Medicaid Landscape Analysis

December 2024

DEPARTMENT OF SOCIAL SERVICES

Report Sections

1. Executive Summary

Executive Summary: Report Objectives and CT Medicaid Current State

Project Approach: The project team conducted an expedited evaluation of Connecticut (CT) Medicaid's performance on key criteria including cost, access and quality; analyzed the value Medicaid managed care (MMC) could bring to the program; and identified key areas for the Department of Social Services (DSS) to further explore for innovation, including the provision of home-and-community based services (HCBS), based on direction from DSS to conduct a more detailed analysis in this area. The analysis leveraged state and federal Medicaid data, industry research and enrollee/provider feedback.

Current State Results	
What CT Is Doing Well	**Areas of Opportunity**
• CT Medicaid has **14% lower per-enrollee spend** than the Northeastern average. • CT's Medicaid administrative **spend compares favorably** to managed care state average (3.8% v. 9.4%). • Access to care for CT Medicaid enrollees is **in line with national benchmarks.** • CT Medicaid performs **above the median for ~70%** of national adult and child quality measures.	• CT Medicaid's per-enrollee spend on individuals with disabilities and older adults is **much higher** than its peers, while performance on many related quality and access measures is average. • CT Medicaid performs **below the median** on about half the measures for acute and chronic conditions for adults and children, with **declining performance** on select behavioral health measures. • Beneficiaries rate their overall and specialty care **less positively than national benchmarks;** scores have declined over time. • State share of Medicaid prescription drug costs increased 30% during past four years, but is **lower than national** Medicaid prescription drug cost growth during the same time period.

Executive Summary: Delivery System Analysis Findings and Recommendation

Findings: CT Medicaid performs well on most health care outcomes and has lower per-enrollee costs than its peer states. While Medicaid managed care often reduces medical service costs, there is little evidence that managed care would reduce CT's overall state Medicaid costs after accounting for managed care administrative spending. In addition, the evidence is mixed on whether managed care would improve access to services or health outcomes for CT Medicaid enrollees.

Recommendation: Based on the potential disruption and cost of transitioning a relatively well-performing Medicaid program to managed care, DSS should explore targeted areas to reduce costs and improve outcomes instead of pursuing a transition to comprehensive managed care at this time.

Key Areas for CT Medicaid to Explore		
HCBS Innovation	**Acute and Chronic Disease Management**	**Pharmacy Benefit Optimization**
DSS should explore – based on a clear vision and analytical approach – new care delivery and integration models for HCBS users to **improve outcomes and reduce costs.**	DSS should explore new care management strategies within the current fee-for-service delivery system to **improve acute/chronic disease outcomes and reduce avoidable hospital utilization.**	DSS should evaluate additional levers to control increases in pharmacy spending, while ensuring beneficiaries continue to have **appropriate access to prescription drugs.**

In each area, Connecticut will need to clarify its vision and further analyze data before designing and implementing new programs. **Stakeholder engagement** and findings from DSS' **ongoing rate studies** should serve as key inputs for solutions based on these recommendations (e.g., the rate study may show where rate adjustments could complement other strategies to improve outcomes).

2. Framework for Managed Care and Area for Innovation Analysis

The project team established a framework and methodology to evaluate the current state, managed care delivery system reform options, and area for innovation (HCBS).

Framework: Criteria For Analysis

The Project Team established criteria to evaluate the current state, managed care delivery system reform and the area for innovation.

Criteria	Current State Analysis	Options Analysis
Service Cost	Evaluate cost performance overall, including state share, across specific service categories and populations	Assess how identified managed care delivery system reform options could contain costs and provide value within categories and populations
Member Access and Experience	Evaluate quality measures and health disparities for key populations and service areas	Assess how identified options can impact health outcomes and health disparities
Health Care Quality and Outcomes	Evaluate access to providers and member satisfaction	Assess how identified options can impact access to services and satisfaction
Provider Impact	Evaluate provider participation in, and satisfaction with, the Medicaid program	Assess how identified options impact provider participation and experience
State Administrative Impact	Evaluate administrative costs and program administrative structure	Assess how identified options impact DSS administrative burden and cost

Framework: Current State Analysis

The Project Team defined a narrow set of measures to analyze the current delivery system, considering health equity where possible. The analysis identified where the program is achieving high levels of value and areas of opportunity.

Criteria	Measure 1	Measure 2	Measure 3
Service Cost	Overall Per Member Per Month (PMPM) [C,T]	PMPM by eligibility category [C,T]	PMPM, total computable and state share for top 5 expenditure categories (as defined by MACPAC categorization of CMS-64 reports) [T]
Health Care Quality and Outcomes	Proportion of Adult Core Set Measures above median [C,T]	Proportion of Child Core Set Measures above median [C,T]	Proportion of Adult and Child Core Set Measures where CT is above the median, by topic area – e.g., behavioral health, maternal health [C,T]
Member Access and Experience	Adult/Child Composite CAHPS: Proportion of composite scores for Medicaid adult, Medicaid child, and CHIP CAHPS above the benchmark score [C,T]	HCBS Composite CAHPS: Proportion of composite measures that exceed performance benchmark [C,T]	Secret Shopper Survey Results: Of providers accepting new patients, percentage accepting CT Medicaid members [T]
Provider Impact	Total number of Medicaid providers [T]	Provider Survey: Overall provider satisfaction with the administration of the CT Medicaid program [T]	Additional data would be needed for additional measures
State Administrative Impact	Connecticut administrative spend percentage compared to average administrative loss ratio for MMC + average administrative cost percentage for managed care states [C,T]	Additional data would be needed for additional measures	Additional data would be needed for additional measures

C = comparison to national or regional performance T = trend of CT Medicaid performance over time

Framework: Managed Care and Area for Innovation Analysis

For the managed care and area for innovation analysis the project team used the defined criteria to analyze managed care's impact to the overall system and HCBS options for CT Medicaid to further explore.

Managed Care Analysis

Managed Care Impact Analysis: The project team assessed the value managed care could bring to CT Medicaid based on the agreed upon framework. The approach combined evidence from the most recent published Medicaid managed care literature review[65] (published in 2021), with an original review of peer-reviewed studies, white papers, and institutional research (e.g., CMS) from the past five years to assess the evidence of managed care effectiveness on cost, quality, and access, including provider and administrative impacts.

HCBS Detailed Analysis

HCBS Current State: Based on available data, the project team focused on prioritized criteria of service cost, health care quality and outcomes, and member experience to analyze the current state and identify where CT Medicaid is performing well and where there are areas of opportunity.

HCBS Options for Innovation: The project team utilized the same criteria of service cost, health care quality and outcomes, and member experience to identify models of care for further exploration based on the emerging body of evidence.

3. Current State Analysis

The project team first conducted a current state analysis to determine how the current delivery system is functioning, with the goal of identifying where the CT Medicaid program is achieving high levels of value and areas that are under delivering value. Second, the team listened to stakeholder feedback on what CT Medicaid does well and where there are areas for improvement. Finally, the team performed a detailed current state analysis within the HCBS service category, based on direction from DSS.

3a. Current Delivery System

Current Delivery System Analysis: Summary

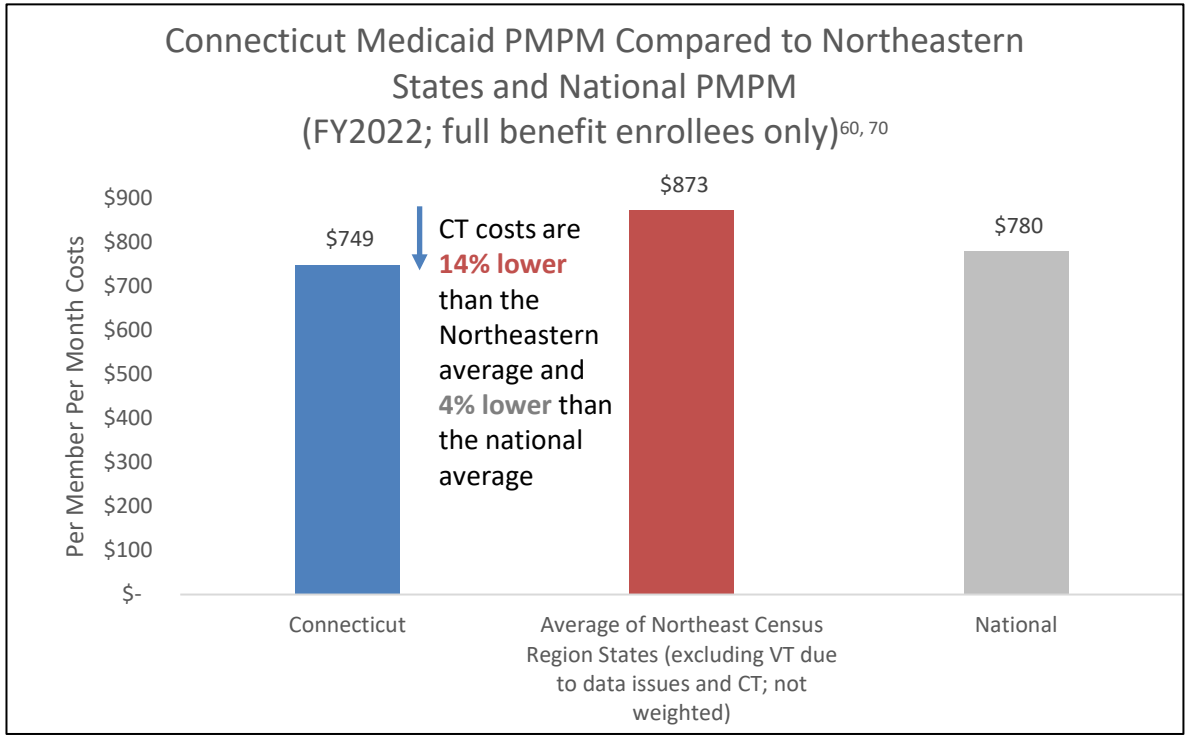
Key Takeaways

- CT per-enrollee Medicaid costs are **lower** than other states, except for spending on individuals with disabilities and older adults.
- CT Medicaid performed **above** the median for more than 80% of Medicaid core set quality measures in behavioral health, maternal health, dental services. However, beneficiaries rate their health care **less positively** than in other states, and CT performs **lower than median** on 53% of core set quality measures related to acute and chronic conditions.
- Findings suggest CT Medicaid could more effectively coordinate patient care to improve acute/chronic disease management and beneficiary care experience.

