



The LEWIN GROUP

Assessment of HUSKY, Connecticut's Medicaid Managed Care Program

*Prepared for the four participating HUSKY managed care
companies:*

- **Anthem Blue Cross Blue Shield**
- **Community Health Network of Connecticut**
- **Health Net of the Northeast**
- **WellCare of Connecticut**

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I. EXECUTIVE SUMMARY

The Lewin Group has been engaged to assess the Connecticut program for Medicaid recipients—known as Health Care for Uninsured Kids and Youth (HUSKY). The program has been implemented by Connecticut's Department of Social Services (DSS) throughout the past decade. Four managed care organizations (MCOs) participate in the program through contracts with DSS and these health plans collectively serve approximately 300,000 HUSKY enrollees.

Key findings from our assessment are described below.

Cost Performance: HUSKY has clearly performed effectively in terms of generating cost savings and lowering the State's cost trend line.

- HUSKY annual per capita inflation is below national norms for TANF subgroups and is well below cost trends for Connecticut's disabled Medicaid subgroups.
- HUSKY MCOs collectively paid out 90.5 percent of their revenue for health care services from 2003-2005. This is well above national norms in the Medicaid managed care industry.
- The HUSKY MCOs provide a wide range of DSS-required and "extra" administrative services (e.g., outreach to members and providers, data reporting). MCO administrative costs averaged < 10 percent of revenue from 2003-2005, which is below national norms for TANF MCO programs.

Quality and Access Performance: HUSKY creates a setting where access and cost can best be measured, and where identified challenges can best be addressed. Several outcomes of the program are highly encouraging, including:

- Connecticut ranked among the top 10 states during both years in which EPSDT statistics were assessed (2002 and 2005) in terms of the percentage of Medicaid children receiving at least one preventive health screen. Regarding the degree to which children received the number of initial and periodic screening services required by the state's periodicity schedule, Connecticut's "screening ratio" of 82.1 percent in 2005 was well above the national average and more than a ten percentage point improvement over Connecticut's 2002 figure.
- While many challenges with physician access exist due to low fee schedules, HUSKY enrollees received an average of 5.5 physician visits during 2005. Each HUSKY MCO includes between 40 and 70 percent of the state's practicing physicians in its provider network.

In both 2005 and 2006, Connecticut's HUSKY member satisfaction survey (CAHPS) results were consistently above, and in many cases far above, the nationwide total.

- The MCOs provide a wide array of outreach initiatives. For example, more than 225,000 proactive, outbound calls to HUSKY members were completed by the MCOs during 2006 (roughly twice this amount were attempted in order to complete the 225,000 calls).

Alternative Models: The study includes an assessment of various Medicaid managed care models, including capitation contracting with MCOs, primary care case management (PCCM), disease management (DM), high cost case management, and various hybrid approaches. Key findings are summarized below.

- The capitated MCO model implements, by far, the largest array of initiatives to control costs and promote access.
- Assuming equal program maturity, costs will be two or more percentage points lower in the capitated MCO model than in any other form of Medicaid managed care, for TANF eligibles. Due to the maturity of the capitated HUSKY program and its proven track record in lowering Connecticut's cost trend line, Lewin estimates that any newly implemented managed fee-for-service model that would replace HUSKY would create added DSS expenditures of at least five percent of current capitation expenditures, or at least \$37 million per year.

Policy Recommendations: Lewin's key policy recommendation is that the capitated HUSKY program continue to serve as the platform for providing a system of coverage for Connecticut's Medicaid program. To strengthen the program going forward, Lewin has included several recommended policy actions. Some of these are outlined below.

- The State is encouraged to increase the Medicaid physician and dental fee schedules *sharply*. MCOs would be required to pass these fee increases through to their participating physicians and dentists, and DSS would need to pay MCOs for the fee increases in the form of explicit capitation payment increases.
- Each MCO would be required to develop a work plan for proactively and regularly tracking its physician network status. This work plan should include monitoring whether each physician is accepting new patients.
- We recommend that various aspects of physician access be studied more thoroughly to better identify the problems that exist and perhaps shed light on how Connecticut's Medicaid program and the MCOs can better address them. Study topics could include a detailed survey of physician access, an assessment of the feasibility (legal and otherwise) of providers offering specific time blocks to HUSKY members for unscheduled, "walk-in" office visits, and an emergency room usage assessment.
- DSS should impose a set of additional contract requirements in areas such as HEDIS reporting, use of GeoAccess reporting to ensure access to primary care physicians (PCPs) and dentists, provider network directory updating, and disease management requirements related to asthma and diabetes. Through many of these requirements, the performance of the Connecticut MCOs can be more readily compared with Medicaid MCOs across the nation.
- Each MCO would be required to obtain accreditation by a recognized quality assurance body (e.g., AAAHC, NCQA, URAC) by December 2009.
- Our final recommendations involve expanding Connecticut's Medicaid managed care activities to its disabled subgroups - particularly the Medicaid only subgroups that are not dually eligible for Medicare coverage. Bringing effective managed care to disabled subgroups should yield Medicaid savings that exceed the cost of enhanced physician and dentist fees.

II. BACKGROUND

Connecticut's mandatory capitated managed care program for Medicaid recipients – known as Healthcare for Uninsured Kids and Youth (HUSKY) – has been in operation for more than ten years. During the mid-1990s, Connecticut's Department of Social Services (DSS) developed and implemented the State's initial Medicaid managed care program, then known as Connecticut Access; after a few years, the program was renamed HUSKY. This program was developed across approximately a two-year timeframe and transformed Connecticut from one of the few remaining states without any Medicaid managed care program to a State with a high concentration of managed care for the TANF population (Temporary Assistance for Needy Families).¹ As of FY2003 Connecticut was one of only three states (along with Arizona and Hawaii) in which more than 80 percent of TANF spending occurred through capitation payments to health plans.²

Two key reasons for the high level of TANF capitation in Connecticut are the statewide implementation of mandatory enrollment and the comprehensiveness of the capitated benefits package. The HMO coverage model is viewed as more viable and effective in relatively urban areas. Connecticut is the 11th most urban state in the U.S. according to the U.S. Census Department – 88 percent of the State's overall population resides in an urban area versus a national mean of 79 percent. The intent of the comprehensive capitated benefits package was to create a fully integrated coverage model for the TANF population that fosters accountability, strong monitoring, and a focus on each member's overall needs. Connecticut has not yet developed a managed care program for its aged, blind, or disabled subgroups.

Four health plans currently participate in HUSKY. HUSKY enrollment levels by Managed Care Organization (MCO) as of December 2006 are summarized in Table 1.

Table 1. Connecticut's Medicaid Managed Care Organization (MCOs) Enrollment as of December 2006

MCO Name	HUSKY A	HUSKY B	HUSKY A & B Combined
Anthem Blue Cross Blue Shield	121,443	11,409	132,852
Community Health Network	54,778	2,925	57,703
HealthNet	82,678	0	82,678
WellCare	33,953	2,245	36,198
Total	292,852	16,579	309,431

Note: HUSKY A serves TANF recipients; HUSKY B is Connecticut's S-CHIP program.

- ¹ Temporary Assistance to Needy Families, formerly referred to as AFDC or Aid to Families with Dependent Children. This population is predominantly comprised of low-income mothers and their children.
- ² Connecticut ranked 16th nationally in FY2003 in terms of the percentage of total Medicaid spending paid via capitation (18.4%). Source of these statistics is Lewin Group tabulations using CMS MSIS data, as published in "Medicaid Capitation Expansion's Potential Cost Savings," April 2006. The study can be downloaded at no charge at www.lewin.com.

Throughout the past several years, concerns have been raised about the performance of the HUSKY program, and some policymakers have advocated for discontinuing the capitated program and replacing it with a "managed fee-for-service" model. This possibility is of course of substantial concern to the State's participating MCOs, for all of whom the capitated HUSKY program represents an important line of business. Each of the four MCOs has made substantial investments and commitments throughout the past decade to serve the State's HUSKY population, and all four companies are highly interested in building positively on this experience base going forward.

The health plans have therefore commissioned this assessment, coordinated through the Connecticut Association of Health Plans. The Lewin Group has been selected due to its familiarity with Connecticut's program, its extensive experience assisting states in implementing a wide variety of Medicaid managed care models, and its national reputation for objective analysis to support the policymaking process in the Medicaid managed care arena.

Lewin's approach assesses the following issues:

- How has the HUSKY program performed financially? (Section III: Financial Performance of HUSKY Program)
- What are the general attributes of the various models of Medicaid managed care? (Section IV: Overall Comparison of Capitated and Non-Capitated Medicaid Managed Care Models)
- What impacts has the program had on access? (Section V: Qualitative Aspects of HUSKY Program)
- What results have occurred in the quality arena? (Section V: Qualitative Aspects of HUSKY Program)
- What policy options are recommended going forward? (Section VI: Policy Recommendations)

Throughout the study, Lewin has compared HUSKY program performance results to the experience of Medicaid managed care initiatives in other states.

III. FINANCIAL PERFORMANCE OF HUSKY PROGRAM

A. Introduction and Background

The financial performance of the program has been assessed in two dimensions. First, the cost trends that have occurred in the HUSKY Program have been compared with TANF cost trends in other states and with cost escalation in non-HUSKY Connecticut Medicaid subgroups. Second, the financial statements of the HUSKY Managed Care Organizations (MCOs) have been assessed to identify the degree to which capitation expenses are being utilized for medical costs, administrative expenses, and operating margin/profit. These indicators have been quantified across a multi-year span and have been compared with several other states' Medicaid MCO programs.

B. Assessment of Cost Escalation Rates

Lewin tabulated trends in costs per Medicaid eligible using Medicaid Statistical Information System (MSIS) data from the Centers for Medicare and Medicaid Services (CMS) website. The most recent available year in the data is 2004; the earliest year available is 1999. Table 2 summarizes the tabulations; Appendix A provides more detailed information.³ These analyses support an assertion that the HUSKY program is cost-effective.

