



MEDICAID MANAGED CARE IN CONNECTICUT AND OTHER STATES

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FEE-FOR-SERVICE AND MANAGED CARE

In fee-for-service delivery systems, health care providers are paid for each service provided to Medicaid enrollees.

In managed care delivery systems, managed care entities, under contract with the state Medicaid agency, accept a set per member, per month payment to provide services to Medicaid enrollees.

ISSUE

This report examines states' experiences with managed care delivery systems within their Medicaid programs. The report includes Connecticut and several other states.

SUMMARY

States may choose to deliver Medicaid services through a variety of delivery systems. In fee-for-service delivery systems, states pay providers for each service provided to Medicaid recipients. In managed care service delivery systems, states sign contracts with managed care entities (e.g., managed care

organizations) to pay an established fee per member each month.

For 15 years, Connecticut used managed care systems to serve most of its Medicaid beneficiaries, before switching back to fee-for-service in 2010. Connecticut is currently one of three states that deliver Medicaid services entirely through fee-for-service systems.

Most other states use some combination of managed care and fee-for-service delivery systems. New Hampshire recently converted much of its Medicaid program from fee-for-service to managed care. New York began experimenting with managed care in the 1960s, accelerated enrollment in the 1990s, and continues to expand its managed care programs through federal waivers and amendments to its state Medicaid plan. Rhode Island has used some form of managed care for at least 20 years. South Carolina has used it since 1996.

MEDICAID HEALTH CARE DELIVERY SYSTEMS

States administer their Medicaid programs through a variety of delivery systems (i.e., the combination of providers, institutional settings, and health care benefit resources used to deliver Medicaid services). According to [the federal Centers for Medicare and Medicaid Services \(CMS\)](#), historically, the standard delivery system for Medicaid has been fee-for-service, in which health care providers are paid for each service (e.g., an office visit, test, or procedure). However, over the past 30 years, many states have shifted their Medicaid programs, in part or in full, towards managed care, in which states contract with managed care entities, paying them a set amount per member, per month. As a result, 70% of Medicaid enrollees nationwide are served through managed care delivery systems.

The type and scope of managed care systems used by states varies widely. States may choose from one or more of the four types of managed care entities recognized by federal law: (1) managed care organizations (MCOs), (2) primary care case management plans (PCCMs), (3) prepaid inpatient health plans (PIHP), and (4) prepaid ambulatory health plans (PAHP) ([42 CFR § 438.1](#)). States may also choose which populations to serve or services to deliver through managed care. For example, in the past, most states have used managed care delivery systems to serve lower cost populations (e.g., families and children) while leaving more costly populations (e.g., aged or chronically ill) in fee-for-service programs. But this may be changing as more states expand their managed care programs, according to a [2012 report](#) from the Robert Wood Johnson Foundation (RWJF). States also vary in the extent to which they carve out (i.e., exclude) certain benefits from their health plan packages. Programs in various states may allow Medicaid recipients to access “carved out” services (e.g., dental care or behavioral health) through a fee-for-service system or an additional limited benefit plan. CMS’ [Managed Care Profiles](#) provide overviews of each state’s program and their (1) participating plans, plan selection, and rate setting; (2) quality and performance incentives, if any; and (3) program features.

Because of the variation in state programs, comparing and evaluating health care delivery systems poses several challenges. According to the [National Council of State Legislatures](#), studies examining the cost impacts of managed care find mixed results, and findings may depend on states’ baseline Medicaid programs, their managed care contracts, and the studies’ analytic methods. The RWJF report summarizes much of the available literature, finding (1) some success by particular

states in controlling costs through managed care, though little national savings; (2) some evidence that managed care may improve access to care, though studies on access to prenatal care had mixed results; and (3) any health plan has only a “limited ability to respond to the social determinants of health that play a large role in the fragmented care Medicaid enrollees receive.”