Criteria	Performing Well	Opportunity for Improvement / Further Exploration
Service Cost	• CT Medicaid's overall **per-enrollee expenditures are lower than** other Northeastern states. • The state's per-enrollee Medicaid costs have increased more slowly than medical inflation.	• CT Medicaid's per-enrollee **spending on individuals with disabilities and older adults is much higher** (93% and 65%, respectively) than other Northeastern states.
Member Access and Experience	• Access to care measures, including specialty care, are comparable to national benchmarks and have been stable over time.	• Beneficiaries rate their health care less positively than national benchmarks, and scores have declined over time.
Health Care Quality and Outcomes	• In 2022, CT Medicaid performed better than the median score for **around 70%** of the national Medicaid adult and child quality measures established by the Centers for Medicare & Medicaid Services (CMS). • For quality measures focused on **behavioral health, maternal health, dental and oral health, and primary and preventive care**, CT Medicaid performed better than the median state score for **more than 80%** of measures.	• In 2022, CT Medicaid performed worse than the median state score for approximately 53% **of quality measures focused on acute and chronic conditions (both child and adult).** • CT Medicaid has **declining performance on select behavioral health measures** related to follow-up treatment after emergency room visits.
Provider Impact	• Providers have been consistently satisfied with CT Medicaid and provider participation in Medicaid has modestly increased.	• From 2021-2022, CT Medicaid primary care provider participation decreased by ~1%.
State Administrative Impact	• CT's Medicaid administrative costs (3.8% of total Medicaid expenditures) are substantially below estimates in managed care states (~9.4%).	N/A

CT Medicaid's Overall PMPM Costs are Lower Than Average

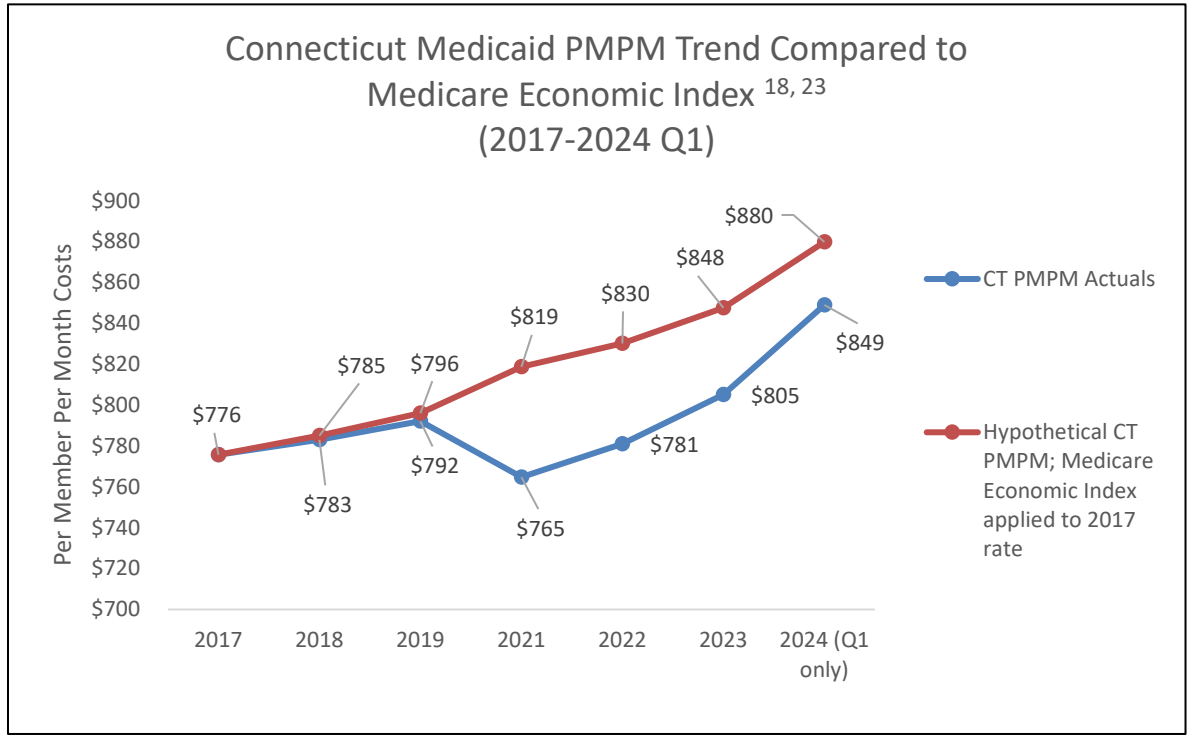
CT Medicaid PMPM expenditures are lower than other Northeastern states…



Notes:

- CT Medicaid PMPM was also below the Northeast average pre-pandemic.
- CT aggregate Medicaid spending as a % of the state budget is also well below that of other nearby states (22% in CT compared to 29% for other Northeastern states in FY2023).

…and CT Medicaid PMPM cost growth since 2019 has tracked below medical inflation.

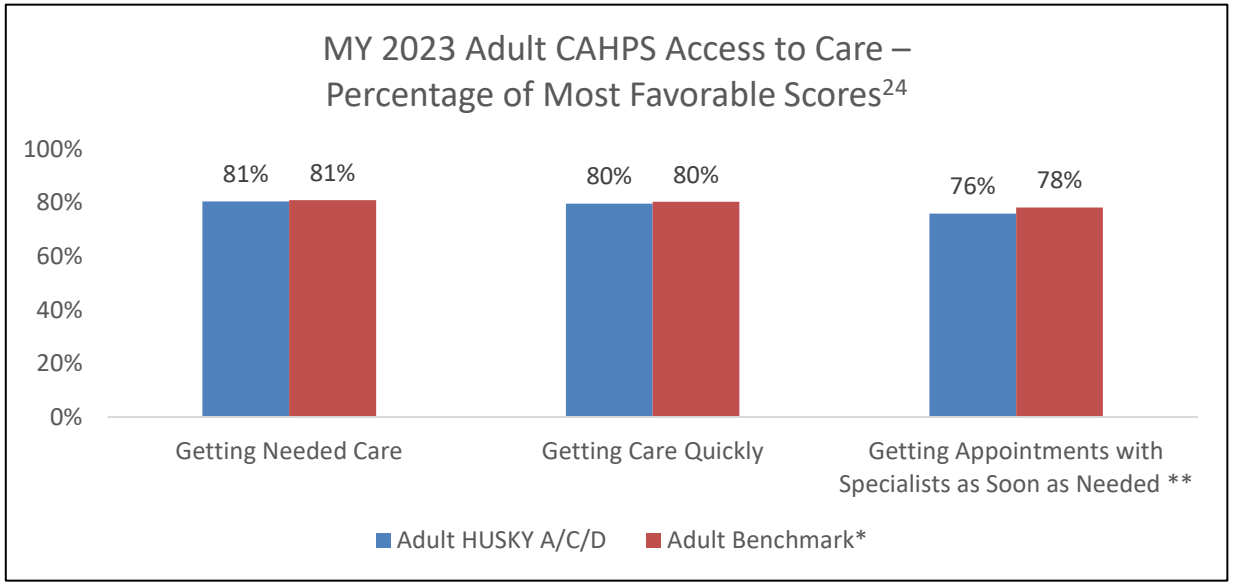


Notes:

- Other PMPM analysis prepared by the State incorporates pharmacy rebates; while figures are slightly different between these two analyses, the overall trend is similar.
- 2020 data not available.

CT Medicaid Members Report Average Access Levels but Worse Than Average Health Care Experience

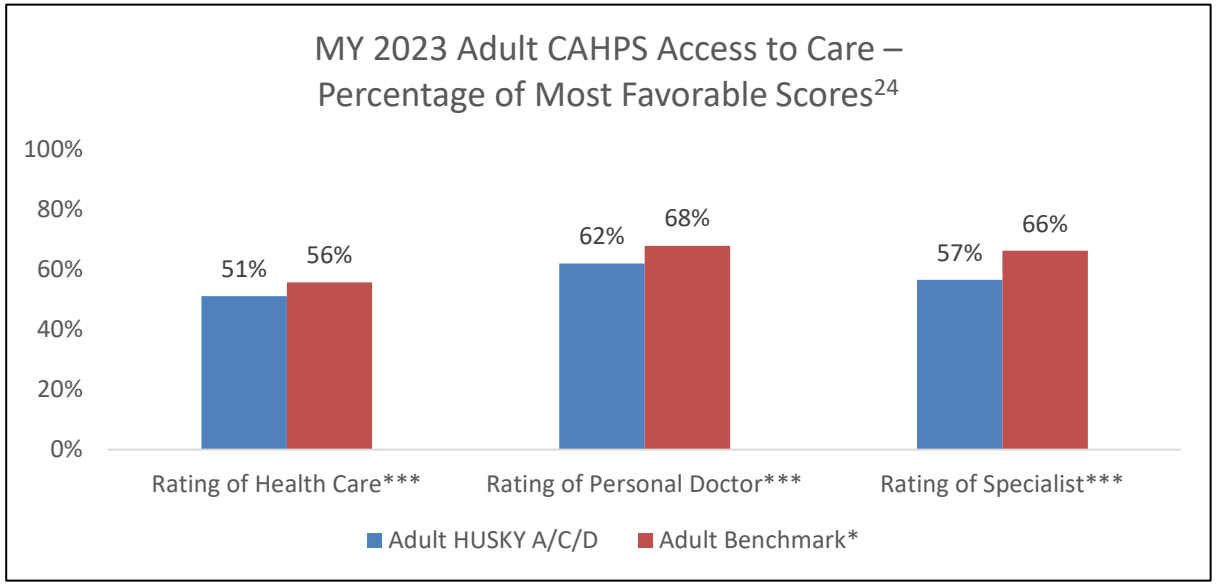
Consumer Assessment of Healthcare Providers and Systems (CAHPS) data show that access to care, including specialty care, is comparable to national benchmarks in Measurement Year (MY) 2023^ and stable over time.



- MY 2023 CAHPS scores for children are similar – CT Medicaid performance is comparable to national benchmarks.[24]
- **Mystery Shopper data** (provided by DSS) also show similar findings – overall appointment offer rates to HUSKY members are stable between MY 2022 and 2023 (55% and 59%). However, primary care providers were less likely to offer a primary care appointment within 4 weeks compared to specialty care providers in MY 2023 (32% vs 41% on average).[69]

Notes:
^ MY 2023 CAHPS are conducted in January-May 2024 and questions typically ask respondents about their experience in the last 6 months.

However, beneficiaries rate their health care experience less positively than national benchmarks, and scores have declined over time.



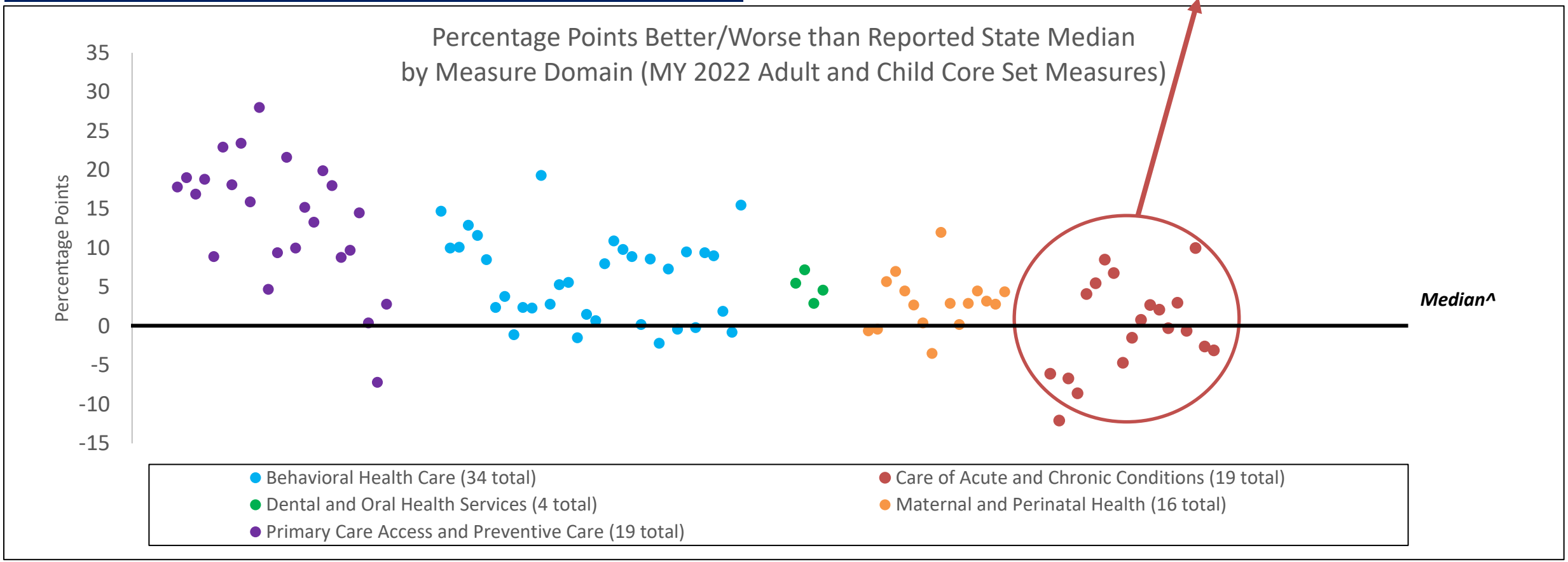
Adult CAHPS Composite Measure	CT Medicaid Performance				National Benchmark PP change '21 to '23
	MY 2021 Summary Rate	MY 2022 Summary Rate	MY 2023 Summary Rate	CT PP Change '21 to '23	
Rating of Health Care**	61.8%	52.6%	51.1%	-10.7	-3.0
Rating of Specialist**	71.0%	68.5%	56.5%	-14.5	-2.8
Rating of Personal Doctor**	65.6%	67.5%	62.0%	-3.6	-1.3