Table 2. Medicaid Cost Per Eligible Trends, Connecticut and USA Total

	Connecticut Eligibles, 1999	Paid/Eligible, 1999		Paid/Eligible, 2004		Annual Cost Trend, 1999-2004	
		Connecticut	USA	Connecticut	USA	Connecticut	USA
TANF Subgroups (Non-Disabled, Non-Dual Eligibles)							
Ages 1 - 5	57,413	\$1,727	\$991	\$2,047	\$1,484	3.5%	8.4%
Ages 6 - 12	73,352	\$1,276	\$774	\$1,625	\$1,070	4.9%	6.7%
Ages 21 - 44	57,492	\$1,898	\$1,701	\$2,350	\$1,844	4.4%	1.6%
Husky Population Weighted Average	188,257	\$1,604	\$1,123	\$1,975	\$1,433	4.3%	5.0%
Disabled Eligibles (non-duals), non-LTC Services							
Adults 21-44	12,053	\$15,167	\$7,581	\$19,987	\$11,776	5.7%	9.2%
Adults 45-64	13,569	\$8,976	\$7,238	\$14,772	\$12,156	10.5%	10.9%

Based on the information provided in Table 2, we find that the per capita cost escalation for Connecticut's HUSKY population has been below both the national rate of TANF cost escalation and the rate of inflation that has occurred in selected Connecticut non-HUSKY Medicaid subgroups. Average cost escalation was tabulated for three large HUSKY subgroups - non-disabled children age 1-5, non-disabled children age 6-12, and non-disabled adults age 21-44. The selected subgroups are those with greater than 50,000 Connecticut eligibles. An advantage of focusing on the two selected pediatric subgroups is that these costs are not influenced by the birth rate (which can often distort per capita cost comparisons in the Medicaid TANF arena). In all three HUSKY subgroups, per capita costs increased annually by an average of less than five percent from 1999-2004.

³ In calculating USA total information for FY2004, MSIS data were available for 38 states. These 38 states comprise approximately 80 percent of national Medicaid expenditures. FY2003 MSIS data, which were available in all 50 states, were also tabulated to ensure that the FY04 national totals were representative. The findings from Lewin's analyses using the USA data for FY2004 are closely matched with the findings that emerge if the FY2003 USA total was used. The FY2004 data are presented to utilize the most recent available information.

Nationwide TANF costs increased more rapidly than Connecticut in the two pediatric comparison subgroups. Nationwide, very little cost escalation occurred in the adult 21-44 TANF subgroup – only 1.6 percent per year. However, due to potential birth rate distortions, this adult comparison may be the weakest of the three subgroups.

A weighted average calculation across all three TANF subgroups, based on Connecticut's mix of eligibles, shows average per capita cost escalation to be 0.7 percentage points per year lower in Connecticut. This difference compounds to a 3.5 percentage point cost differential as of FY2004. Given that there has been widespread use of capitation (as well as other managed care models) nationally in the TANF population, the HUSKY program's cost trend versus national norms is a favorable finding for the program.

A comparison of per capita cost escalation *within* the Connecticut Medicaid program between the HUSKY population and the disabled adult population is highly favorable to HUSKY. Connecticut's disabled adult per capita costs increased 5.7 percent per year from FY99-04 in the 21-44 age group, and 10.5 percent per year in the 45-64 age group.⁴ The weighted average increase between these two groups is a 7.5 percent annual trend, 3.2 percentage points above Connecticut's weighted average annual cost trend for the HUSKY subgroups. If costs in the HUSKY subgroups had increased at the same rate as the disabled adult subgroups during the five-year timeframe assessed, FY04 costs for the HUSKY subgroups would have been 17.1 percent higher than the actual costs observed.

The national trend line comparison between the disabled and TANF subgroups also suggests substantial cost savings are occurring through capitation. In the TANF population, where capitation is widely used nationally, annual per capita cost escalation averaged close to 5 percent from 1999-2004. Conversely, in the disabled population subgroups where capitation has been only sparsely, nationwide annual per capita cost escalation has been *twice as high* during this same period, averaging approximately 10 percent.

In summary, the MSIS analysis summarized in Table 2 indicates favorably low cost trends for HUSKY, both when compared to nationwide TANF cost escalation trends, and when compared to Connecticut Medicaid cost escalation trends for non-HUSKY subgroups. The assessment also shows much lower trend line results nationally for TANF (where capitation is widely used) than for SSI (where capitation represented less than 15 percent of national spending).

C. Analysis of Financial Statements

Lewin obtained audited CY2003-2005 financial statements for each of the four HUSKY MCOs as well as financial statements from a wide variety of Medicaid MCOs in other states. Altogether, 216 annual Medicaid MCO financial statements were included in the analysis. A summary of the aggregated financial performance of capitated health plans in various states is presented in Table 3.

⁴ To create an appropriate in-state comparison, dual eligible persons were removed in tabulating the Table 2 figures, since Medicare is the primary payer. Similarly, long-term care services were removed since they are not covered by the HUSKY MCOs and can be a major component of disabled persons' costs.

Table 3. Financial Performance of Medicaid Health Plans Across Various States

State	Year	Mandatory Enrollment Population	# Of Health Plans	Medical Loss Ratio	Admin Cost Ratio	Operating Gain (Loss)
Connecticut	2003	TANF	4	91.0%	8.8%	0.2%
Connecticut	2004	TANF	4	90.0%	9.5%	0.5%
Connecticut	2005	TANF	4	90.9%	10.2%	-1.1%
Delaware	2004	TANF & SSI	1	89.6%	10.0%	0.4%
Delaware	2005	TANF & SSI	1	89.5%	10.0%	0.5%
District of Columbia	2001	TANF	2	82.2%	14.4%	3.4%
District of Columbia	2002	TANF	3	78.2%	19.6%	2.2%
District of Columbia	2003	TANF	3	74.9%	15.6%	9.6%
District of Columbia	2004	TANF	3	75.5%	13.4%	11.1%
Maryland	2002	TANF & SSI	7	87.8%	12.1%	0.1%
Maryland	2003	TANF & SSI	7	86.3%	11.3%	2.4%
Maryland	2004	TANF & SSI	7	91.5%	9.9%	-1.4%
Pennsylvania	1996	TANF & SSI	2	88.6%	13.7%	-2.3%
Pennsylvania	1997	TANF & SSI	3	89.6%	13.1%	-2.7%
Pennsylvania	1998	TANF & SSI	3	88.7%	11.7%	-0.3%
Pennsylvania	1999	TANF & SSI	4	87.9%	8.9%	3.1%
Pennsylvania	2000	TANF & SSI	4	88.7%	8.8%	2.5%
Pennsylvania	2001	TANF & SSI	5	87.9%	9.8%	2.2%
Pennsylvania	2002	TANF & SSI	6	88.3%	9.1%	2.6%
Pennsylvania	2003	TANF & SSI	6	88.5%	8.4%	3.1%
Pennsylvania	2004	TANF & SSI	6	88.4%	8.6%	3.0%
West Virginia	2000	TANF	2	88.2%	9.8%	2.0%
West Virginia	2001	TANF	2	87.2%	9.9%	2.9%
West Virginia	2002	TANF	2	89.5%	8.4%	2.1%
West Virginia	2003	TANF	2	88.1%	8.9%	3.0%
New Mexico	2005	TANF & SSI	3	85.3%	11.7%	3.0%
Texas	2001	mostly voluntary	10	84.8%	14.2%	1.0%
Texas	2002	mostly voluntary	12	82.6%	14.0%	3.3%
Texas	2003	mostly voluntary	8	82.6%	14.0%	3.3%
New York	2002	TANF	18	73.7%	19.2%	7.1%
New York	2003	TANF	18	76.7%	16.2%	7.1%
Washington State	1999	TANF	6	88.5%	11.0%	0.5%
Washington State	2000	TANF	6	86.7%	12.0%	1.3%
Washington State	2001	TANF	6	85.3%	13.5%	1.2%
Washington State	2002	TANF	6	85.3%	13.3%	1.4%
Arizona (long term care)	2003	SSI	8	90.9%	7.8%	1.3%
Arizona (acute care)	2003	TANF & SSI	10	92.0%	7.6%	0.4%
Illinois	2002	all voluntary	2	65.8%	26.2%	8.0%
Illinois	2003	all voluntary	4	74.0%	21.7%	4.4%

Three key financial performance statistics are presented in Table 3: 1) the “medical loss ratio,” defined as MCO medical costs divided by premium revenue; 2) the “administrative cost ratio,” defined as the MCO administrative costs divided by premium revenue; and 3) the plan’s operating gain (or loss), derived by subtracting both medical and administrative costs from premium revenue.

Other factors that are not included in the above statistics or in Table 3 also contribute to the health plan’s profitability, most often including investment and interest income, tax payments or costs. However, the key economic performance of a capitated Medicaid managed care program can typically be assessed using the “metrics” shown in Table 3.

The aggregate Connecticut figures, shown in the first three rows of Table 3, are highly favorable from a public policy perspective, with the exception that the health plans likely need to fare 2-3 percentage points better financially going forward. Specific findings are summarized below.

Medical loss ratio: The average medical loss ratio across all 216 MCO plan-years nationwide was 85.4 percent. The HUSKY aggregate medical loss ratios were 90-91 percent throughout the three-year period 2003-2005. Along with Arizona – the nation’s longest-standing statewide capitated Medicaid managed care program – Connecticut’s MCOs spend the greatest share of premium revenue on health care costs of any of the twelve states shown in Table 3.

Administrative cost ratio: The national average administrative cost ratio (12.2%) is considerably higher than Connecticut’s recent figures. Administrative costs consumed between 8.8 percent and 10.2 percent of premium revenue in HUSKY from 2003-2005. The HUSKY figures are particularly low in consideration that Connecticut’s program is purely TANF-focused. Nearly all the states with administrative cost ratios consistently below 10 percent (Connecticut and West Virginia being the exceptions) serve both the SSI and TANF populations.⁵

With regard to administrative costs, it is often asserted that MCO administrative expenses are a pure “drain” on available Medicaid funds. However, the balanced reality is that there are administrative components that take place in every aspect of health care delivery and insurance coverage. Any organization’s administrative spending levels can fall on a continuum between efficiency and excess. Similarly, administrative activities can occur anywhere on a “functional continuum” between being exceptionally valuable and completely unnecessary. As a result, judgments about administrative costs should be made by discerning where administrative spending lies on two metrics: 1) how valuable the administrative activity is; and 2) how efficiently it is being undertaken.

In the Medicaid HMO setting, the purpose of administrative functions is to create an integrated system of care delivery, access, patient education and cost-effectiveness. Certainly, when designed and implemented well, such efforts do not represent negative “takeaways.” To the contrary, the administrative functions performed by MCOs in successful capitated Medicaid managed care programs are often exceptionally effective and valuable to the programs, representing “spending to save” initiatives and a variety of approaches designed to detect and resolve health issues before they become major problems.⁶ Put simply, cost-effective coverage and care cannot occur without a significant administrative investment.

Connecticut’s experience demonstrates that administrative costs in successful TANF Medicaid mandatory managed care programs can be kept at approximately ten percent of capitation revenues. Some key positive attributes of Connecticut’s current program configuration are the mandatory enrollment model (through which the MCOs’ resources are focused on “serving” rather than “selling”), and the reasonably large average Medicaid enrollment level of each participating health plan (average is roughly 75,000 with no plan having fewer than 30,000), which fosters administrative scale economies.