DELIVERY SYSTEMS IN CONNECTICUT

Transition to Managed Care

Like other states, Connecticut’s Medicaid programs began as fee-for-service. The transition to managed care began in 1994 with the application for a federal waiver ([PA 94-5, June Special Session](#)). The program, “Access Connecticut,” served cash assistance recipients and other low income individuals (see [OLR Report 95-R-1081](#)). A [Program Review and Investigations report](#) from that year described Connecticut’s existing Medicaid health care delivery and finance systems and recommended, among other things, that the state move all its health services, with the exception of long term care, into managed care. The report noted that the fee-for-service model made it difficult to oversee provided services and prevented states from selectively contracting with providers to obtain the most cost-effective services.

From 1995 to 2010, Connecticut used some form of managed care delivery system in parts of its Medicaid program. Generally, low income children and their families received Medicaid services through arrangements with MCOs, while the remaining Medicaid populations (e.g., the elderly or people living with disabilities) received services on a fee-for-service basis.

Early Outcomes

[A 1996 report](#) from the Office of the State Comptroller noted some early program outcomes for the initial population transitioned to managed care. Surveys of program recipients indicated overall satisfaction with their plans, noting that most (1) understood enrollment material and obtained answers to questions, (2) chose their health plan voluntarily (in contrast to being assigned to a default MCO), and (3) considered provider participation as the principal factor affecting plan choice. However, the report also noted that (1) approximately 10% of enrolled children did not have a primary care provider within six months of enrollment, (2) provider network adequacy issues resulted in the suspension of one MCO, and (3) the MCOs did not meet target participation levels for early and periodic screening for children.

Contract Terminations

In 2008, Governor Rell terminated the contracts of the four MCOs administering DSS' medical assistance program (HUSKY) at that time, largely because two of them refused to comply with the state's Freedom of Information Act. DSS took over certain functions that the MCOs had assumed: provider rate setting, prior authorization criteria, and provider enrollment criteria. DSS also contracted with administrative service organizations (ASO) for member services, provider enrollment, claims processing, case management, and outreach and education (see [OLR Report 2008-R-0615](#)).

Transition Back to Fee-for-Service

In 2010, [PA 10-179](#) converted DSS' medical assistance programs from an MCO model to a fee-for-service model with an ASO, the model currently in use. By 2012, DSS had contracted with an ASO for all HUSKY programs. The agency explained, in [a presentation](#) to Connecticut's Medical Assistance Program Oversight Council, that the change to an ASO model was prompted in part by a loss of confidence in managed care, noting uncertain cost-effectiveness and modest measured performance. In [a summary document](#), DSS noted some improved outcomes in 2013, including increased provider enrollment and reduced emergency department use.

According to [the Kaiser Family Foundation](#), Connecticut is one of three states with no managed care delivery systems in its Medicaid program (the other two are Alaska and Wyoming).

MANAGED CARE IN OTHER STATES

New Hampshire

In 2011, New Hampshire's legislature passed a bill to convert its Medicaid program from fee-for-service to a comprehensive managed care program for most Medicaid enrollees ([SB 147](#)). Lawmakers explained the change was a cost-saving measure that would also increase efficiency and quality of care for Medicaid recipients.

In 2013, the state Department of Health and Human Services' Medicaid Care Management program (MCM) began enrolling all Medicaid beneficiaries in MCOs, except individuals in need of long-term care. In 2014, the MCM began enrolling (1) individuals newly eligible for Medicaid under the Affordable Care Act and (2) Medicaid-eligible populations in need of long-term care and support. The state

contracts with one national for-profit plan and one local, not-for-profit plan to provide health services to Medicaid recipients. (As of August 2014, another for-profit plan that recently pulled out of New Hampshire's managed care system was still providing services.)

According to [CMS](#), New Hampshire uses various performance measures to monitor the quality of care and requires the MCOs to annually complete four performance improvement projects. Additionally, "the state withholds a percentage of the capitation payment made to MCOs and allows them to earn back up to 25 percent for each of four improvement targets met or exceeded."

A recent [external quality review report](#) found that the MCO plans were in compliance with the state standards for access to care, structure and operations, and quality measurement and improvement. Because the MCO system was recently implemented, the evaluators were unable to assess the performance of the MCO programs.