Notes:
* Benchmarks shown here are the National Committee for Quality Assurance (NCQA) Quality Compass [71] benchmark (as reported in DSS provided CAHPS data).
** Getting Appointments with Specialists is included in the Getting Needed Care Composite Measure.
*** Percentage of scores with a rating of 9 or 10 out of 10.
PP above means Percentage Point

Connecticut's Quality Scores Suggest Opportunities to Improve Care Management for Individuals with Acute/Chronic Disease and Behavioral Health Conditions

While CT Medicaid performed better than the median^ state score for more than 80% of Medicaid core set measures in behavioral health, maternal health, dental services, and primary care…

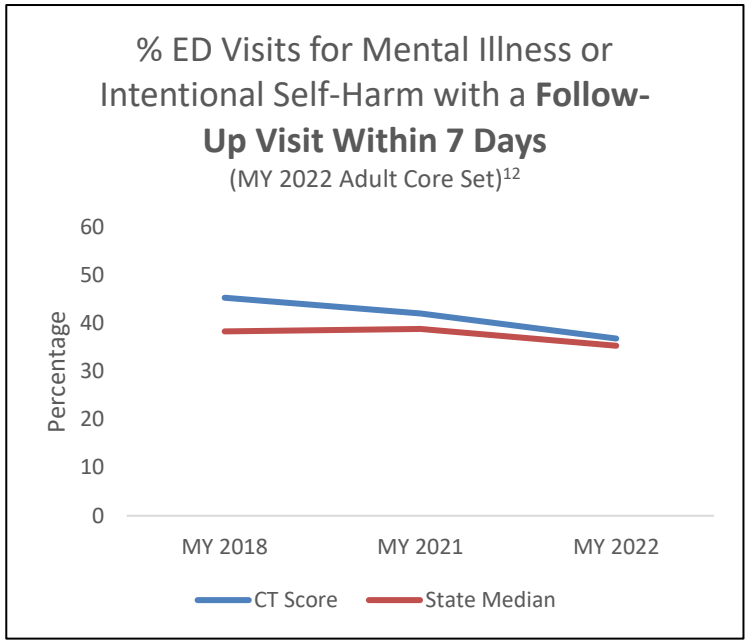
…the state performed below the median on 53% of core set measures focused on acute and chronic conditions.[12]

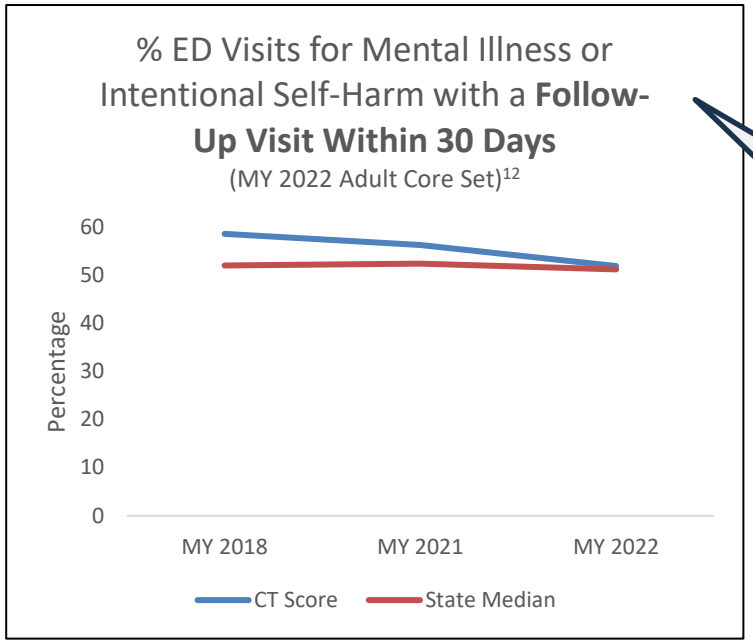


Notes: ^ Median refers to the median of scores reported by other states and collected by CMS for that measurement year.
The comparison to median accounts for measures where a lower rate than median would be considered "better" (e.g., rate of pediatric ED visits per 1,000 beneficiary months).
See Appendix Section 6c. for more details about which measures fell below the median in MY 2022 across these domains.

Connecticut's Quality Scores Suggest Opportunities to Improve Care Management for Individuals with Acute/Chronic Disease and Behavioral Health Conditions

While CT performs above the median for most behavioral health measures, the state has seen declines over time on select adult core set measures focused on behavioral health, outpacing changes in the median score reported by other states to CMS.





For example, CT's score declined by 6.7 pp while median declined by 0.8 over this period.

Less positive performance on management of acute/chronic disease; declining performance on select behavioral health measures requiring coordination across care settings; and declining member experience suggests CT Medicaid could more effectively coordinate patient care, especially for those with significant physical and behavioral health needs.

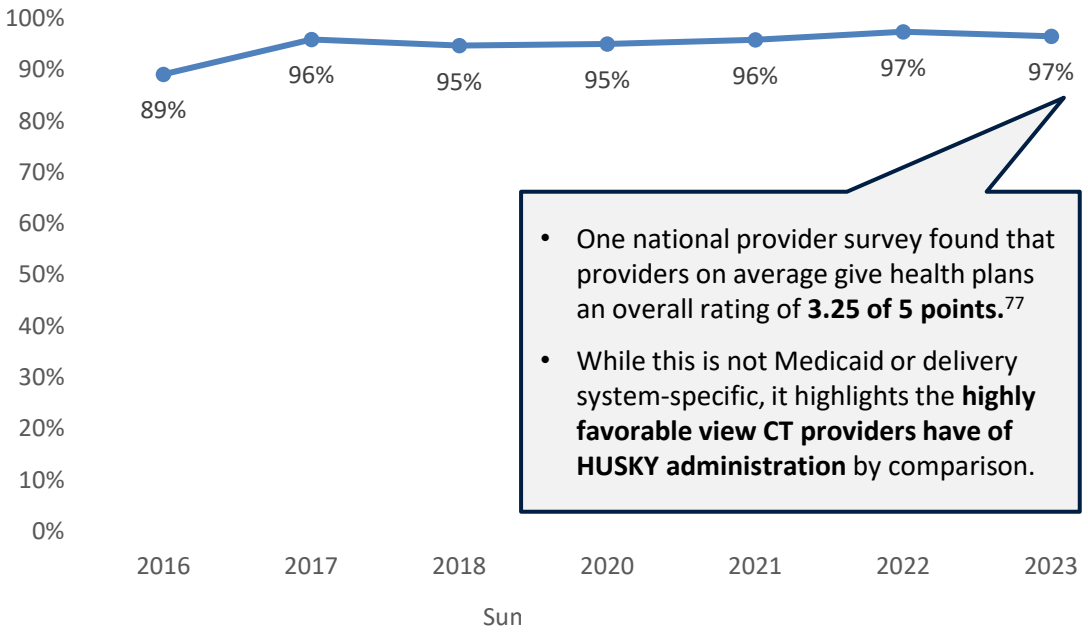
Notes:
* When reviewing trends over time, only included measures that CT reported on and remained consistent (e.g., CMS or measure steward definitions did not change) across measurement years.
** BH Measures on this slide only include Adult.
*** "Other SUD" refers to an episode that does not involve opioids or alcohol (e.g., methamphetamines).
ED means Emergency Department; SUD means Substance Use Disorders

Providers Are Relatively Satisfied with HUSKY Program Implementation and Provider Participation Has Shown Modest Growth

Providers year-over-year have been satisfied with the administration of the HUSKY program.

Provider Satisfaction Survey Summary Rate Scores[82]

Overall, how satisfied are you with the administration of the HUSKY Health program?

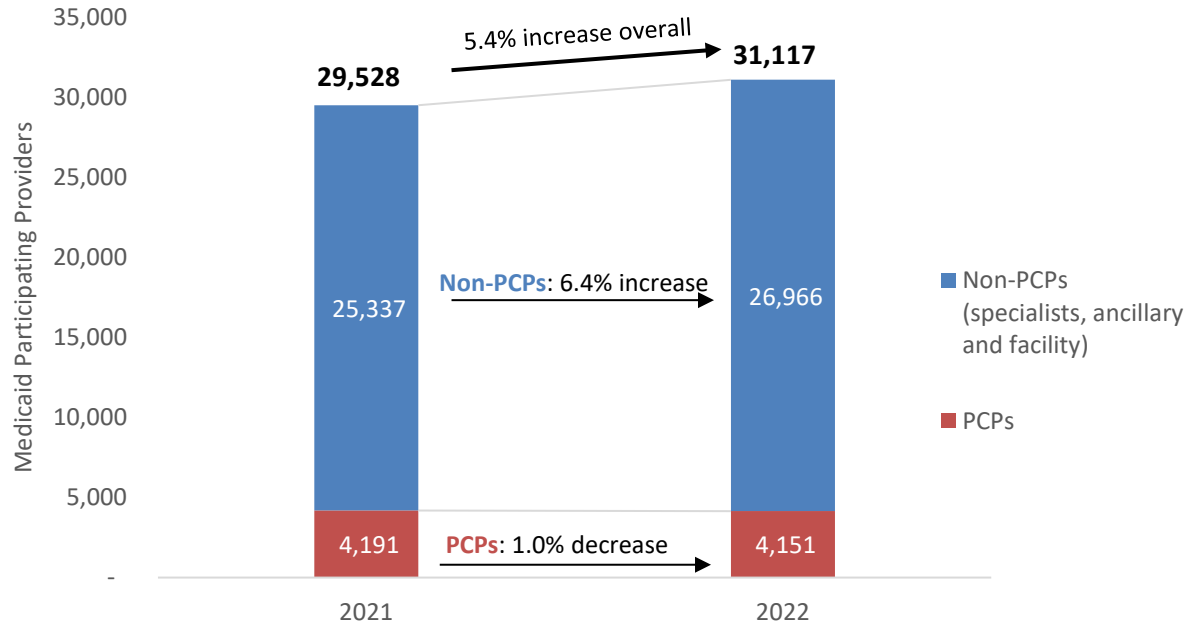


- One national provider survey found that providers on average give health plans an overall rating of **3.25 of 5 points.**[77]
- While this is not Medicaid or delivery system-specific, it highlights the **highly favorable view CT providers have of HUSKY administration** by comparison.