⁵ For a variety of reasons, MCOs are generally able to provide administrative services for SSI enrollees at a lower percentage of revenue than for TANF (primarily due to the very high capitation rates for SSI relative to TANF).

⁶ This study did not involve a compilation of the MCOs’ administrative activities. Anecdotally, we are aware that a wide range of special initiatives have been implemented by the HUSKY MCOs (e.g., in disease management, health education, compliance with needed pharmacy regimens, etc.), to go beyond simply meeting contract requirements in each administrative services area (claims processing, utilization management, member services, provider services, etc.).

Operating gain/loss ratio: The national average operating gain (2.4%) is also well above the audited HUSKY statistics in the most recent three available years. HUSKY program-wide operating margins were 0.2 percent in 2003, 0.5 percent in 2004, and a negative 1.1 percent in 2005. On this statistic, the national norm is arguably more favorable than HUSKY's recent performance, given that the health plans require a reasonable operating margin to conduct business with the State and to be willing to take on the considerable financial risk that capitation brings about. The HUSKY program has been financially successful throughout the 2003-2005 timeframe, although probably more successful for taxpayers and less successful for the MCOs (collectively) than would reflect an ideal partnership.

D. Summary Financial Assessment of HUSKY

The financial performance of the HUSKY program has been exemplary. The program has achieved a modest inflation trend line throughout the five-year period assessed (1999-2004), below TANF norms nationwide and well below Connecticut's Medicaid acute care cost escalation in its SSI (non-Medicare) population. The program has clearly been cost-effective in terms of State budget (and thus Connecticut taxpayer) outlays. Based on estimates derived in the ensuing section and the financial performance of HUSKY to date, expenditures under HUSKY are at least five percent below what any newly implemented non-capitated Medicaid managed care model would be able to deliver. This translates to an annual Medicaid spending differential of at least \$37 million. This is derived as 5% of the MCOs' collective 2005 revenue of \$740 million.

Across the most recent three-year period where audited financial statements are available (2003-2005), the HUSKY program's capitation costs were divided among 90.6 percent medical care payments, 9.5 percent administrative costs, and an operating *loss* of 0.1 percent. The MCOs' administrative costs are well below national TANF norms as a percentage of revenue, and Connecticut's MCOs are deploying a particularly large proportion of their revenue to pay for their enrollees' medical care expenses. While these are favorable findings, the MCOs need to earn a positive margin going forward and the rate-setting efforts should ensure that this occurs.

IV. OVERALL COMPARISON OF CAPITATED AND NON-CAPITATED MEDICAID MANAGED CARE MODELS

A. Description of Medicaid Managed Care Approaches

Since some Connecticut policymakers are considering policy options with regard to Medicaid managed care, it is useful to provide an overview of the various models of Medicaid managed care. This section briefly describes the different approaches to Medicaid managed care, beginning with a short description of the fee-for-service setting that all the various managed care models are seeking to improve upon.

1. *Unmanaged Fee-for-Service*

Fee-for-service is the traditional design of Medicaid programs where doctors, hospitals and other providers are paid for each service they provide and recipients choose any doctor willing to accept Medicaid. In fee-for-services programs, recipients are often left on their own to manage the health care system. Typically, fee-for-service programs offer little to no beneficiary education, case management or provider profiling. Due to low physician fee schedules in most Medicaid programs, it is often common for Medicaid patients to face difficulty gaining access to "mainstream" physicians. Fee-for-service programs offer little support in this regard – it is usually left up to the recipient to locate a physician who will treat a Medicaid family member.

Providers are paid for claims submitted to the state or the state's contracted fiscal intermediary for payment and the state is at full risk for the cost of medical care. All providers are paid from a state determined fee schedule; typically, all physicians receive the same payment for the same services. This system has little to no prior authorization, utilization review, provider education or quality monitoring as a means to control costs or improve quality of care or health outcomes.

2. *Capitated Health Plans*

Across the country, most states have implemented capitated managed care programs with goals of improving recipient access to medical care, improving the quality of care received and reducing overall medical costs. Capitated health plan initiatives are widely regarded as the most comprehensive means of establishing a "system" of coordinated care coverage.

As of 2003 the CMS MSIS data show that 40 states used capitation to some degree for the TANF population, and 33 states used capitation to some degree for their SSI population. Connecticut ranks 15th among the 50 states in the proportion of its FY2003 Medicaid expenditures paid via capitation (18.4%). Various studies have shown capitated managed care models have had positive impacts on access and continuity of care while reducing overall medical costs.⁷

Under a capitated model, a managed care organization (MCO⁸) is paid a fixed monthly premium per recipient and assumes financial risk for the delivery of the capitated benefits.

⁷ *Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program*, The Lewin Group, May 2005, *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen States*, The Lewin Group, July 2004.

⁸ Most Medicaid MCOs nationally are licensed as health maintenance organizations (HMOs). The terms MCO and HMO are used interchangeably in this paper.

Because the MCO is at full “dollar for dollar” financial risk for the costs of the medical services included in the capitated arrangement, there is a strong incentive for the MCO to prevent minor health problems from escalating into costly (and often tragic) crises, to monitor utilization, and ensure that recipients receive appropriate care through cost-effective treatment approaches.

Populations, services and geography included in managed care programs vary by state. The Federal Balanced Budget Act of 1997 (BBA) sets the minimum standards for all state Medicaid managed care contract specifications. However, the minimum standards leave a great deal of latitude to the state to design a program that addresses state-specific concerns or reflects legislative direction. Nationally, 16 percent of Medicaid spending during FY2003 occurred through capitation payments to MCOs. MCO capitation contracting programs have tended to focus more on the TANF population (where 36 percent of nationwide FY2003 spending was capitated) than on the higher-need subgroups. For example, only 6 percent of FY2003 spending was capitated for Medicare/Medicaid dual eligibles, and 14 percent of FY2003 spending for non-dual eligible disabled persons occurred through MCO capitation payments.⁹

3. Primary Care Case Management (PCCM)

Under the Primary Care Case Management (PCCM) model, each Medicaid recipient is guaranteed a medical home, through the designation of a primary care provider (PCP). The patient’s PCP acts as a “gatekeeper” to approve and monitor the provision of services to recipients. Studies have shown that PCCM models improve access to care for members compared to a traditional fee-for-service system.¹⁰

PCCM providers do not assume financial risk for the provision of services, and typically receive a per-member per-month case management fee (e.g., \$3). Under this model, the state maintains the financial risk for the recipients and the state (or its contractor) reimburses providers on a fee-for-service basis. Traditionally, PCCM generates a small savings compared with fee-for-service but fewer savings than full risk capitated models.

As of 2003, CMS MSIS data shows that 25 of the 50 states had implemented a PCCM program for some portion of its TANF population, and 24 states had implemented PCCM for some portion of its SSI population. Examples of more recent developments related to PCCM since 2003 are described below:

- Oklahoma has discontinued its capitated program and has moved to managed FFS models that include a PCCM component. Oklahoma’s program ranked 25th in the nation as of FY2003 in terms of capitated dollars paid.
- Georgia and Florida, which had two of the nation’s four largest TANF PCCM programs in 2003, are discontinuing their PCCM programs in favor of adopting capitated models for their TANF populations. Georgia is continuing to use PCCM for various SSI subgroups.

⁹ *Medicaid Capitation Expansion’s Potential Savings*, The Lewin Group, April 2006. This study can be downloaded at no cost at www.lewin.com

¹⁰ Smith, Vernon et al. “CHCS Informed Purchasing Series, Exemplary Practices in Primary Care Case Management,” June 2000.

- Pennsylvania has added a PCCM program in rural areas. This program has been implemented only in counties where capitation is not in place.

Capitation is used more widely than PCCM in the Medicaid arena: roughly 40 states currently use capitation for TANF versus 25 states with PCCM. Capitated programs have also grown much more quickly than PCCM in recent years. Throughout 2001-2006, 5-6 million beneficiaries have been served through the PCCM model. During this timeframe, the number of Medicaid beneficiaries enrolled in capitated programs increased from roughly 14 million to 20 million. Currently more than three times as many Medicaid beneficiaries are enrolled in capitated settings than PCCM.¹¹

4. Disease Management

Disease management (DM) models seek to generate savings through patient education and better care management, which leads to more appropriate use of health care. These programs often target high-risk recipients with specific diseases such as asthma, diabetes, heart disease and other chronic conditions. In one sense, the mental health carve-out programs that many states have implemented can be considered the nation's longest-standing Medicaid disease management initiatives. Medicaid health plans have typically utilized disease management strategies in their overall management of care. In addition to disease management through MCOs, states have the option to contract with a designated DM vendor or to build and operate a fee-for-service based program.

Under DM programs, as with PCCM, providers are paid through the underlying Medicaid FFS system (and thus at Medicaid FFS payment rates). DM and PCCM contractors do not take on the role of payor. Rather, they often function without any form of contract with the provider community, or entail contracts with selected primary care providers that involve only certain potential "add-ons" to the prevailing payment system (e.g., a monthly case management fee).

At least 28 states are operating, have approved, or are considering a disease management program for Medicaid enrollees. Programs currently in operation take a variety of forms. For example, Indiana, Montana, Mississippi, and Florida have established similar programs in which all patients with covered diseases have access to, and are managed by, care managers at a central call center. High-risk patients receive more intensive care management from local or field-based care managers. Other states that have adopted disease management programs may target different diseases or combinations of diseases. Programs also vary in structure: some address patient education through pharmacists (Mississippi); some contract with mail-order pharmacies to provide Medicaid patients with discounted drugs and educational materials (Tennessee); some contractually require managed care organizations to provide disease management services (New Mexico).¹² Savings estimates have been difficult to quantify and many of the programs are still in the first years of development. In FY2004, a total of 19 states planned to take action to implement or expand disease management programs.¹³ Connecticut

¹¹ Source: CMS data.

¹² Source: Lewin ongoing disease management research.

¹³ Smith, V., Ramesh, R., Gifford, K., Ellis, E., Wachino, V., and O'Malley, M. "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," Kaiser Commission on Medicaid and Uninsured, January 2004.

is among the states that has indicated an interest in developing a Medicaid DM program. On January 1, 2006, Connecticut carved behavioral health services out of the MCOs' at-risk benefits package, in the process essentially creating a disease management initiative for behavioral health services.

