving $750 million annually in taxpayer funds was discussed, which resulted in the company agreeing to be bound by the Freedom of Information Act, although it was later revealed that the company had been overpaid on the Medicaid side.

Improving Payment Conditions and Long-Term Care

Sheldon proposed that non-profit organizations like CHN could offer better payment conditions, which could lead to success. Rep. Johnson supported this and suggested that the Complex Care Committee express their concerns to the DSS regarding cost discrepancies in patient care. Rep. Johnson also discussed ongoing legislation aimed at improving long-term care services and addressing issues with Medicaid and Medicare, particularly regarding access to behavioral health medications. Brenda agreed on the importance of these issues and the need for public awareness. The team also considered the potential cost implications of reforming computer systems to address these problems.

Medicaid Challenges and Medicare Advantage Surveys

The team discussed the challenges faced by providers in dealing with Medicaid, with issues such as delayed payments and the need for external collection agencies being highlighted. They agreed that these problems pose a significant financial burden on providers. The team also discussed the problematic preauthorization process and payment issues specific to Medicaid. A proposal was made by Rep. Johnson to survey providers as a method to gather more information, which could be presented in a future request for information (RFI) process. Concerns were raised about the increasing opacity of Medicare advantage plans, with examples of unresolved appeals and difficulties in accessing the organizations responsible for enforcing them. The team proposed a survey to gather more insights on these issues, specifically targeting those who have been around longer than 2012 and those who deal with Medicare in multiple states.

Survey Initiation and Husky Cuts Discussion

The team decided to initiate a survey directed at two specific groups to gain valuable insights. Rep Johnson emphasized the need for full committee support for this initiative. Sheldon raised concerns about significant cuts made to Husky, including reductions in eligibility and services offered. He also discussed changes to the eligibility for Medicaid in Connecticut, particularly for elderly people and those with disabilities, highlighting that a law passed last year to increase the financial eligibility limit by 147% was later repealed, resulting in the new limit only slightly exceeding the poverty level, and expressed concerns that these changes were implemented without any public hearings or input.

Medicaid Prescription Drug Prior Authorization Concerns

Sheldon voiced concerns about proposed changes to the Medicaid prescription drug prior authorization process, which would increase approval times and potentially deny more claims. Rep. Johnson and others agreed, noting these changes would also impact the Connecticut Disability Commissioners and suggested a unified effort to oppose them. There were discussions about issues with the current FQHC Rates and the need to include behavioral health in future discussions. Brenda raised concerns about the focus on higher-income areas in healthcare improvements, prompting Rep. Johnson to thank everyone and commit to future analysis and continued conversation.