Note:
Summary Rate Scores represent the response options "Very Satisfied" & "Satisfied"

From 2021-2022, CT Medicaid provider participation increased by ~5.4%, driven by an increase in non-primary care providers.

Percent Change in Medicaid Provider Participation CY 2021 - 2022[81]

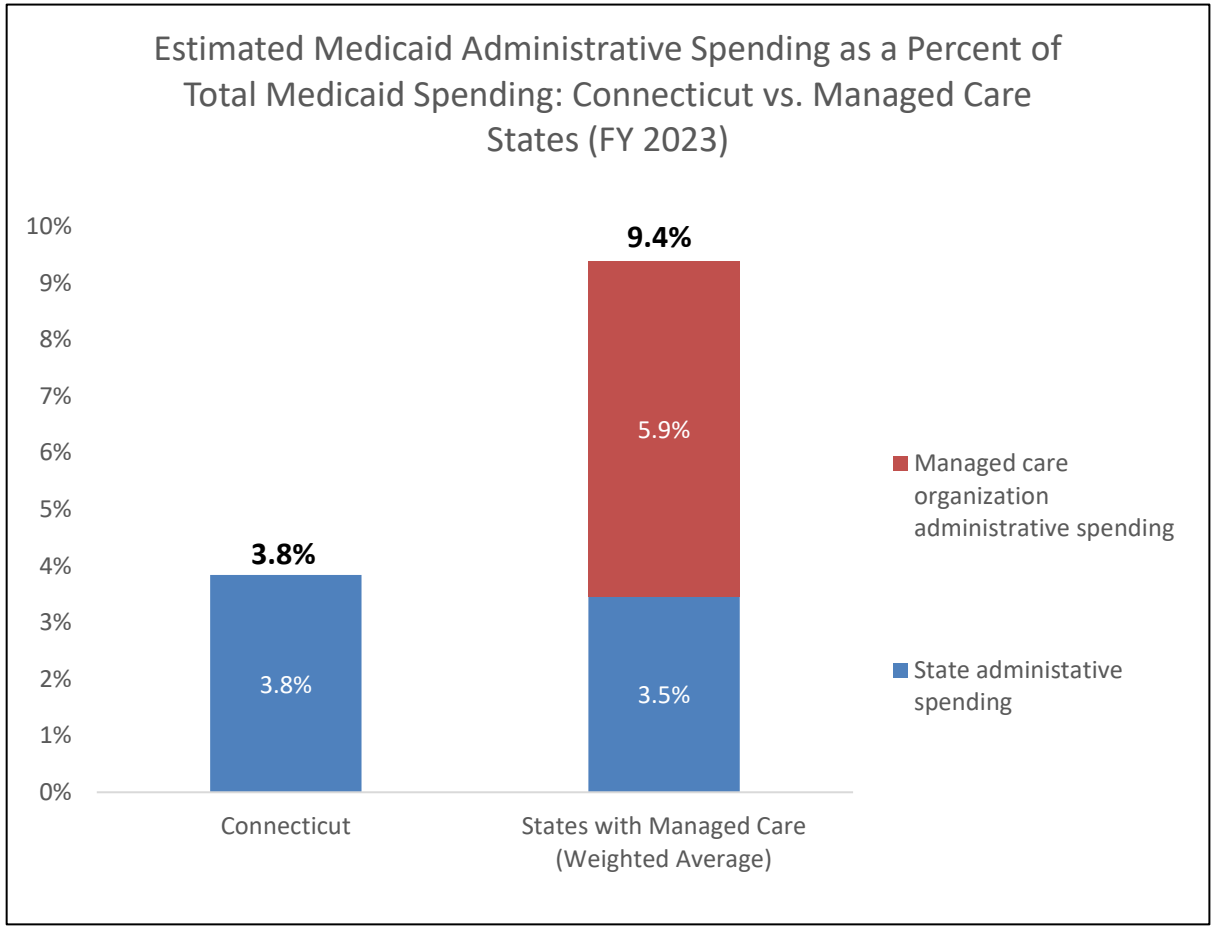


Note:
PCP means primary care provider; CY means Calendar Year

CT Medicaid Administrative Spending Is Substantially Lower Than Managed Care States

CT's Medicaid administrative costs (3.8% of total Medicaid expenditures) are substantially below estimates in managed care states, after accounting for both state and managed care organization (MCO) administrative spending. Connecticut should consider the ongoing administrative costs to operate and oversee comprehensive managed care and whether savings on service costs (see Managed Care Analysis) would offset the additional spending.

- If CT's total administrative spending equaled the managed care state average (9.4%), the state's annual non-federal Medicaid expenditures would **increase by ~$240 million.**
- Estimates include **ongoing administrative costs only** and do not account for (1) potential offsetting managed care medical cost saving or (2) start-up costs for initial program development and implementation.



Estimation methodology notes:

- State administrative spending percentage was calculated based on MACPAC data for each state. [58]
- State administrative spending for managed care states represents a weighted average across the states included in Milliman's managed care report,[75] weighted by total Medicaid expenditures per state from MACPAC. [58]
- MCO administrative spending is estimated by (1) taking the sum of the administrative loss ratio and the underwriting ratio in the Milliman managed care report;[75] and (2) multiplying that sum by managed care spending as a percent of total Medicaid spending for managed care states, from KFF.[40]

Stakeholder Engagement Themes

CT Medicaid held a series of three engagement sessions with key stakeholders to discuss successes and opportunities of the CT Medicaid program: a recipient engagement session on 10/30/24, provider engagement on 11/7/24 and a session with the Medical Assistance Program Oversight Committee (MAPOC) on 11/8/24. Written feedback was also considered as an input.

Themes on what CT Medicaid Does Well

- Administrative Services Organization (ASO) structure is perceived to have multiple benefits including enabling innovation, improving transparency and division of labor that leads to efficiency gains and better care
- DSS takes a transparent and collaborative approach with multiple avenues for stakeholder engagement
- Strong access and coverage, particularly through the pandemic and public health emergency unwinding
- One uniform set of rules and policies

Themes on what CT Medicaid Could Improve

- Strengthening provider participation and member access through increased reimbursement rates (particularly behavioral health)
- Moving beyond access conversations to focus on quality and outcomes
- Improving transparency, data availability, and information to enable care coordination and data-driven decisions
- Shifting site of service and reducing unnecessary hospitalization
- Improving access to community-based Long Term Support Services (LTSS)
- Addressing upstream drivers of health and health inequities

Key Takeaways for Project

- Stakeholders expressed a high degree of satisfaction related to their experience with the existing ASO model
- A majority of stakeholders expressed fear, doubt, or were opposed to shifting to managed care
- Stakeholders across the board expressed the need to raise reimbursement rates to improve access and quality of care
- Consistent across conversations was the desire to focus on quality and outcomes, driven by data
- Stakeholders expressed the need to continue to enhance care coordination/care management for recipients moving between settings and/or recipients that could benefit from more preventive community-based services

3b. Area for Innovation: Home and Community Based Services (HCBS)

Area for Innovation (HCBS) Current State Summary

CT Medicaid's per-enrollee spending on individuals with disabilities and older adults—the **groups that use most HCBS—is much higher than other Northeastern states.**

CT Medicaid's aggregate and per-enrollee HCBS spending—while large as a share of Medicaid spending—has been relatively stable over time. However, **specific HCBS programs** are showing recent signs of substantial cost increases.

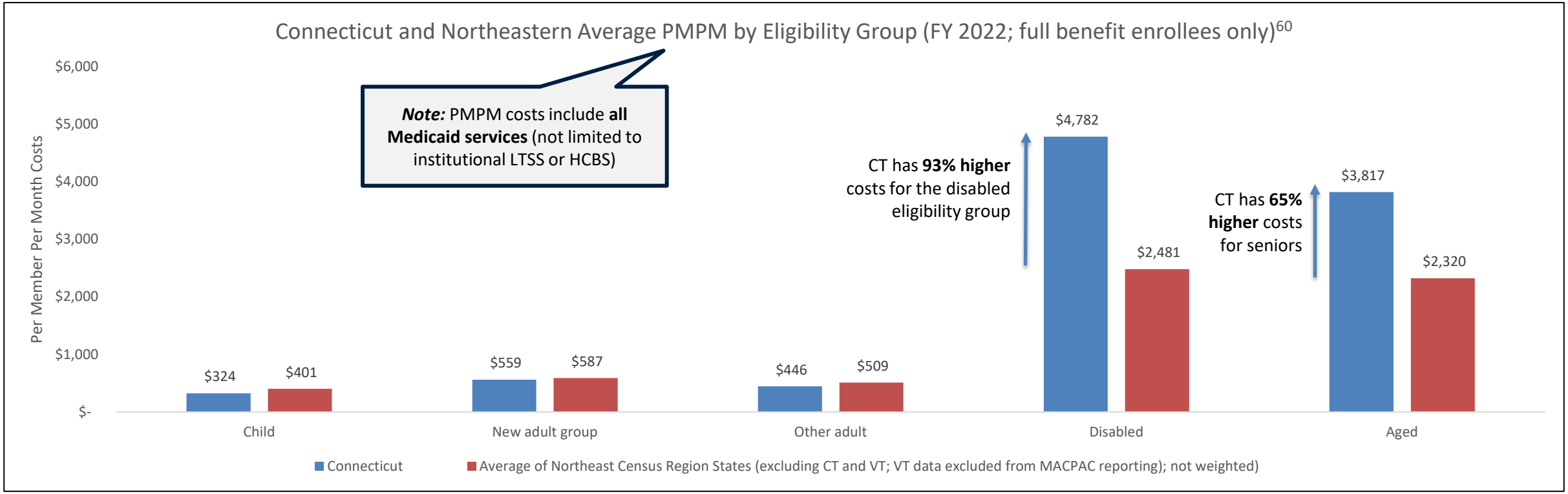
Despite high per-enrollee spending, **the state's performance on HCBS quality, member experience, and access is average compared to other states.**

Factors driving CT's higher than average per-enrollee spending on individuals with disabilities and older adults need additional analysis. Several hypothesis emerged from discussions with DSS staff, including that:

- To ensure beneficiaries can access needed services in the appropriate setting, CT has a more expansive eligibility and/or service array for home-and-community based (HCBS) waiver services;
- To address workforce shortages and improve access, CT has increased wages for personal care attendants (PCAs) and/or made other provider investments; and
- With HCBS programs excluded from ASO contracts, there may be care management gaps, especially among dual eligible beneficiaries.

Connecticut Pays Much More than Nearby States for Individuals with Disabilities and Older Adults

CT Medicaid's per-enrollee spending on the disabled and aged eligibility groups – which disproportionately include Long Term Services and Supports (LTSS) users – is substantially higher than average compared to other Northeastern states.