5. Integrated PCCM/DM

Although typically PCCM and DM programs have been operated separately, there is growing interest in several states around the potential benefits of a blending these approaches. For example, Pennsylvania has created an enhanced PCCM program integrated with a disease management model. This approach seeks to promote integration of disease management with the primary care physician's treatment strategies. Pennsylvania's disease management vendor has access to participating primary care physician offices and has a nurse who spends time working in the physician's office. Pennsylvania's approach eliminates the monthly PCP fee and instead offers the physician a pay for performance bonus system based on metrics run through the disease management vendor.¹⁴

6. Complex Case Management

Complex case management (CCC) programs are driven by the fact that a relatively small group of individuals incurs the vast majority of Medicaid health care costs. Care coordination initiatives can focus on the 0.5 to 5 percent of the population that comprises "the sickest of the sick." These initiatives are typically coupled with claims data analyses that seek to identify the high-cost recipients who are amenable to case management interventions as well as predict which individuals are at high risk of joining the high-cost population. Examples of characteristics of individuals in this high-risk population include:¹⁵

- At risk for high acuity care within the year
- Identified proactively
- Diagnosed with co-morbidities
- Facing social and psychological difficulties
- Deteriorating clinically
- Susceptible to growing dependence on the medical system

Aggressive management of these populations can produce significant clinical and financial results. Intensive support of the sickest patients can "break the cycle" of reliance on high-cost treatment, and DM support can help at-risk individuals avoid future high-cost care. Even with aggressive medical care coordination, this model cannot achieve its full potential through medical case management support alone. Non-medical barriers can be a substantial barrier to effective case management. Social and environmental challenges such as drug abuse, domestic violence, and poor housing conditions can make effective medical treatment very difficult to

¹⁴ Discussion with McKesson Corporation, March 30, 2004, and <http://www.dpw.state.pa.us/omap/hcmc/accessplus.asp>.

¹⁵ These concepts have been articulated by John Lynch, M.D., Associate Professor of Medicine at Washington University School of Medicine in St. Louis.

maintain. Case managers implementing the complex care coordination model need to be skilled at accessing these environmental factors and at linking patients to available community resources.

High cost case management in the Medicaid arena most often occurs in capitated MCOs, but this approach can also be implemented directly by the State or can be purchased through an independent contractor.

Two important considerations with regard to CCC and DM models for the TANF population are the relatively small number of persons who have the chronic conditions, and the short average duration of Medicaid eligibility. Due to these challenges, CCC and DM initiatives are often deemed better-suited to Medicaid SSI populations than for TANF subgroups.

7. Additional Hybrid Models

The above models are not mutually exclusive. In fact, combinations of the models are used in several states. In addition, the capitated MCO model typically incorporates all of the aspects identified above – primary care case management, disease management, and complex case management.

B. Cost Containment Capability of Each Medicaid Managed Care Model

Given the almost perpetual problem of there being “too little money in Medicaid” to meet the health needs of low-income persons, the medical cost containment attributes of various policy alternatives are often a paramount consideration for policymakers. In the absence of achieving needed budget savings through effective medical cost management, policymakers can only meet budget constraints by imposing cuts on benefits and eligibility, or by freezing or lowering provider payment rates. Low Medicaid provider payment rates jeopardize the very access to care that Medicaid coverage is intended to foster.

The cost savings created by various Medicaid managed care models can only be estimated and cannot be precisely quantified. Because of this limitation and since various parties have stakes in certain savings “outcomes” occurring, Lewin has developed a comparison chart that portrays the cost containment attributes of each alternative model. These attributes are depicted in Exhibit A on the following page, which presents a summary of the ratings of each model. A more detailed chart is provided in *Appendix B*, providing text that explains and supports each rating. The ratings use the following scheme:

●	Model fully implements the cost containment measure shown
◐	Model employs a limited use of the cost containment measure shown, or broad use for small portion of beneficiary population
○	Model does not use the cost containment measure shown

Exhibit A. Cost-Effectiveness Features of Various Medicaid Managed Care Models

Medical Cost Containment Techniques	UNMANAGED FFS	PCCM/ DISEASE MGMT	COMPLEX CASE CARE MGMT	PCCM/ DM/ CARE COORD	CAPITATED HMO
General Attributes					
Channels Patient Volume Using Contracted Network	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Eliminates Unnecessary Services	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Uses Lower-Cost Services Where Available	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Vendor At Risk For Medical Costs	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Wide Array of Quality Improvement and Access Enhancement Programs	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Directly Pays For Services and Negotiates Prices	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Specific Attributes					
Primary Care Physician Required	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Prior Authorization for Costly Services	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Referrals Required for Outpatient Specialty Care	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Disease Management	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Individually Tailored Care Management	<input checked="" type="radio"/>				
Enrollee Outreach and Education	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Can Pay for Uncovered Services on Exception Basis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Provider Profiling/Reporting	<input checked="" type="radio"/>				

Generally, the more of the cost containment techniques that are deployed, and the more fully each individual technique is deployed, the greater the cost containment outcomes are likely to be.

As identified in Exhibit A, the capitated Health Maintenance Organization (HMO) model adopts *by far* the widest set of measures to contain health care costs, and implements these measures most aggressively due to the level of financial risk the capitated health plans accept. The other managed care models (PCCM/DM and Complex Case Care Management) are primarily administrative services only models, with the vendors bearing far less financial risk than occurs under capitation. Furthermore, as payers HMOs have a close contractual relationship with network providers. Under the other managed care models, the State's vendors would hold little or no such advantage, and the vendor would be only minimally affected by the physicians' treatment decisions.

Table 4 presents Lewin's estimated percent savings in medical costs, relative to unmanaged fee-for-service, that each model of Medicaid managed care is expected to achieve for the TANF population.

Table 4. Estimated Percent TANF Medical Cost Savings by Model

Medicaid Managed Care Model:	Percent Medical Savings
HMO	19.9%
PCCM/DM	5.7%
CCC	5.0%
PCCM/DM/CCC	8.0%
HMO/PCCM	6.2%

Source: Percentage savings estimates of each model prepared as part of Lewin Group report, "Assessment of Medicaid Managed Care Expansion Options in Illinois," May 2005. Savings percentage shown depict the region that is deemed most comparable to Connecticut, and represent percentage savings during the first implementation year.

Note that the "unmanaged fee-for-service (FFS) model," which is currently in place for the majority of Connecticut's Medicaid spending, incorporates some cost containment measures. Thus, the baseline FFS model is not completely unmanaged. However, imposing very low payment rates on the provider community remains the key cost containment feature at this model's disposal.

Occurring between the FFS model and the HMO model with respect to cost containment features are the various "managed FFS" models: PCCM/Disease Management, Complex Case Care Management, and a model combining all of these approaches. While Disease Management and Complex Case Care Management are similar in the number and strength of cost containment attributes, we have not considered Disease Management as a stand-alone approach but rather applied in conjunction with a PCCM model. Thus, the Complex Case Care Management approach alone has fewer cost containment features than the combined PCCM/DM model. While there is some overlap between Disease Management and Complex

Case Care Management in terms of the populations targeted, there is still some additional impact from establishing both programs. Therefore, the model combining the three managed FFS approaches is somewhat stronger than either the Complex Care Management approach in isolation or the PCCM/DM model in terms of potential for medical cost savings.

Table 4 also presents the estimated TANF medical cost savings associated with operating a capitated MCO program and a PCCM initiative simultaneously. Several states have attempted this approach, seeking to create an "open and ongoing competition" between the capitated and managed FFS models. However, the experience of this approach has not been favorable and Lewin does not project this approach as likely to yield large program-wide medical cost savings. The key challenges associated with this hybrid approach are summarized below.

- a) The need to compete with the PCCM model can impose large marketing costs on the health plans to attract market share, and/or forces administrative scale diseconomies on the health plans.
- b) The State must be concerned with enrollment selection bias issues, given that capitated settings typically attract healthier-than-average enrollment when operating side-by-side with fee-for-service coverage models.

Because of both of the above dynamics, the compelling cost advantages of the MCO model can quickly erode if PCCM is mixed in.

C. Administration and Profit Components of Each Managed Care Model

As noted earlier, *all* aspects of the health care system have administrative components. On the FFS side, states experience cost associated with paying FFS claims and processing program eligibility, enrollment, and disenrollment. On the managed care side, the states incur vendor costs, such as the internal administration charged by HMOs, PCCM contractors, and disease management vendors. States also directly incur additional administrative costs when they engage external contractors (enrollment counselor activities, actuarial services for capitation rate setting, quality assessments, etc.) to implement and monitor their programs.

1. Capitated HMO/MCO Model

As shown earlier (Table 3), capitated programs serving only TANF and TANF-related categories of beneficiaries often experience administrative costs above 10 percent of revenue. The HUSKY program's experience demonstrates that administrative costs can be held to approximately 10 percent of revenue.

In addition to requiring payment for administrative services provided, contractors will not do business with a state Medicaid agency without a realistic opportunity to achieve a favorable operating margin. The Lewin Group views an operating margin of approximately 3% to be a reasonable target. MCOs can also obtain a modest gain (usually less than one percent of revenue) through investment income, since the cash flow dynamics of a capitated program are generally favorable.

2. *Managed FFS Models*

For all the managed FFS models under consideration, it is assumed that external contractors will be engaged to implement the selected approaches. PCCM, DM, and case management vendors will also incur and need to be reimbursed for administrative costs associated with operating these programs. Estimated administrative costs for the TANF population for each model are presented in Table 5. These estimates take into consideration contractors' administrative costs, contractor profit needs/expectations, and State administrative costs for program implementation and oversight.

As noted previously, states that contract with external vendors for managed care program administration continue to perform various administrative functions internally (and/or through specialized vendors), and thus incur administrative costs that are in addition to the managed care program vendor's administrative costs. Administrative services typically contracted for include enrollment broker services, quality review, and actuarial services. In addition, states incur direct personnel costs associated with managing the contracts with the various vendors, as well as systems costs (e.g., for modifications necessary to monitor program operations). Many states also operate a beneficiary complaint line, a state-level appeals process, and program integrity units. The costs of these functions are at least partially allocated to the HMO program.

Again, state administrative costs are considerably lower in the managed FFS models than in the HMO model, but the non-MCO approaches also requires some system redesign, oversight, and financial reconciliation monitoring.

Administrative costs under managed FFS approaches will be significantly lower than (generally less than half of) those associated with the MCO model, since the managed FFS models engage in fewer cost containment initiatives and do so less aggressively than do capitated MCOs (as previously shown in Exhibit A). Profit needs also are assumed to be somewhat lower than in the MCO model due to the lower level of financial risk borne by the contractors in the managed FFS models and the fact that some of the models (e.g., DM and CCC) are applicable only to relatively small subsets of the overall TANF population.

