

# **Assessment of HUSKY, Connecticut's Medicaid Managed Care Program**

Summary Testimony of Joel Menges

Human Services Committee Public Hearing  
On Proposed Medicaid Managed Care Legislation --  
HB 7322 and SB 1425

Hartford, Connecticut

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# Key Findings From Lewin's Assessment

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- ◆ Cost Performance: HUSKY has 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.
- ◆ Additional Services: HUSKY MCOs provide a range of required and "extra" administrative services. MCO administrative costs averaged < 10% of revenue, which is below national norms.
- ◆ Access: Enrollees averaged 5.5 physician visits during 2005. CT ranked among the top 10 states during 2002 and 2005 in the percentage of Medicaid children receiving at least one preventative health screen.

## Key Findings (continued)

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- ◆ Quality: HUSKY member satisfaction survey results were consistently above nationwide figures in 2005 and 2006.
- ◆ Alternative Models: The capitated MCO model adopts a much broader set of cost containment and access enhancement approaches than any managed fee-for-service model (see chart on next slide). Annual cost of shifting from HUSKY to the *most effective* fee-for-service alternative would be at least \$37 million.

## **New Bills' concept of "adding" a PCCM option for HUSKY is misleading – this would be a subtraction from what now exists**

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- ◆ State already has PCCM: HUSKY health plans have used a primary care case management model for all their enrollees since the program's inception
  - Each enrollee is matched with a PCP
  - MCOs have strong PCP networks (and specialist networks) and vast array of access support programs
  
- ◆ HUSKY MCOs do far more to facilitate access than any managed FFS program would be able to afford
  
- ◆ Connecticut has a mature and successful MCO-based program – replacing it (even partially) with a less integrated model is not in best interests of State or the HUSKY population

# Cost-Effectiveness Features of Various Medicaid Managed Care Models

- 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

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

# Policy Recommendations

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1. Keep the capitated HUSKY program intact and work within this successful framework to create further program improvements:
  - Increase the Medicaid fee schedule sharply to improve access to physicians; require each health plan to pay providers at least at the enhanced Medicaid rates.
  - Conduct additional studies on various aspects of physician access such as a detailed physician survey and emergency room usage dynamics.
  - Increase DSS contract requirements for MCOs (i.e. obtaining national accreditation and submitting specific performance measures).
2. Implement a managed care program for Connecticut's Medicaid-only disabled population.