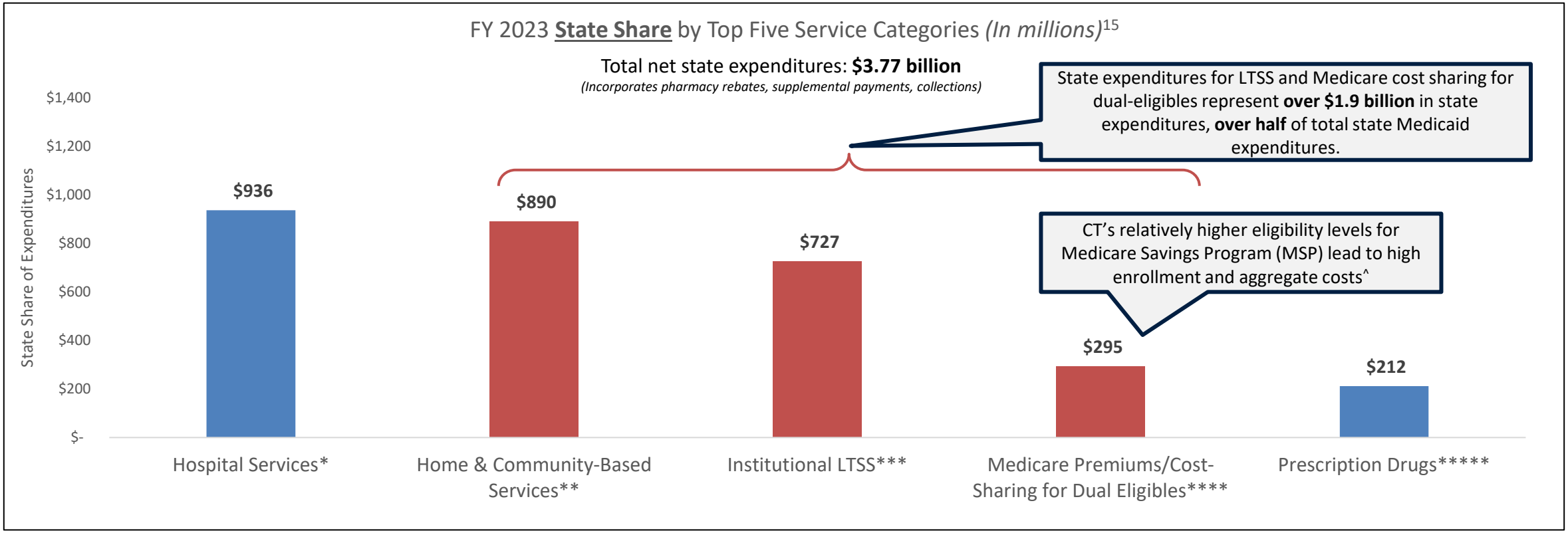


Notes:

- High relative Medicaid per-enrollee spending for the Disabled and Aged eligibility groups is consistent with pre-pandemic trends. Includes total Medicaid spending for full benefit enrollees only (i.e., those receiving limited benefits, such as partial benefit dual-eligibles or those with coverage for emergency services only, are excluded). This ensures that differences in partial benefit eligibility and enrollment across states do not impact results.
- Eligibility groups are defined by MACPAC, based on claims data. The Aged eligibility groups include all full benefit enrollees over 65, including those who are eligible for Medicaid based on their disability status. The "New Adult Group" includes adults eligible under 1902(a)(10)(A)(i)(VIII) of the Social Security Act (i.e., the adult expansion population).
- Per-member per-year MACPAC figures were converted to per-member per-month figures.
- FY means Fiscal Year

LTSS and Medicare Premiums/Cost-Sharing Account for Almost Half of State Medicaid Expenditures

HCBS is the second largest category of CT Medicaid program expenditures, as measured by state share.



Notes:

^ CT has the second highest MSP eligibility threshold in the country (after DC) and has the greatest percentage of dual-eligible members that have "limited benefits" (i.e., MSP) compared to dual-eligible members with full-benefits.[56, 57]

*Includes hospital inpatient and outpatient base and supplemental payments.

**Includes 1915(c) waivers,1915(k) Community First Choice (CFC) services, and home health services.

***Includes nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility.

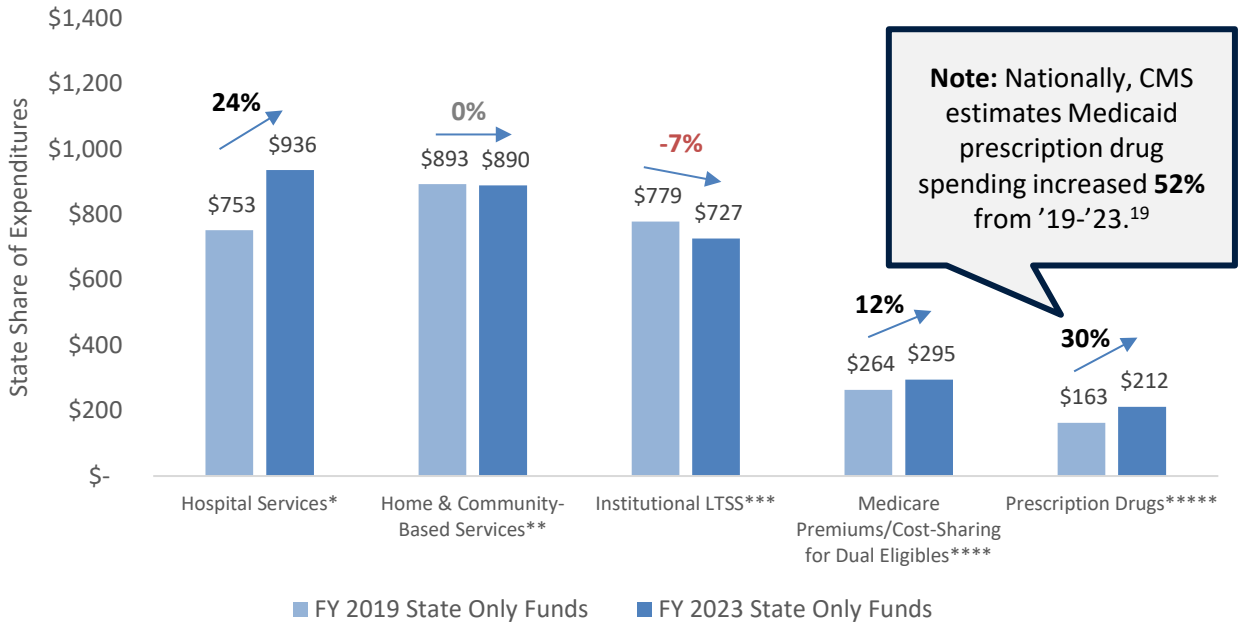
****Includes Medicare Part A and B premiums and cost sharing.

*****Includes national and state drug rebate offsets.

High Overall HCBS Spending is Compounded by Substantial Program-Specific Cost Growth

HCBS spending, while substantial in total, has been relatively stable over time.

Change in State Share by Top Five Service Categories (FY 2019 - FY 2023) *(In millions)*[15]

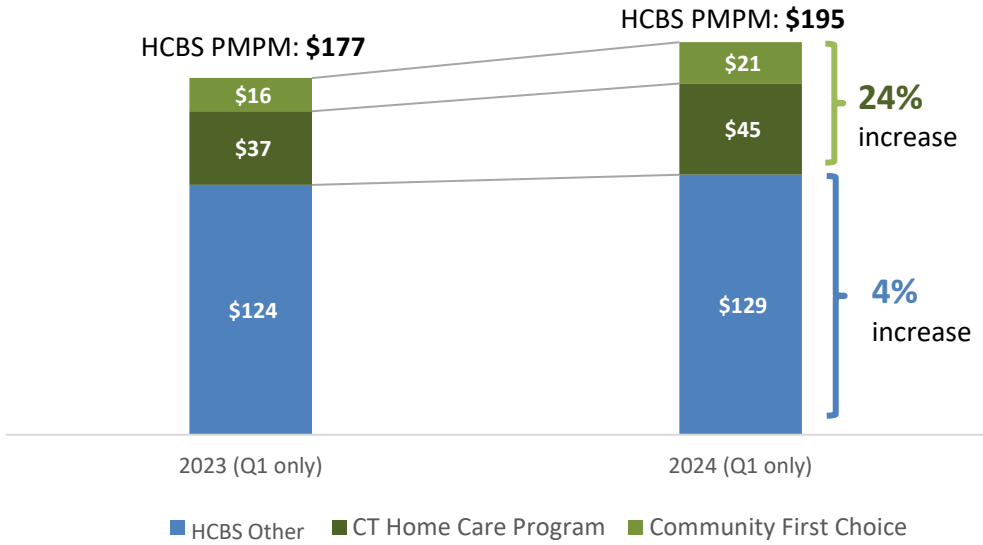


Note: Nationally, CMS estimates Medicaid prescription drug spending increased **52%** from '19-'23.[19]

Notes:
*Includes hospital inpatient and outpatient base and supplemental payments.
**Includes 1915(c) waivers,1915(k) CFC services, and home health services.
*** Includes nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility.
****Includes Medicare Part A and B premiums and cost sharing.
*****Includes national and state drug rebate offsets.

However, recent data show early signs of large HCBS program-specific cost increases.

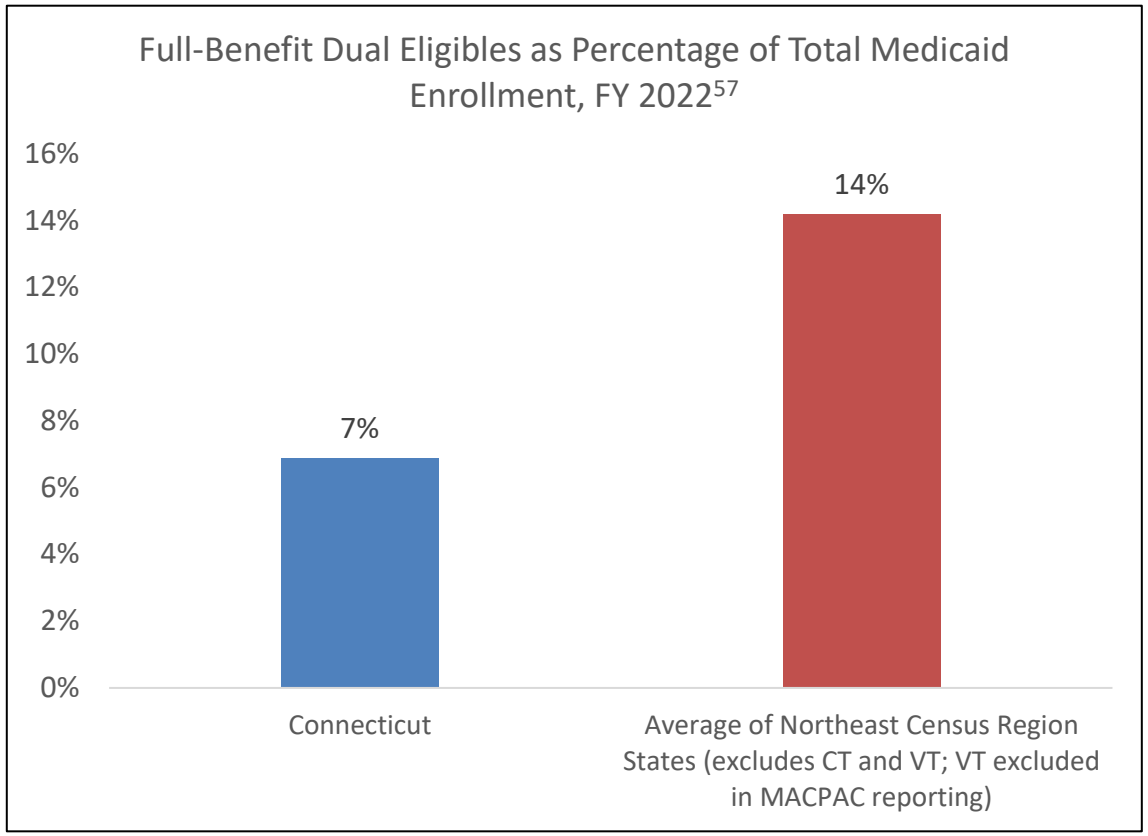
HCBS PMPM by Program Q1 2023 - Q1 2024[23]