The figures in Table 5 track well with the Exhibit A chart (shown on page 17), in that the more comprehensive the "package" of administration and outreach activities taking place in a given model, the higher the *administrative* costs will need to be. The administrative cost comparisons in Table 5 cannot be assessed in isolation, however. As shown in Table 6 and its corresponding narrative, total (medical plus administrative) costs in the MCO setting are well below those of any of the managed fee-for-service alternatives.

Table 5. TANF Administrative Cost PMPM Estimates For Various Models, CY2006

Figures reflect general national norms rather than actual Connecticut experience.

Medicaid Managed Care Approach	Contractor Administration	Contractor Profit	State Admin.	Total *
Capitated MCOs	\$14.86 - \$17.06	\$3.72 - \$4.26	\$3.00	\$21.58 - \$24.32
PCCM/DM	\$3.26 - \$4.08	\$0.65 - \$0.82	\$1.50	\$5.31 - \$6.40
Complex Care Coord. (CCC)	\$0.82 - \$1.05	\$0.08 - \$0.10	\$0.50	\$1.40 - \$1.65
PCCM/DM/CCC	\$4.08 - \$5.13	\$0.73 - \$0.92	\$2.00	\$6.71 - \$8.25

Source: PMPM estimates prepared as part of Lewin Group report, "Assessment of Medicaid Managed Care Expansion Options in Illinois," May 2005.

PMPM costs for non-MCO models may be misleadingly low, since some services (e.g., DM and CCC) will be applied only to a small subgroup of the TANF population, whereas the PMPM calculation uses the total TANF population as a denominator. DM and CCC costs for those beneficiaries *engaged* in these programs often average greater than \$25 PMPM, for example. MCOs' estimated administrative costs are depicted only in the "Contractor Administration" column.

While the Table 5 figures do not represent Connecticut-specific experience, it is important to note that the HUSKY MCOs collectively held administrative costs below ten percent of premium revenue throughout the 2003-2005 timeframe - below national norms for TANF capitation programs. Thus, the HUSKY program appears to be operating efficiently with regard to the volume of administrative services occurring and the program's administrative costs as a percentage of revenue.

D. Overall Cost Savings Estimates for Each Managed Care Model

The estimated overall percentage savings each model can achieve with the TANF population is summarized in Table 6. These savings estimates show the capitated HMO/MCO model to yield the largest overall expected savings for the TANF population, with the PCCM/DM/CCC option yielding the next-highest savings. The least attractive Medicaid managed care option financially involves jointly implementing the HMO and PCCM models, which is projected to lead to approximately 3 percent *higher* costs than pure fee-for-service primarily due to enrollment selection bias challenges.

Note also that the figures shown in Table 6 depict savings during the initial implementation year. The capitated MCO/HMO model is expected to yield growing savings over time, an outcome that appears to have occurred in Connecticut's HUSKY program based on the trend analyses conducted herein. Based on the financial performance of HUSKY to date, Lewin estimates that expenditures under HUSKY are at least five percent below what any newly implemented non-capitated Medicaid managed care model would be able to deliver. This translates to an annual Medicaid spending differential of at least \$37 million (five percent of the four MCOs' collective CY2005 Medicaid premium revenues of \$740 million).

Table 6. Estimated Overall Percentage Savings by Model, TANF Population

Medicaid Managed Care Model	Overall Savings (Loss) Percentage Versus FFS
HMO	6.7%
PCCM/DM	2.0%
CCC	4.0%
PCCM/DM/CCC	4.2%
HMO/PCCM	(3.1%)

Source: Percentage savings estimates of each model prepared as part of Lewin Group report, "Assessment of Medicaid Managed Care Expansion Options in Illinois," May 2005. Savings percentage shown depict the region that is deemed most comparable to Connecticut, and represent percentage savings during the first implementation year.

V. QUALITATIVE ASPECTS OF HUSKY PROGRAM

The qualitative performance of HUSKY has been assessed from a variety of dimensions including physician access, preventive care screening statistical findings, enrollee survey results, and other factors. This section describes the program's performance on these dimensions.

A. Physician Access

Throughout most of the nation, access to "mainstream" care in Medicaid is usually compromised by substandard Medicaid payment schedules to front-line providers. In most states, Medicaid recipients often face daunting challenges in finding physicians and dentists who will accept them. Accepting large numbers of Medicaid patients is not a viable business proposition for physicians and dentists in most states.

This issue clearly exists in Connecticut. According to a Lewin study of each state's Medicaid physician fee schedule as of 2000, Connecticut ranked 23rd in the nation in its Medicaid fees as a percentage of Medicare's allowed charge. Connecticut ranked 11th in terms of the dollar value of the fees, but this ranking dropped to 25th when the fees were geographically adjusted for the cost of living.¹⁶ Connecticut's Medicaid physician fee situation has worsened considerably since CY2000, as the Medicaid fee schedule has been kept essentially flat throughout the past seven years (with occasional exceptions, including a four percent increase in payments for primary care services). It is likely that Connecticut now ranks well into the bottom half of states in terms of Medicaid physician fee adequacy. Given that very few states are paying fees that the physician community would deem adequate in the first place, being outside even the top five states on this continuum is likely to result in access challenges.

An encouraging aspect of physician access is that the HUSKY population is obtaining a large volume of office visit services. Aggregating each MCO's utilization reports for calendar year 2005 shows that more than 1.7 million office visits occurred, split 54% between primary care and 46% specialist care. On average, HUSKY enrollees obtained 2.9 primary care visits during 2005 and 2.5 specialist visits.

Connecticut's MCOs have made considerable efforts to build and maintain strong physician networks, but for the most part have not found it feasible to substantially increase physician fees above the underlying Medicaid fee-for-service fee schedule. Regarding network participation levels, physician access looks quite strong, as summarized in Table 7.

¹⁶ "Comparison of Physician and Dental Fees Paid by State Medicaid Programs," Lewin Group, April 2001. The study can be downloaded at no cost from the California Health Care Foundation's website: www.chcf.org

Table 7. Summary of MCO Physician Networks (all figures are approximate)

MCO	Primary Care Physicians	Specialist Physicians
Anthem BCBS	1,500	4,000
Community Health Network	1,350	4,200
HealthNet	2,000	5,000
WellCare	1,200	3,000

The HUSKY plans have approximately 30 to 80 enrollees per network PCP, which indicates a wide physician panel and suggests the HUSKY population is reasonably dispersed such that the vast majority of the participating physicians are not "burdened with" large numbers of HUSKY enrollees. At the same time, our understanding is that several PCPs in the MCO networks are currently serving large numbers of HUSKY patients.

Recent U.S. Bureau of the Census data indicates that Connecticut has approximately 10,200 active physicians. The Table 7 figures show that each MCO's physician network includes between 41 percent and 69 percent of the State's active physician community. This is a positive finding, given that the HUSKY population represents only 9 percent of the total Connecticut population, and given the relatively low reimbursement paid for HUSKY patients relative to all other insured patients.

Connecticut has a large physician supply, which bodes well for access for all the State's citizens. Connecticut has 298 physicians per 100,000, which is the fourth highest in the nation (behind only Massachusetts, Maryland and New York). The nationwide rate is 209 physicians per 100,000. Thus, Connecticut's physician to population ratio is 43 percent above the national average.

Beneath all these favorable figures, however, lies an important "inconvenient truth" in that many of the HUSKY program's participating physicians do not want to serve new Medicaid patients. This results in a widespread dynamic of physician practices being closed to new HUSKY patients. In addition, as has been documented in the recent "Mystery Shopper" study conducted by Mercer, it appears that many physicians who appear to be in MCO networks with open panels are in fact not taking new HUSKY patient appointments.

It is therefore insufficient to simply count the number of physicians who "take Medicaid" or who belong to a certain MCO's network. All parties closely involved in Connecticut's Medicaid program understand that physician access is a much more complex issue due to the dynamics created by the fee schedule. It is also worth noting that the fee schedule is not the only reason physicians are hesitant to serve Medicaid patients. For example, physicians indicate that the missed appointment rate for HUSKY patients who do have scheduled appointments is often well above that for physicians' other insured subgroups.

The office visit access challenges create a corresponding problem, in that every emergency room in the State is open on a 24 hours a day, 7 day a week basis with no appointment necessary. For persons facing difficulties and delays in scheduling "mainstream" doctor appointments, the

option of going to the ER becomes much more attractive than for privately insured individuals (who usually are further dissuaded from using the ER by large co-payments – which are not imposed on HUSKY patients). The MCOs have made extensive efforts to discourage unnecessary ER use, such as proactively contacting member families and PCPs after an ER visit occurs.

B. Access to Preventive Services for Children

Medicaid's child health component, known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Federal law – including statutes, regulations, and guidelines – requires that Medicaid cover a very comprehensive set of benefits and services for children, different from adult benefits. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older. EPSDT is designed to help ensure access to needed services, including assistance in scheduling appointments and transportation assistance to keep appointments. EPSDT offers an important way to ensure that young children receive appropriate health, mental health, and developmental services.

Each State is required to fill out an annual EPSDT report that provides basic information participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children who are provided various child health screening services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a State's screening periodicity schedule. Table 8 shows average national performance and Connecticut's among selected EPSDT indicators for 2002 and 2005.

The Table 8 figures demonstrate strong and improving Connecticut EPSDT performance through the HUSKY program, but also demonstrate the inherent, nationwide challenges associated with *accomplishing* access to care in the Medicaid environment. Connecticut ranked among the top 10 states in the nation in both 2002 and 2005 in terms of the percentage of child eligibles receiving at least one EPSDT screen, and Connecticut's performance on this statistic increased from 43.6% in 2002 to 50.2% in 2005. However, this still leaves considerable room for improvement, as half Connecticut's target population did not have a documented health screen in 2005.

Table 8. Selected EPSDT Indicators for Connecticut and Total USA

	Percent Of Eligibles Receiving Any Screen	Screening Ratio: Actual Screens As % Of Expected Screens	Percent of Eligibles Receiving Dental Services	Percent of Eligibles Receiving Screening Blood Lead Tests
Connecticut 2002	43.6%	71.5%	30.6%	13.2%
Connecticut 2005	50.2%	82.1%	30.1%	12.3%
National Average 2002	35.8%	72.6%	27.9%	5.3%
National Average 2005	41.7%	77.0%	32.4%	7.0%
Connecticut Rank 2002*	6th	27th	16th	1st
Connecticut Rank 2005*	6th (8th)	13th (18th)	22nd (31st)	4th (6th)

Note: 2002 ranking is across all 50 states and the District of Columbia. 2005 ranking is across 35 states plus the District of Columbia (data were not available for the remaining states); the ranking in parentheses pro-rates the initial ranking to 50 states.