New York

According to [CMS](#), New York experimented with managed care delivery systems as early as 1967, but accelerated enrollment in managed care plans in the 1990s. New York currently operates five managed care programs. A large percentage of recipients are enrolled in the Medicaid Managed Care Program, which initially served (1) low income adults and children on a mandatory basis and (2) foster children on a voluntary basis. Through a federal waiver in 2006, the state expanded the program to also include (1) people living with disabilities; (2) blind or elderly individuals; and (3) children, caretaker relatives, and pregnant women in certain counties.

In addition, New York's Managed Long Term Care Program covers institutional and community-based long term care services and supports (primary and acute care services are carved out). Two programs, Medicaid Advantage and Medicaid Advantage Plus, operate in limited geographical areas and provide services to certain dual-eligible populations (i.e., those eligible for both Medicare and Medicaid). The Program for All-Inclusive Care for the Elderly provides all Medicaid and Medicare services to certain individuals, at least age 55, who require nursing home-level care.

From 2011 to the present, New York has attempted to expand its managed care programs by (1) eliminating exclusions for certain populations such as foster children, (2) expanding mandatory enrollment into managed long-term-care plans

for certain populations, and (3) reinstating some carved out services. New York has contracts with for-profit plans (both national and local) and non-profit plans (local only). The various managed care programs include MCOs, PCCMs, and PIHPs.

[External quality review reports](#) provide aggregate data for New York's 16 managed care entities, however assessments of strengths and areas for improvement vary by plan and are available in [plan specific reports](#).

Rhode Island

According to [CMS](#), Rhode Island first offered comprehensive, risk-based managed care about 20 years ago through its Rite Care program. The program originally covered low-income children and families but has expanded to include low-income working families and children with special health care needs. In 2014, Rhode Island expanded its managed care primary care case management to include adults without dependent children. Rhode Island also provides managed care for children and adults with disabilities through Connect Care Choice, a PCCM, and Rhody Health Partners, a comprehensive, risk-based program. Rhody Health Partners provides some long term services and support as well.

Rhode Island requires each managed care plan to (1) submit to various national and state performance measures and (2) be accredited by the National Committee for Quality Assurance. The state provides incentive payments to the plans if they meet certain performance goals.

According to a 2014 [external quality review report](#), "in 2013, the Rhode Island Medicaid managed care program and both of the participating Health Plans have had a positive impact on the accessibility, timeliness and quality of services for Rhode Island Medicaid recipients." The report suggests that "continued collaboration on [quality improvement] initiatives may drive both individual and statewide successes."

South Carolina

South Carolina began using managed care in 1996 through a comprehensive risk-based MCO program for children, pregnant women, and some adults with disabilities. In 2006, the state introduced the Medical Home Network PCCM Program. According to [CMS](#), the PCCM "utilizes networks of primary care providers to provide and arrange for most Medicaid acute, primary, or specialty care, and behavioral health" for participants. Currently, most Medicaid beneficiaries must enroll in either the MCO or PCCM. Certain children in foster care, Medicaid waiver enrollees, certain people in institutions, and dual-eligible beneficiaries are exempt from the managed care requirement and may opt instead for fee-for-service.

The state contracts with two national, for-profit plans; one local, for-profit plan; and one national, not-for-profit plan to provide care to MCO enrollees. It also contracts with three physician networks to provide care to PCCM enrollees.

The state requires the MCO plans and PCCM to submit quality performance measures. According to CMS, “to encourage quality in MCOs, the state uses both withholds and performance incentive. . . . Additionally, the state employs an auto-assignment algorithm to direct beneficiaries to MCO plans that have higher quality and better performance on quality measures.” The state may also impose damages, sanctions, or restrict enrollment in the PCCM if it fails to provide acceptable care.

A 2013 Medicaid health care [performance evaluation](#) found both strengths and deficiencies in each of the three programs: MCO, PCCM, and fee-for-service. For example, the scores each received for drug and alcohol treatment services were high, while the scores for women’s care were low to average.

RESOURCES

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