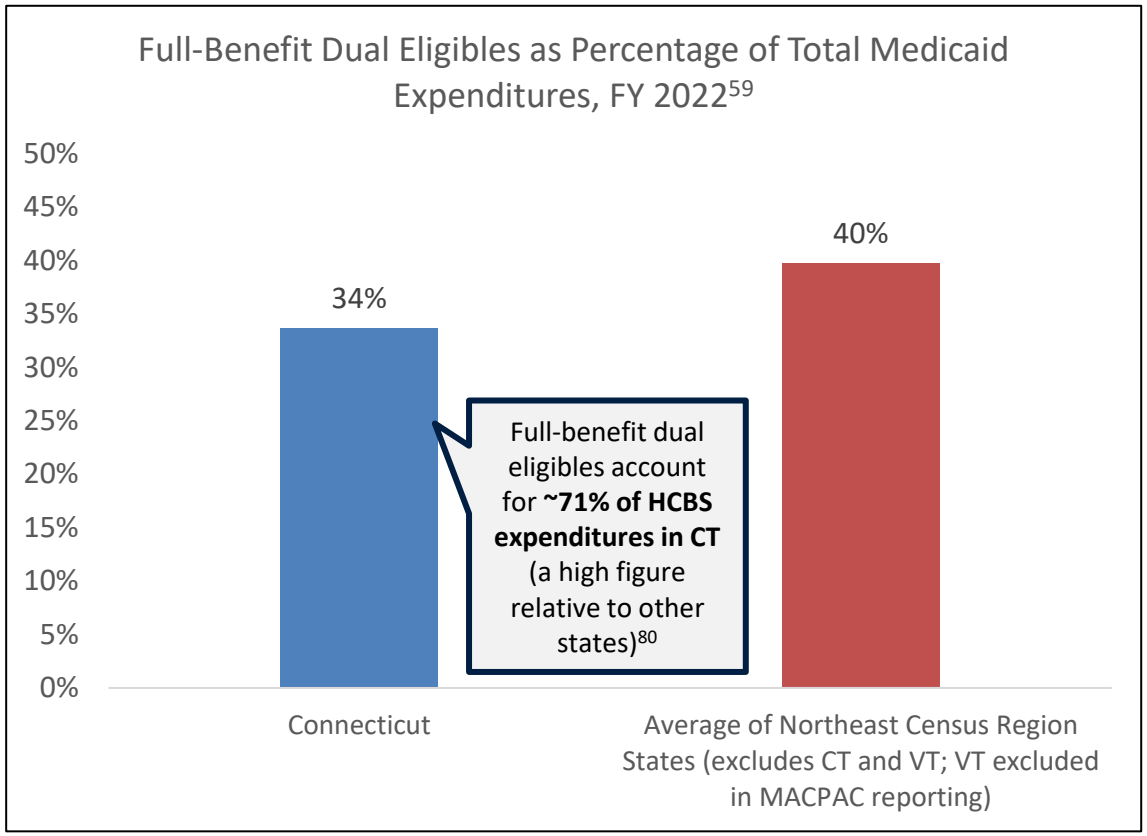
Note: PMPM data from July 2022-June 2023 compared to July 2023 – June 2024 shows similar trends.

Full-Benefit Dual Eligible Beneficiaries Drive CT Medicaid Expenditures Disproportionately Compared to Program Enrollment

Connecticut's full benefit dual-eligible enrollment is half the Northeast average…



Yet full-benefit duals represent near the same percentage of expenditures as other Northeastern states.



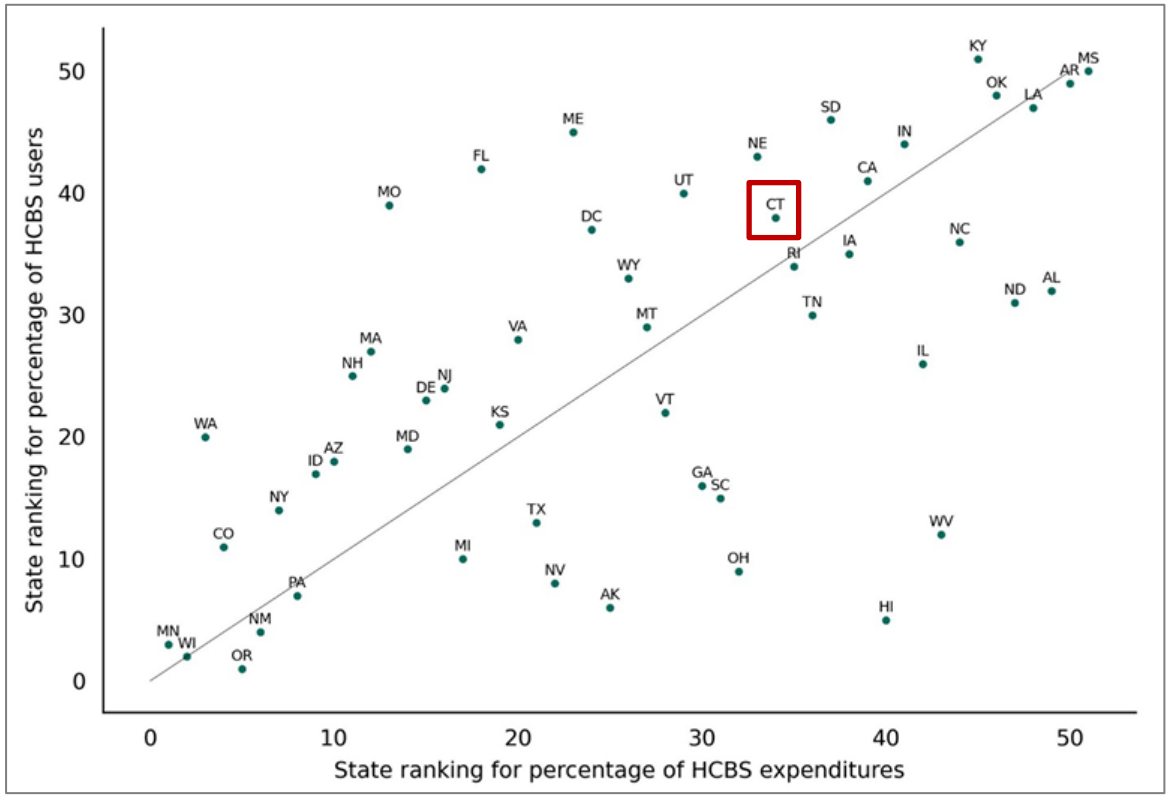
CT Medicaid's spending overall – and HCBS spending in particular – is disproportionately driven by spending on full-benefit dual eligibles, compared to nearby states. **Findings suggest DSS should further evaluate spending on dual eligibles to identify key cost drivers. See slides 37-38 for additional details.**

Connecticut's LTSS Rebalancing is Lower than the Median State, but HCBS Waiver Spending is Higher

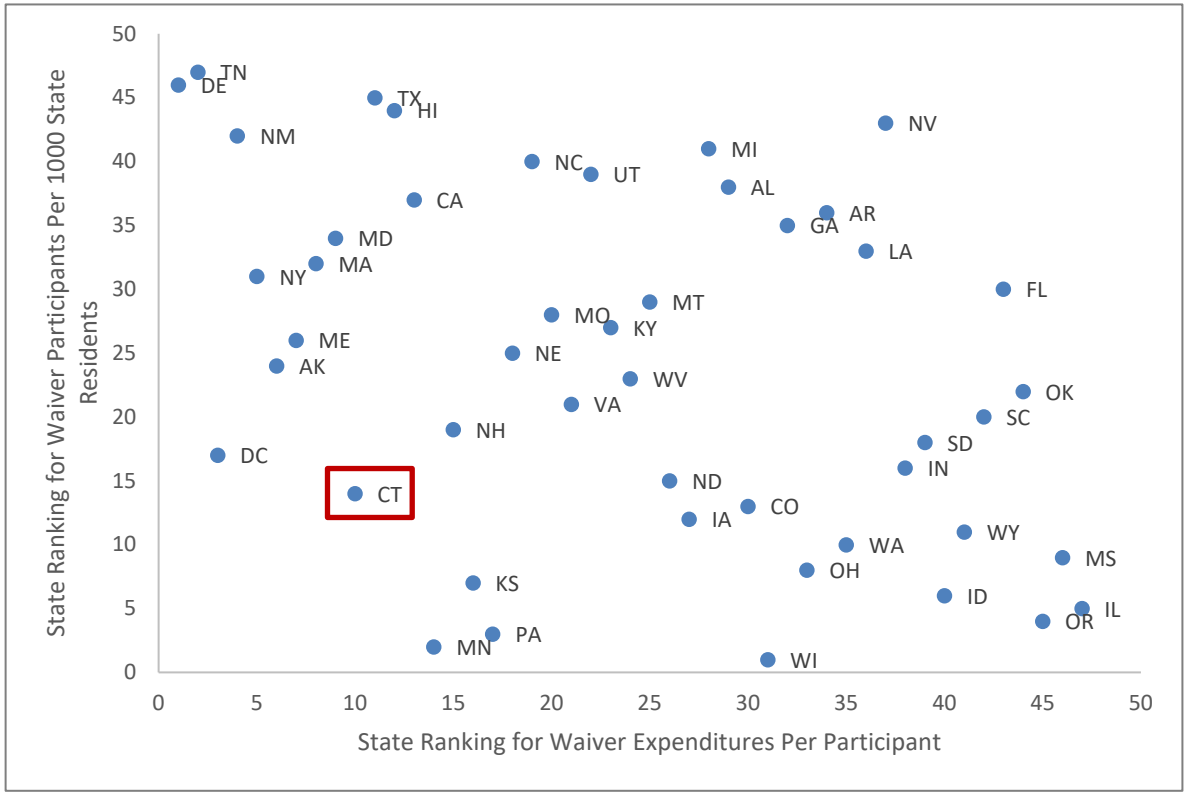
Connecticut's LTSS rebalancing—measured by LTSS users and expenditures—is average or slightly below average, suggesting additional opportunities to transition members to the community.

Connecticut's 1915(c) waiver enrollment and expenditures rank in the top quartile across states, which is higher than expected based on average rebalancing ratio.

2022 Medicaid LTSS User and Rebalancing Ratio Rankings by State[67]



2019 Medicaid 1915(c) Waiver Enrollment and Expenditure Rankings by State[17]



Note: In both figures, **lower rankings** represent relatively **high performance**. **High rankings** represent relatively **low performance**.