The "screening ratio" is the extent to which EPSDT-eligible children receive the number of initial and periodic screening services required by the state's periodicity schedule, adjusted by the proportion of the year for which the targeted children were covered by Medicaid. Although Connecticut did not perform above the national average in 2002, the state increased its screening ratio significantly (by more than ten percentage points) during the next three years and was well above the national average as of 2005.

Connecticut also ranks in the top five in the nation in terms of the percentage of children receiving lead screenings.

Dental access is a vexing challenge in Medicaid, as only approximately 30% of the target population of Medicaid children (both in Connecticut and nationally) received some dental care.

C. Consumer Assessment of Health Plans Survey

The National Committee for Quality Assurance (NCQA) has developed HEDIS measures, which is a set of standardized performance measures for managed care health plans, and the Consumer Assessment of Health Plans Survey (CAHPS), which provides information about consumer satisfaction with managed care plans.

CAHPS results were reported by all four health plans in Connecticut's Medicaid managed care program and are summarized in Table 9. NCQA determines a health plan's HEDIS®/CAHPS® 3.0H performance by comparing the MCOs' results to nationwide figures.

Connecticut's figures are generally above, and in many cases far above, the nationwide total with regard to "top line" results (i.e. the most positive survey response categories). Among the nine indicators shown in Table 9, HUSKY CAHPS Survey results are above the national results. However, the drop-off in most of the HUSKY CAHPS statistics from 2005 to 2006 is somewhat concerning. It appears from the CAHPS survey that the Medicaid recipients are finding it more difficult to obtain access to needed care. This is consistent with what we would expect to find given the fee schedule situation, coupled with the fact that the MCOs have been collectively

operating almost exactly at a financial breakeven level and thus are not positioned to improve the fee schedule situation.

Table 9. 2006 and 2005 Adult CAHPS® Survey Results

ADULTS	Nationwide Total*		HUSKY Average Percentage**		# of Plans Reporting Data	
	2006	2005	2006	2005	2006	2005
Getting Needed Care	67%	66%	69.2%	70.0%	3	3
Getting Care Quickly	45%	45%	68.6%	73.1%	3	3
Doctors Who Communicate Well	61%	61%	86.0%	85.7%	3	3
Courteous and Helpful Office Staff	67%	67%	90.4%	89.4%	4	4
Customer Service	69%	70%	66.4%	68.1%	3	3
Rating of Personal Doctor	59%	59%	80.2%	80.4%	4	4
Rating of Specialist	59%	59%	69.1%	72.2%	4	4
Rating of Health Care	55%	54%	68.6%	71.5%	2	2
Rating of Health Plan	53%	51%	73.0%	73.2%	4	4

 = Above National Results

Note: *National results shown are the "top line" results (i.e., the most positive survey response categories) by sector for the CAHPS Health Plan Survey Adult. **HUSKY average represents straight average of percentage figures for each MCO that reported data on a given indicator.

NCQA defines each of the measures shown in Table 9 as follows:

- Getting Needed Care: summary rate is the percentage of members who responded "not a problem" in attempting to get care from doctors and specialists in the last six months
- Getting Care Quickly: summary rate is percentage of members who responded "always" in experiences receiving care or advice in a reasonable time and includes experiences with time spent in the office waiting room
- Doctors Who Communicate Well: summary rate is percentage respondents reporting "always" in how well providers listen, explain, spend enough time with, and show respect for what members have to say
- Courteous and Helpful Office Staff: summary rate is percentage members responding "always" in composite measures of the member's treatment by office staff in the last six months
- Customer Service: summary rate is the percentage of members who responded "not a problem" in composite measures of how much of a problem it was for members to get information and help from customer service in the last six months
- Rating of Personal Doctor: rate is the percentage of members who ranked his or her personal doctor or nurse a 9 or 10 on a scale of 0 to 10, where 10 is the "best possible."

- Rating of Specialist: rate is the percentage of members who ranked his or her specialist a 9 or 10 on a scale of 0 to 10, where 10 is the "best possible."
- Rating of Health Care: rate is the percentage of members who ranked all of his or her health care a 9 or 10 on a scale of 0 to 10, where 10 is the "best possible."
- Rating of Health Plan: rate is the percentage of members who ranked his or her health plan a 9 or 10 on a scale of 0 to 10, where 10 is the "best possible."

D. HEDIS

Connecticut does not require HEDIS reporting for its Medicaid population. Instead, Connecticut has its own requirements for specific disease and preventative measures, some of which are very similar to HEDIS. Therefore, it is not currently possible to use HEDIS to contrast HUSKY performance with external benchmarks.

E. Outreach Initiatives

As described in the financial assessment, the HUSKY MCOs' administrative costs appear to be economical in the context of MCOs serving TANF populations nationally – collectively representing close to 10 percent of capitation revenue. The scope of this engagement does not involve conducting a detailed assessment of the administrative services and outreach initiatives taking place, although clearly a wide range of important efforts occur. A few examples are summarized below:

- All four MCOs conduct outreach to family members when a member has a "non-emergency" visit to the emergency room. The objective is to help connect ER-using members more strongly with their primary care physician.
- The MCOs were asked to provide the volume of proactive outbound calls they have successfully completed with their Medicaid members during 2006, to provide an indication of the volume of outreach activity taking place. This information is routinely tracked by all four MCOs. Program-wide, approximately more than 225,000 outbound calls were completed during CY2006. (Approximately twice this number of calls were attempted in order to successfully complete the 225,000 calls.) The proactive outbound call volume is approximately two calls per HUSKY household per year. These calls address a wide range of issues, such as new member welcome/orientation, encouragement of initial PCP visits and ongoing EPSDT and other preventive health services (including appointment scheduling and follow-up), disease management support, support to pregnant enrollees, following up with non-compliant members (when scheduled appointments are missed), etc.
- All four MCOs have extensive programs in place to promote prenatal care and to identify and support high-risk pregnancies.
- The MCOs also provide a broad array of community outreach, through participation in health fairs at schools, churches, community centers, and other public events.

- The MCOs disseminate written educational materials on wellness, preventative care, women's health care (receiving mammograms and cervical screenings), dental care, treatment of asthma, safety, care of newborn, importance of immunizations, annual eye exams for diabetics, healthy living guides for preventative care, and other topics.

VI. POLICY RECOMMENDATIONS

Lewin was asked to put forth any policy recommendations that we felt were warranted based on our assessment. We offer suggestions in several key areas: 1) whether the State's managed care model should be changed to a managed fee-for-service approach; 2) how the physician access challenges confronting the State and the MCOs might be best addressed; 3) what issues warrant closer study; 4) what additional DSS contract requirements might strengthen the program; and 5) what Medicaid managed care approach makes sense for the Medicaid disabled population.

A. Capitation Versus Managed Fee-For-Service

There will always be strong opponents to the HMO coverage model, and the HUSKY access challenges that have been documented recently have perhaps broadened the number of persons who believe a managed fee-for-service approach that replaces the capitated MCO model would strengthen Connecticut's Medicaid program. Lewin does not believe this would be a sound policy decision, for a variety of reasons summarized below.

Costs. The financial savings of the capitated model cannot be matched under a managed FFS approach. We are confident that the capitated model achieves initial (Year 1) savings that are two to four percent greater than the savings that can occur under the strongest managed FFS approach (which would combine PCCM, DM, and high cost case management). Further, the savings gap between capitation and alternative models widens as time passes, as the capitated MCO model is most successful in lowering the inflation trend line. We would estimate that the costs in a mature (now in year 12 of operation) HUSKY program would be at least five percent below those of a newly implemented managed FFS approach.¹⁷ With the annual capitated dollars of the HUSKY program currently at approximately \$750 million, the cost savings differential of using HUSKY versus the most effective managed FFS model would be at least \$37 million annually. As shown earlier in the report (Exhibit A), the capitated model applies far more cost containment techniques, and does so more intensively, than can occur under any managed FFS approach.

Full Risk. The motivation that capitated managed care organizations have to contain costs cannot be matched in a FFS payment structure. Managed FFS models such as PCCM and DM can provide important financial incentives to the contractors, but these arrangements cannot approach the dollar-for-dollar risk and cost management incentives that capitation creates. The converse of the full risk borne by the MCOs is increased budget predictability for the State,

which is highly valuable. It is perhaps also worth noting that the incentive under capitation is not to deny access to a needed service, as this often would lead to increased costs as the person's condition worsens. Rather, the true incentives are to provide education support and to

¹⁷ Our savings estimates apply to any given level of Medicaid eligibility and benefits package. A State can of course achieve almost any desired level of savings in the fee-for-service (or capitated) setting by cutting benefits, eligibility, or reducing provider fee schedules. However, all of these approaches are simply "cuts" to the program that further marginalize the value of Medicaid coverage.

facilitate access to needed services, in order to maintain (and/or improve) an enrollee's health status.

Integration. Capitation creates a highly integrated system of care in which the contracting health plans are responsible for access, delivery, and payment of a comprehensive array of acute care services. Although mental health services are no longer included in the HUSKY program's capitated benefits package, the MCOs are responsible for all other Medicaid services for nearly 300,000 enrollees. No PCCM-based and/or DM approach can provide nearly as high a level of integration as the capitated HUSKY model. Under HUSKY, the MCOs are simultaneously concerned with a wide range of issues including an enrollee's environmental circumstances, health needs, level of awareness and access barriers, usage habits, medication mix, co-morbidities, since *they* bear the medical costs that come with not addressing these challenges effectively.

Provider Interaction. The capitated model is bolstered considerably by the fact that the MCOs pay various providers throughout the acute care system for the services rendered. Providers need to interact constructively with HUSKY MCOs in order to obtain payment, and the MCOs need to interact constructively with providers to maintain an attractive network for prospective enrollees (and to serve them effectively). Contractors operating PCCM or DM programs do not serve as a payer – except in sometimes implementing minor performance-based payments – and thus play a more tangential role than do MCOs in their relationships with the provider community. In addition, several HUSKY MCOs are uniquely positioned to attract “mainstream” physicians to serve their Medicaid clients because they also provide commercial and/or Medicare coverage products that channel “desired” patient volume to these providers. A managed FFS approach can only offer Medicaid patients to the provider community.

Competition. Managed fee-for-service programs are typically “given” an enrollee population to work with. The selected vendors do go through a significant competitive procurement to be awarded the contract, but face no meaningful competition for patients thereafter. In contrast, HUSKY MCOs compete for Medicaid business with one another on a daily basis. This ongoing competition appears to be creating dynamics where the managed care organizations are continually striving to attract and retain enrollees, and to be perceived as the organization that provides the best service to the beneficiary population.