HCBS Access and Quality Performance is Average Compared to Other States

HCBS access and quality measures are limited. Available indicators suggest that despite CT Medicaid's higher per-enrollee spending on LTSS users, scores on access, choice, and member experience are mostly around average.

Selected Measures from 2023 AARP LTSS Scorecard[1]

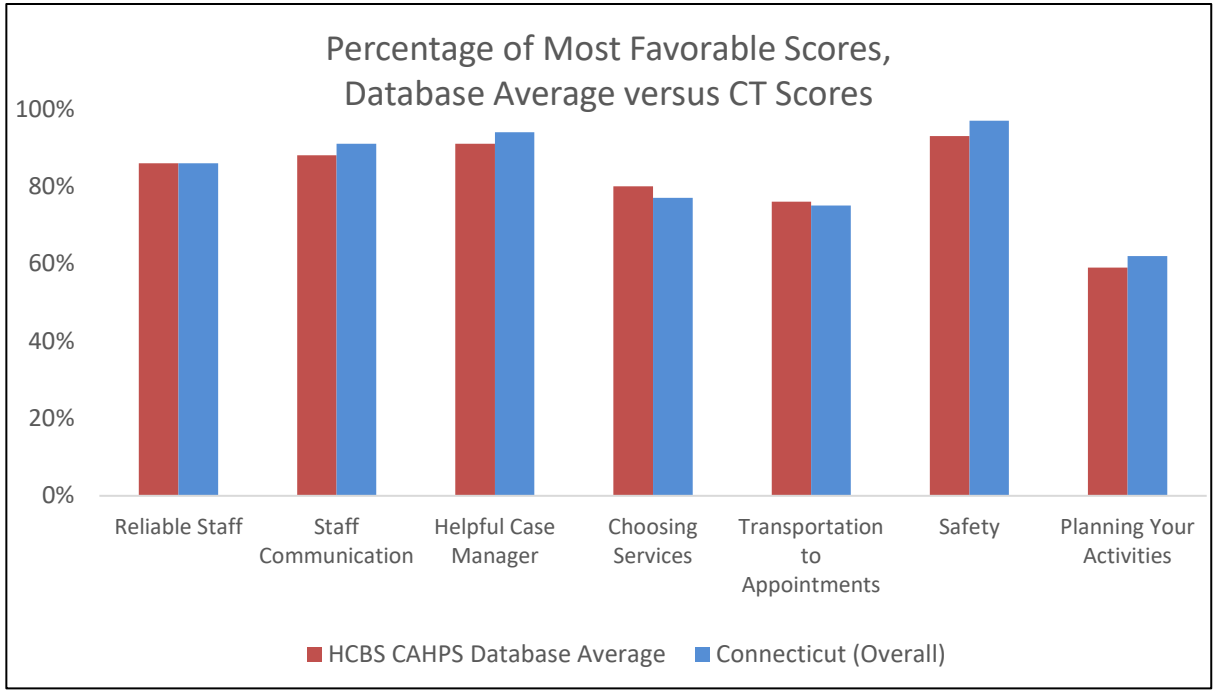
***Key:** Green ranks in top third of states, orange ranks in middle third, and red ranks in bottom third.*

Category	Measure	CT Rank
Affordability and Access	ADRC/NWD Functions	**9**
	Medicaid for Low-Income People with Disabilities	**8**
	Medicaid Buy-In	**13**
Choice of Setting and Provider	Medicaid LTSS Balance: Spending*	**19**
	Self Directed Program Enrollment	**25**
	Home Health Aide Supply	**9**
	Adult Day Services Supply	**27**
	LTSS Worker Wage Competitiveness	**31**

CT's **potentially avoidable hospitalization rate** among full benefit dual-eligible beneficiaries—who use the most HCBS in the state—was **average** compared to national benchmarks.

Notes: *"Medicaid LTSS Balance: Spending" measure uses data from 2020 – older data than used within Section 3b. showing Medicaid LTSS expenditures. See **Appendix Section 6c.** for more information about each measure, including definitions and methodology.
AARP means American Association of Retired Persons; ADRC/NWD means Aging and Disability Resource Center / No Wrong Door

MY 2022 HCBS CAHPS[24]



Scores across HCBS programs are mixed and remain close to the average, with slightly better than average results overall, but slightly worse than average results for people with intellectual and developmental disabilities or substance use disorders.

Note: percentage of most favorable scores means the percentage of people who responded using the "top box" response, e.g., percentage of people who responded "Always" to questions on a scale from "Never" to "Always".

Eligibility, Workforce and Care Management Policies May Contribute to High HCBS Service Costs

In discussions with DSS, staff proposed a number of factors that could be driving relatively high HCBS spending compared to other states, which could be explored further in subsequent phases of work.

Hypothesis 1

To ensure beneficiaries can access needed services in the appropriate setting, Connecticut has both (1) a relatively **low functional eligibility threshold** for HCBS (1915(c)) waivers and (2) a comprehensive set of HCBS **waiver benefit packages**. Coupled together, these factors could lead to relatively high per-enrollee and aggregate costs.

Supporting Evidence

- Percent of CT HCBS utilization and expenditures attributable to 1915(c) waivers is much larger than figures nationally.[89]
- Number of 1915(c) waiver participants per thousand state residents and average waiver spending per waiver participant were above 75th percentile nationally.[62]

Hypothesis 2

To address workforce shortages and improve access, Connecticut has **increased wages for Personal Care Attendants (PCAs)** providing services under consumer-directed models, which may also underlie significant HCBS costs compared to nearby states.

Supporting Evidence

- The recent PCA labor agreement increases wages by **26%** from 2024 to 2026.
- The prior PCA labor agreement increased wages **12%** from 2022 to 2024.

Hypothesis 3

Connecticut provides **minimal care management for dual-eligibles and other populations using LTSS**. In other states,* integrated care and complex care management can reduce Medicaid costs by (1) transitioning utilization from institutional to community-based care, and (2) reducing avoidable hospital utilization (for non-dual eligibles, where costs accrue to Medicaid).

Supporting Evidence

- Connecticut does not have any integrated care delivery models for duals (e.g., FIDE-SNPs, HIDE-SNPs or PACE programs) or deliver LTSS through managed care.
- In addition, current ASO model—which does provide care management for physical and behavioral health services—does not include most LTSS.

* 14 states offer FIDE-SNPs,[20] 16 states offer HIDE-SNPs,[20] and 32 states offer PACE programs[2] *(states include DC)*

Note: Options analysis focuses on potential care management/ care integration solutions

4. Managed Care and Area for Innovation Analysis

The project team then evaluated managed care as a potential delivery system reform option based on the evaluation framework. In addition, the project team assessed potential options for innovation within HCBS.

4a. Managed Care Summary

Managed Care Analysis: Background

Because of the substantial variation in program design across managed care states, national studies may not capture the impact of program design choices on cost, quality and / or access outcomes. State-specific research may not translate across states.

- **The literature on MMC and its effectiveness on cost, quality, and access is limited for several reasons**.
  - First, many studies are observational and do not use experimental designs to evaluate cause-and-effect; only some studies have been able to leverage natural experiments to approximate randomization – so while we limited the evidence included in this report to peer-reviewed or reputable sources, we do not weigh each article's methodological rigor.
  - Second, **states make different design choices in managed care related to network adequacy, covered populations and benefits, payment rates, care management, and other program elements to prioritize access, outcomes and/or cost containment.** As a result, state-specific or population-specific research may be the most insightful, but may not always apply to other states where program design choices differ. (More details about design choices on slide 34).
- **Our methodology to assess these articles is also limited** – because the available literature varies substantially by chosen methodology, population, and outcome variables, there may be different ways to categorize each article and interpret its conclusions. For example, only studies that focus specifically on the LTSS population are included in our review of Managed Long-Term Services and Supports (MLTSS) evidence, but it is possible that studies evaluating the impact of managed care on chronic disease management more broadly (e.g., Section 6a) could also include people who use LTSS.
- Overall, while there is strong evidence in specific contexts from which we draw directional conclusions, there is no conclusive evidence from robust (e.g., randomized or quasi-experimental) national studies that managed care will **always** improve or reduce beneficiary access, experience, quality, or costs.

Managed Care Analysis: Evidence Review Methodology

The project team combined evidence from the most recent published MMC literature review (from 2020) with an original review of studies from the past five years to assess the evidence of managed care effectiveness on cost, quality, and access.

1. **Gather Evidence:**
   a. Close review of most recent peer-reviewed literature review from 2020[59]
   b. PubMed search of more recent published, peer-reviewed literature on managed care
   c. Additional white paper and institutional research (e.g., CMS)
2. **Review Evidence:**
   a. Review of >68 unique articles on managed care impact
   b. Identify and remove exclusions*
   c. Options analysis leverages 53 published articles and studies
3. **Connect Literature to Current State:**
   a. Categorized each article by criteria (e.g., quality) and subpopulation (e.g., LTSS users) and tagged each article's takeaways with a review category
   b. Tabulated a quantitative roll up of the tagged articles by criteria to indicate how many articles indicated on of the above categories
   c. Assessed impact of managed care for each criteria and specifically on the areas of opportunity or further exploration identified in the current state analysis

MMC Literature Review Categories: Positive, Negative, Mixed, or No Impact based on how the findings impacted framework criteria in the current state.

** Note: We removed qualitative studies from the quantitative assessment of managed care effectiveness in the report, removed articles that evaluated the impact of tools within managed care (e.g., state network adequacy standards for managed care plans to improve access) rather than a comparison of delivery models, and removed older articles where authors updated the same analysis but with newer data.*

Managed Care Analysis: Key Takeaways

The evidence does not provide certainty that comprehensive MMC is likely to lower overall Medicaid costs and improve health care access and outcomes for the CT Medicaid program. However, some evidence suggests MLTSS can improve access and lower costs for LTSS users.

	Current State	Key Question	Evidence	Findings and Implications for CT Medicaid
Costs (Services and Admin)	• CT Medicaid per-enrollee costs are **lower** than other Northeastern states. • However, state Medicaid costs have recently **exceeded** budgeted appropriations, putting pressure on the state budget.	Does MMC reduce state Medicaid program costs?	**Positive (Service Costs)** **Mixed (Overall)**	• MMC often lowers service costs, typically by reducing hospital utilization. • A study of one state found that MMC reduces state Medicaid costs after accounting for MMC administrative spending. • MMC does not appear to improve budget predictability.
Member Access and Experience	• CT Medicaid beneficiaries' access to care is **average** compared to other states and has been relatively stable.	Does MMC increase access to services?	**Mixed**	• While overall access evidence is mixed, studies point towards a decrease in primary care and outpatient access related to MMC.
	• CT Medicaid member experience scores are **lower than average**.	Does MMC improve member experience?	**No Impact**	• MMC appears to have no impact on member experience.
Health Care Quality and Outcomes	• CT Medicaid performs **better** than median on most Medicaid quality measures reported to CMS but performs **worse** than the median on many measures related to acute/chronic disease management.	Does MMC improve health outcomes for beneficiaries with acute and chronic diseases?	**Mixed**	• Evidence of MMC impact on acute and chronic disease management—including on ED visits—is mixed. • Evidence review identified no studies showing MMC improves behavioral health outcomes.
Provider Impact	• Provider satisfaction is **high**, and participation in CT Medicaid has been relatively **stable**.	Does MMC increase provider satisfaction?	**Negative**	• Some evidence finds a decrease in provider satisfaction after MMC implementation.
LTSS Users	• CT Medicaid per-enrollee spending on individuals with disabilities and older adults is **higher** than other Northeastern states. • Most member experience / outcome measures for HCBS users are **average**.	Could MLTSS control costs for LTSS users while improving (or not harming) quality, access, and outcomes?	**Positive (Cost and Access)** **Mixed (Quality)**	• Some evidence suggests MLTSS can control costs while improving Medicaid LTSS rebalancing from institutional to community-based services and reducing HCBS waiting lists. • Mixed evidence on whether MLTSS improves health outcomes.