Innovation. The fee-for-service coverage model – even when it is significantly enhanced – is ill equipped to go “outside the box” to achieve a positive result. For example, provider-specific investments, such as paying a selected primary care provider to extend its office hours, can much more readily occur in the capitated setting than in the fee-for-service environment. Similarly, a HUSKY MCO enrollee can receive a special benefit from a health plan that believes its investment will be more than offset by lower health care costs. Capitated health plans can implement a wide range of “spend to save” investments in the capitated setting that simply cannot occur within the fee-for-service model.

Core challenges. The access problems that exist in Connecticut stem from “too little money in the system” rather than failure of the capitated model. For a variety of reasons, most prominently the Medicaid fee schedule, most physicians in the State are unwilling to take on the “next” Medicaid patient who is seeking care. Conversely, most of these same physicians are probably quite willing to take on the next commercially-insured patient who is seeking care.

This is a simple reality in the vast majority of states. No Medicaid managed care model can completely "fix" this problem unless there is enough money to work with.

Accountability. In many States, Lewin has reviewed in detail the access requirements in State contracts with Medicaid MCOs. In comparing these with the access requirements in State contracts with managed FFS and PCCM contractors, a clear distinction emerges. The MCO requirements are typically detailed, explicit, and numerous. The managed FFS requirements are far fewer in number and tend to be much more vague. These contract differences are indicative of the heightened levels of accountability in the capitated model versus what can realistically be expected to occur in the managed FFS environment.

For these reasons, we would strongly discourage the State from dismantling the HUSKY program. Such a change would not do anything to resolve the problems that currently confront Connecticut's Medicaid program, but would remove some significant strengths.

B. Physician Access Challenges

We believe that several mechanisms warrant consideration to strengthen physician access under HUSKY and Connecticut's Medicaid program. These are described below.

Explicit Rate Increases: There is a significant "you get what you pay for" element to physician and dental access. A strong case can be made that Connecticut's Medicaid fee schedules represent the root challenge that must be addressed. MCO physician fees in the aggregate appear to be slightly higher than the underlying Medicaid fee schedule, but to a large degree the MCO fees closely parallel with the State's fee levels. The MCOs' current payments form the basis of the DSS capitation rates paid to the MCOs; MCOs cannot meaningfully increase physician payments without a commensurate capitation rate increase from DSS.

It is important to note that some states have implemented Medicaid fee schedules that are on par with other covered populations. Physician access challenges in the Medicaid (and Medicaid MCO) setting are far less prevalent in states where the fee schedules are more parallel with Medicare and private insurance, such as New Mexico.

One unfortunate aspect of the favorably low DSS cost trend line that has occurred under HUSKY is that the MCOs have not felt that they can increase physician fees above the underlying Medicaid schedule and still remain viable. Given that the MCOs have collectively experienced an operating loss throughout the past three years where audited financial statements are available (calendar years 2003-2005), the MCOs do not appear to have "room" to increase physician payments in a meaningful fashion without explicit support from their funding source (DSS).

Our key physician and dental access recommendation is that DSS increase its Medicaid fee schedules sharply (e.g., by 10 percent for each of the upcoming three years), as well as build in minimum annual physician fee schedule rate escalators going forward thereafter. While increases of this magnitude may not be financially or politically feasible immediately, it is important that the State recognize that this problem does not have any easy or inexpensive "fix."

All Connecticut Medicaid fee increases that are approved should be combined with new contract requirements imposed on the HUSKY MCOs including:

- Each MCO would be required to pay network physicians and dentists at least at the enhanced Medicaid rates. If an MCO wishes to pay below Medicaid FFS, it would be required to disclose the providers with whom it is seeking this fee and the rationale for paying below Medicaid.
- Each MCO would also need to document that in the aggregate, they have increased their physician and dental fees by at least the same weighted average percentage as DSS has increased its Medicaid fee schedule.
- Each MCO would develop a workplan for proactively tracking its physician network status (including whether each physician is accepting new patients) on a regular, specified timeframe. This workplan would be reviewed by DSS. The workplan's implementation as approved by DSS would become an MCO contract requirement. The workplan would also need to address how the network directory will be regularly updated.
- The capitation rates put forth by DSS would need to incorporate the added fee schedule costs at their full actuarial value. No efforts would be made to adjust other aspects of the capitation rate trends downward in order to offset the costs of increasing physician and dentist fees.

C. Recommended Studies

We further recommend that various aspects of physician access be studied more thoroughly to better identify the problems that exist and perhaps shed light on how Connecticut's Medicaid program and the MCOs can better address them. Study topics could include:

- A detailed survey of physicians to obtain frank input on the Medicaid access issues. It may be useful in obtaining open and honest input if the surveyed physicians are not identified in the survey report. Components of the study could include the degree to which the practice has accepted Medicaid patients, how their acceptance of Medicaid patients has evolved, statistics on rate adequacy versus other payers, statistics on missed appointments versus other payers, requesting ideas for best addressing the problems, etc.
- An assessment of the feasibility of some physicians and/or dentists blocking away certain time periods (e.g., Thursday afternoons) for unscheduled walk-in visits by HUSKY enrollees. This assessment would need to include a legal component (e.g., the process could be deemed discriminatory), as well as a "merit" component as to the pros and cons of adopting this approach. One possibility might be to pilot test this approach.
- An updated version of the "Mystery Shopper" exercise that assesses access from the perspective of both new and existing patients, and which also compares HUSKY patients' appointment-seeking efforts with non-HUSKY patients.
- A focused assessment on emergency room usage among the HUSKY population, interviewing families with high ER usage, low (but some) ER usage, and no ER usage.

Physician Participation: With regard to physician participation, historical high-volume “safety net” providers will typically participate in almost any Medicaid model. The key issue is which model will go the furthest to draw in the “mainstream” physician community. MCOs are best positioned to do this for a number of reasons: a) the capitated model creates the largest overall cost savings, creating a mechanism for State investment in higher physician fees; b) the MCOs often serve non-Medicaid enrollees who are highly attractive to the physician community; c) the MCOs provide a strong array of programs and resources pointedly focused on fostering access to care.

In conclusion, Connecticut’s HUSKY initiative is an established program with substantial demonstrated success in the key areas it was designed to influence – delivering cost savings to the State and its taxpayers and creating a true “system” of coverage whereby access and quality can best be continuously monitored and fostered. Connecticut’s best policy options involve working within this model going forward and making appropriate adjustments.

APPENDICES

Appendix A. Medicaid Cost Trend Comparisons using MSIS Data, 1999-2004 ¹⁹

CONNECTICUT	1999			2003			2004			annual cost per elig trend, 99-04	annual cost per elig trend, 99-03
	Eligibles	Amount Paid	paid/elig	Eligibles	Amount Paid	paid/elig	Eligibles	Amount Paid	paid/elig		
Disabled Non-Duals (all services)											
21-44	12,053	\$223,305,752	\$18,527	11,464	\$248,778,297	\$21,701	11,978	\$287,609,465	\$24,011	5.32%	4.03%
45-64	13,569	\$156,171,394	\$11,509	14,857	\$240,617,492	\$16,196	16,262	\$294,434,148	\$18,106	9.48%	8.91%
Disabled Non-Duals (non-Itc)											
21-44	12,053	\$182,813,665	\$15,167	11,464	\$203,621,561	\$17,762	11,978	\$239,399,981	\$19,987	5.67%	4.03%
45-64	13,569	\$121,790,472	\$8,976	14,857	\$190,333,266	\$12,811	16,262	\$240,221,554	\$14,772	10.48%	9.30%
Children (non-disabled, non-dual)											
All Children											
Age 1-5	57,413	\$99,142,989	\$1,727	68,743	\$136,332,810	\$1,983	73,799	\$151,074,727	\$2,047	3.46%	3.52%
Age 6-12	73,352	\$93,626,270	\$1,276	84,205	\$123,928,173	\$1,472	89,484	\$145,413,347	\$1,625	4.95%	3.62%
Cash Assistance Children											
Age 1-5	18,524	\$29,920,913	\$1,615	12,843	\$25,560,931	\$1,990	13,316	\$27,816,551	\$2,089	5.28%	5.36%
Age 6-12	22,390	\$26,719,396	\$1,193	13,443	\$18,234,728	\$1,356	13,001	\$19,241,667	\$1,480	4.40%	3.25%
Non Cash Assistance Children											
Age 1-5	38,889	\$9,222,076	\$1,780	55,900	\$110,771,879	\$1,982	60,483	\$123,258,176	\$2,038	2.74%	2.72%
Age 6-12	50,962	\$66,908,874	\$1,313	70,762	\$105,693,445	\$1,494	76,483	\$126,171,680	\$1,650	4.67%	3.28%
All Adults, 21-44	57,492	\$109,143,230	\$1,898	61,692	\$183,935,103	\$2,252	89,626	\$210,603,750	\$2,350	4.36%	4.36%
Cash Assistance Adults, 21-44	18,826	\$35,447,231	\$1,883	11,824	\$26,959,669	\$2,319	12,543	\$29,155,679	\$2,324	4.30%	5.35%
Non-Cash Adults, 21-44	38,666	\$73,695,999	\$1,906	70,068	\$156,975,434	\$2,240	77,083	\$181,448,071	\$2,354	4.31%	4.12%

USA	1999			2003			2004			annual cost per elig trend, 99-04	annual cost per elig trend, 99-03
	Eligibles	Amount Paid	paid/elig	Eligibles	Amount Paid	paid/elig	Eligibles	Amount Paid	paid/elig		
Disabled Non-Duals (all)											
21-44	1,360,217	\$13,163,506,471	\$9,678	1,528,238	\$20,059,302,155	\$13,126	1,228,267	\$17,387,075,706	\$14,156	7.90%	7.92%
45-64	1,446,610	\$12,122,454,129	\$8,380	1,882,967	\$22,364,633,928	\$11,877	1,606,478	\$21,539,886,605	\$13,408	9.86%	9.11%
Disabled Non-Duals (non-Itc)											
21-44	1,360,217	\$10,312,375,408	\$7,581	1,528,238	\$16,618,220,297	\$10,874	1,228,267	\$14,463,682,310	\$11,776	9.21%	9.44%
45-64	1,446,610	\$10,471,207,829	\$7,238	1,882,967	\$19,553,329,983	\$10,384	1,606,478	\$19,528,476,559	\$12,156	10.93%	9.44%
Children (non-disabled, non-dual)											
All Children (non-disabled, non-dual)											
Age 1-5	5,793,265	\$5,739,962,788	\$991	8,035,969	\$10,718,998,843	\$1,334	7,173,587	\$10,646,446,416	\$1,484	8.42%	7.72%
Age 6-12	6,141,760	\$4,756,508,753	\$774	8,285,303	\$8,743,712,180	\$1,056	7,172,648	\$7,677,952,711	\$1,070	6.69%	8.04%
Cash Assistance Children											
Age 1-5	1,793,339	\$1,850,953,830	\$1,032	2,454,229	\$3,534,186,157	\$1,440	2,266,398	\$3,311,668,119	\$1,461	7.20%	8.68%
Age 6-12	2,230,341	\$2,018,241,861	\$905	2,708,441	\$3,385,159,952	\$1,250	2,460,318	\$3,056,519,411	\$1,242	6.54%	8.41%
Non-Cash Assistance Children											
Age 1-5	3,999,926	\$3,889,008,958	\$972	5,581,740	\$7,184,812,686	\$1,287	4,907,189	\$7,334,778,297	\$1,495	8.98%	7.27%
Age 6-12	3,911,419	\$2,738,266,892	\$700	5,576,862	\$5,358,552,228	\$961	4,712,330	\$4,621,433,300	\$981	6.97%	8.24%
All Adults, 21-44	5,217,611	\$8,872,639,034	\$1,701	10,025,278	\$17,359,929,797	\$1,732	9,781,868	\$18,037,572,459	\$1,844	1.63%	0.45%
Cash Assistance Adults, 21-44	1,909,494	\$3,419,312,913	\$1,791	2,880,665	\$6,575,462,521	\$2,283	2,864,028	\$6,674,066,165	\$2,330	5.41%	6.26%
Non-Cash Adults, 21-44	3,308,117	\$5,453,326,121	\$1,648	7,144,613	\$10,784,467,276	\$1,509	6,917,840	\$11,363,506,294	\$1,643	-0.07%	-2.18%

¹⁹ The Medicaid Statistical Information System (MSIS) source data used for these tabulations are available at the following CMS website: msis.cms.hhs.gov

Appendix B. Detailed Chart Comparing Cost Containment Attributes of Each Model

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
General Attributes					
Ability to Channel Patient Volume to Cost-Effective Providers Using a Contracted Network	None – FFS program accepts all willing providers and has no patient channeling aspect.	Minimal – PCCM programs have contracted PCP networks; PCPs that participate may receive higher patient volume.	None – Case management is provided within a FFS setting, with no patient channeling aspect.	Minimal – PCCM programs have contracted PCP networks; PCPs that participate may receive higher patient volume.	Medium to Strong – HMOs develop competitive provider networks and direct patient volume to those networks. However, Medicaid's low payment rates in many service categories (e.g., physician services) limits the ability of HMOs to leverage their patient channeling power – many providers do not want more Medicaid patient volume.
	○	○	○	○	●

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
General Attributes					
Eliminating Unnecessary Services	Minimal – FFS setting is highly vulnerable to unnecessary usage of services.	Some – Through PCP-driven model, PCCM program seeks to eliminate beneficiary freedom to self-refer throughout the delivery system for care and conducts utilization management. In addition, DM model seeks to ensure appropriate mix and level of services for the population being disease managed. However, neither model is designed to aggressively weed out unnecessary usage for the entire program population.	Some – For the small proportion of the Medicaid population receiving care coordination services from care managers, individualized care plans will seek to avoid unnecessary care.	Medium – The combination of primary care case management, disease management for recipients with specified chronic illnesses, and care coordination for additional high-cost complex patients, unnecessary care may be avoided more often than if just one or two of these approaches are in place.	Strong – HMOs implement wide range of measures to identify and avoid unnecessary usage. They bear full risk of the cost of unnecessary care and are thus highly motivated.

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Using Lower-Cost Services Where Available	None – FFS actually does the opposite, as its payment structure promotes care occurring at relatively high-cost settings. For example, low physician fee schedule and relatively adequate payments to hospitals promotes a shift in care away from office setting and towards institutional setting.	Some – Through PCP-driven model, PCCM program seeks to render more “front-line” services in lower-cost settings; and DM seeks to ensure preventive and primary services are provided at appropriate points to avoid exacerbation of condition and need for more costly services. However, PCPs and PCCM contractors generally do not have incentives to refer care to more cost-effective settings, and DM vendors have relatively weak incentives since they are not at dollar-for-dollar risk.	Some – CM seeks to ensure patients receive necessary social supports, preventive and primary services that will help to avoid exacerbation of condition and need for more costly services. However, CM contractors typically do not have incentives to refer care to more cost-effective settings.	Some – through combination of PCCM, DM and CM approaches, this model can have an impact on a larger portion of the population than any single approach or combination of two of the three approaches. However, this approach still does not provide strong incentives to refer care to more cost-effective settings.	Strong – HMOs seek to move services to lowest-cost setting and provider type. HMOs can also have some success in smoothing out payment anomalies between Medicaid providers (FFS can pay vastly different amounts for the same service depending on who provided the service.)
Directly Pays For Services and Negotiates Prices	State has significant leverage as one of the largest payers in the market, plus the fact that those covered by Medicaid would otherwise be uninsured.	PCCM programs often pay case management fees or enhanced rates to PCPs, with other providers receiving Medicaid FFS rates. PCCM and DM contractors typically do not serve as payers.	Medicaid FFS rates apply, but the case management contractor does not serve as a payer.	PCCM programs often pay case management fees or enhanced rates to PCPs, with other providers receiving Medicaid FFS rates.	HMO can base its negotiated prices at or near Medicaid levels in securing network participation.

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Specific Attributes					
<p>Primary Care Physician Required</p>	<p>Beneficiaries do not choose a PCP and may be treated by any MD that accepts Medicaid patients.</p>	<p>Beneficiaries must select a PCP – PCPs may include: general practitioners, OB/GYNs, pediatricians.</p> <p>PCP is expected to: Assess members' medical needs; make referrals; coordinate care after referrals; make arrangements with home and community support services agencies; coordinate care with other entities that provide medical, nutritional, behavioral, educational and outreach services; and coordinate inpatient hospital care (pre-admit and discharge).</p> <p>Specialists and other providers in majority of PCCM programs are paid without conferring with the PCP, simply by knowing who the enrollee's PCP is.</p>	<p>Beneficiaries do not select a PCP; PCP gatekeeper model is not used.</p>	<p>Beneficiaries must select a PCP – PCPs may include: general practitioners, OB/GYNs, pediatricians.</p> <p>PCP is expected to: Assess members' medical needs; make referrals; coordinate care after referrals; make arrangements with home and community support services agencies; coordinate care with other entities that provide medical, nutritional, behavioral, educational and outreach services; and coordinate inpatient hospital care (pre-admit and discharge).</p> <p>Specialists and other providers in majority of PCCM programs are paid without conferring with the PCP, simply by knowing who the enrollee's PCP is.</p> <p>DM and care management program scope and efficacy are broadened in the PCCM setting.</p>	<p>Beneficiaries must select a PCP.</p> <p>PCP is expected to: Assess members' medical needs, make referrals, coordinate care after referrals, make arrangements with home and community support services agencies, coordinate care with other entities that provide medical, nutritional, behavioral, educational and outreach services, coordinate inpatient hospital care (pre-admit and discharge).</p> <p>Adherence to PCP model is most stringent in HMO setting, where unique referrals are typically needed for other providers to obtain payment.</p>

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Prior Authorization for Inpatient Care	Prior authorization is not necessary. <input type="radio"/>	Typically in PCCM programs, prior authorization is necessary and program contractor also receives notification of admission for non-emergent care to determine whether the care is medically necessary. <input checked="" type="radio"/>	Prior authorization is not necessary. <input type="radio"/>	Typically in PCCM programs, prior authorization is necessary and program contractor also receives notification of admission for non-emergent care to determine whether the care is medically necessary. <input checked="" type="radio"/>	Prior authorization is necessary. HMOs try to achieve inpatient cost-savings in many ways; their prior authorization process is deemed more stringent than PCCM techniques. <input checked="" type="radio"/>
Referrals Required for Outpatient Specialty Care	Referrals are not necessary. <input type="radio"/>	Typically in PCCMs, patients need a referral for specialty care. However, the process typically is less formal and rigorous than in most HMOs (it suffices for the specialist to provide the referring PCP's ID number, so that requirement to obtain an explicit referral may possibly be sidestepped). <input checked="" type="radio"/>	Referrals are not necessary. <input type="radio"/>	Typically under PCCM, patients need a referral for specialty care. However, the process typically is less formal and rigorous than in most HMOs (it suffices for the specialist to provide the referring PCP's ID number, so that requirement to obtain an explicit referral may possibly be sidestepped). <input checked="" type="radio"/>	Typically, service-specific referrals are required for non-emergent care. Specialists cannot generate follow-up care, tests, surgeries, etc. without PCP approval and explicit referral number. <input checked="" type="radio"/>

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Enrollee Outreach and Education	The FFS program does not provide enrollee education or outreach services, with the exception of EPSDT services for children and for women with high risk pregnancies. ○	Typically include an enrollee education and outreach component, though generally not as rigorous as seen in the HMO setting. ○	Includes an enrollee education and outreach component for identified high-risk beneficiaries. ○	Includes enrollee education and outreach component. ○	HMOs implement a variety of enrollee education and outreach programs. ●
Vendor At Risk for Medical Costs	The vendor acts purely as a claims administrator and bears no risk. ○	The vendor conducts a range of cost containment programs, but bears only limited risk for claims costs incurred by the enrollee (and usually just for those enrolled in DM component). ○	The vendor conducts a range of cost containment programs, but bears only limited risk for claims costs incurred by the enrollee (and just for those enrolled in CM component). ○	The vendor conducts a range of cost containment programs, but bears only limited risk for claims costs incurred by the enrollee (and just for those enrolled in DM and/or CM components). ○	HMOs are fully at risk for the medical costs of their enrollees, except for pharmacy services, which are carved out. ●
Provider Monitoring/Profiling, Accountability for Quality of Care and Cost-Effectiveness	FFS setting is very weak at fostering accountability and measuring provider performance. ○	PCCM generates provider monitoring reports, including tracking ER usage. Reports traditionally used only for informational/educational purposes, although some PCCM programs are building in "Pay for Performance." ○	Incorporates some accountability and monitoring of provider performance, although reports used only for informational/educational purposes. ○	PCCM generates provider monitoring reports, including tracking ER usage. Reports traditionally used only for informational/educational purposes, although some PCCM programs are building in "Pay for Performance." ○	HMO environment is conducive to extensive data reporting, profiling and monitoring, and (where necessary) provider sanctioning. ●