State Design Choices Impact Managed Care's Effectiveness in Addressing Costs, Access, Outcomes

States can use different levers to impact costs, quality, and access in a managed care delivery system, including:

- **Covered Populations:** States sometimes exclude certain populations from managed care.
- **Benefit Design:** States can carve in or carve out benefits from managed care (e.g., HCBS waiver programs or retail pharmacy).
- **Capitation Rate Development:** States have flexibility to set managed care capitation rates within federal actuarial soundness guardrails.
- **Plan Withholds and Incentives:** Some states withhold a certain percentage of premium to ensure plans meet certain metrics, pay plans quality incentives based on quality performance, or change beneficiary auto-assignments based on quality performance.
- **Limits on Administrative Spending:** Most states require a minimum Medical Loss Ratio (MLR) and a remittance back to state if plans go beyond that minimum.
- **Directed Payments:** Some states require plans to make additional payments to certain providers to improve access.
- **Utilization Management:** States can set parameters on how plans can implement utilization management strategies (e.g., prior authorization criteria).
- **Network Adequacy Requirements:** While there is a federal baseline, states can hold plans to different standards for network adequacy (e.g., certain number of in-network primary care offices within a certain time and distance to enrollees).*
- **Care Management:** States can require plans to implement robust care management strategies to engage in care and better connect enrollees to services.
- **Quality Improvement.** States are required to establish a quality strategy that informs contract design and reporting requirements.

Fee For Service (FFS) considerations: Some of the above managed care levers have **equivalent or similar levers in FFS delivery systems**. For example, in Connecticut's current system, DSS is able to make design choices around benefit design and payment strategies.

**Note: effective 2027, CMS will require all states to set maximum appointment wait time standards for certain "routine appointments" (e.g., primary care) in Medicaid and CHIP, with state flexibility to vary standards based on certain criteria (e.g., geography).[94]*

Managed Care Analysis: Implementation Effort

In addition to program design, DSS should consider the breadth of efforts that require upfront investment to implement an effective managed care program.

Implementation Costs Vary Across States

	Design (9-12 months)	Implementation (12-24 months)	Operations (Ongoing)
Program and Oversight	• Define business requirements for needed functions • Identify needed contracts and release procurements (i.e., MCOs, enrollment broker, ombudsman)	• Procure needed vendors • Set up project structure to manage multiple vendor implementations • Employ project status tracking for processes and system build	• Contract amendments and change management • Monitoring liquidated damages, service-level agreements, and corrective action plans • Actuarial support
Technology and Data Architecture	• Assess Medicaid system architecture against managed care needs (i.e. Encounters) • Define technology requirements for needed process changes, data exchanges, reporting	• Refine technology requirements, develop file layouts, and system integration points • Create test plan for unit and system end-to-end testing • Oversee system changes and deployment	• Continued adaptation of technology to meet state/federal requirements • Monitor operational reporting and issue tracking/resolution
Organizational Infrastructure and Staff Capacity	• Identify cross-functional governance structure for business and technology change management • Review organizational structure internally to align with MMC oversight	• Create end user procedures, operational monitoring playbooks, etc. • Complete readiness planning and reviews	• Utilize end user procedures, operational monitoring playbooks
Stakeholder Engagement and Costs	• Collaborate with provider groups on impact analysis and community needs • Develop beneficiary engagement strategy	• Set up single point of issue tracking and resolution among stakeholders, i.e., members, providers, and MCOs • Continue community engagement • Provider capacity building	• Ongoing issue tracking and resolution reporting • Continue community engagement • Claims Runout

Note: Timelines provided are estimates and will differ based on state administrative infrastructure and the MMC program being implemented

4b. Area for Innovation (HCBS) Summary

State Vision and Detailed Analytics Should Guide HCBS Delivery System Reform Strategy and Program Development

Vision

What are the state's HCBS goals and objectives related to cost, quality and access for older adults and people with disabilities?

Analytics

How do specific HCBS programs and services perform on cost, quality and access? Which areas should the state prioritize to achieve goals and objectives?

Strategy and Program Development

Benefits and Services –

- Should new program(s) provide care management services only or also cover some (or all) Medicaid benefits?
- If so, which benefits?

Population(s) –

- Which population(s) should the program(s) serve?
- Will people eligible for both Medicaid and Medicare (duals) be included? If so, will those benefits be integrated?

Delivery and Payment Model –

- Which entities will deliver/coordinate those benefits and services?
- Will the delivery be provider-based or plan-based?
- Will delivery be organized regionally or statewide?
- How will the state pay the entities covering these services for the designated populations (e.g., FFS or a capitated basis)?

! ***Options analysis focuses on improving care management and integration for HCBS users. DSS could also explore other levers to improve efficiency, including adjustments to waiver eligibility, benefits, utilization management and payment rates.***

Analytics Deep Dive: DSS Will Need to Further Evaluate HCBS Current State to Align Delivery System Reform Options with Opportunities for Reform

Component	What We Know	What We Need to Know
Benefits and Services 	• **Per-enrollee spending for HCBS users is high.** CT Medicaid's per-enrollee spending on individuals with disabilities and older adults is higher than other Northeastern states. • **HCBS waivers drive HCBS spending more than in other states.** 1915(c) waiver spending as a percentage of total HCBS expenditures (e.g., state plan, 1915(k), etc.) is much higher than other Northeastern states.	• Is waiver spending driving high per-enrollee costs for individuals with disabilities and older adults, or are other services (e.g., hospital, pharmacy) responsible for high costs (especially for non-duals, where most costs accrue to Medicaid)? • Which specific waiver programs are driving CT Medicaid program costs? How do waiver utilization and costs compare to other states with similar waivers? • Within each waiver program, which services are key cost drivers, and how have costs changed over time? • Where are rates for waiver services above and below average (based on waiver rate study)?
Populations 	• **Duals are responsible for a greater share of HCBS waiver spending compared to other states.** Full-benefit duals comprise almost 75% of 1915(c) waiver spending, which is higher than most other states. • **Avoidable hospitalization rate for duals – a key quality indicator – is average compared to other states.**	• Why do duals comprise a disproportionate share of HCBS waiver spending compared to other states? • What is the existing Medicare delivery system for duals? • Which Medicaid services and programs are highest volume and cost for duals? • What are avoidable hospitalization and ED utilization rates for dual and non-dual HCBS users? How do rates compare to other states and over time?
Delivery and Payment Model 	• **CT Medicaid's LTSS rebalancing ratio is average, but HCBS waiver enrollment and spending is in the top quartile across states.** • **LTSS users' satisfaction with care and health outcomes are average** compared to other states (based on limited available measures).	• What are the barriers to increasing rebalancing from institutional to community-based services? • How are beneficiaries utilizing waiver case management services? Could increased access to comprehensive care management/care integration improve outcomes and member experience? • Are there constraints on provider capacity to deliver HCBS?

DSS Can Choose From Variety of Program Models Based on State Objectives and Analytics Takeaways

States can use an array of models to improve care for HCBS users, including but not limited to, MLTSS. These models share certain features (like providing integrated care management) but can be targeted to different populations and services.

Strategies focus on pathways for improved care management and integrated care. DSS could also explore other strategic areas, including waiver eligibility and payment rates.

	Program of All Inclusive Care for the Elderly (PACE)	Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)	Comprehensive Care Management for HCBS Users	Managed Long-Term Services and Supports (MLTSS)
Duals	Mostly duals (but not all)	Duals only	Duals and/or non-duals	Duals and/or non-duals
Populations	For LTSS users (nursing home level of care, age 55+)	For dual eligible enrollees; could include just those with LTSS needs or all duals	State-defined eligibility criteria (typically based on functional assessment or level of care complexity, e.g., serious mental illness)	State-defined criteria. Could be all Medicaid LTSS users (duals and non-duals) but most states have exclusions (e.g., carve out Intellectual/Developmental Disability (I/DD) population)
Benefits and Services	All Medicaid benefits, and Medicare (if dual eligible)	Integrated Medicaid and Medicare benefits, including LTSS	Care management only	MLTSS typically covers all Medicaid benefits for defined population of LTSS users – could be combined with integrated benefits for duals (e.g., with D-SNP)
Payment Model	Risk-Based Capitation	Risk-Based Capitation	Varies	Risk-Based Capitation
Delivery System	Provider-driven	MCOs – Dual Eligible Special Needs Plans (D-SNPs) only	Varies (typically provider-driven or regional care management organization, could also leverage ASO model)	MCOs (in limited cases, provider-owned), typically in an existing MMC structure

Emerging Body of Evidence Can Guide State Decision-Making on Models Most Likely to Succeed in Connecticut

Strategy	Evidence	Preliminary Implications for Connecticut
Program of All Inclusive Care for the Elderly (PACE)	• PACE is associated with lower likelihood of long-term nursing home placement • Some evidence of lower Medicaid spending	• Capitated and integrated care delivery model could improve CT's LTSS rebalancing • Provider-driven approach may better align with current FFS model than MLTSS • PACE programs are typically small – DSS would want to ensure PACE can enroll enough beneficiaries to allow for systemic change; a recent report estimates there are 9,255 CT residents eligible for PACE[68]
Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)	• FIDE-SNPs are also associated with lower likelihood of long-term nursing home placement • No studies on Medicaid spending impact	• Could leverage existing D-SNP platform in CT without the operational hurdles of implementing MLTSS more broadly • Based on experience in other states, may be able to more successfully scale than PACE
Comprehensive Care Management for HCBS Users	• Models are limited to several states • Evidence of Medicaid cost savings is promising but limited	• Typically, provider-delivered model; aligns well with CT's existing managed FFS environment • Could provide opportunity for integrated care management across care settings for LTSS users not eligible for PACE or FIDE-SNPs
Managed Long-Term Services and Supports (MLTSS)	• Current research indicates positive impacts on costs, access, and member experience • Mixed evidence of MLTSS impact on quality measures like preventable ED visits	• Would accelerate full integration of benefits for HCBS users (HCBS, behavioral health, physical health, etc.); could be combined with FIDE-SNP for duals integration

DSS should consider the following next steps to develop its HCBS Innovation Strategy

1. **Articulate DSS goals and objectives** for HCBS innovation strategy related to cost, quality, and access.
2. **Analyze HCBS service area** by program and population (see slide 38 and slide 39).
3. **Prioritize specific populations and/or services** based on state objectives and findings from data.
4. **Evaluate program models based on defined criteria**, including alignment with priority population(s) (step 3); likelihood to achieve state objectives related to cost, quality and access; state administrative burden; and time-to-launch.
5. **Utilize the above analyses to decide** whether to move ahead with implementation.
6. **Select program model(s) and develop implementation workplan**, including activities related to program design; procurement; federal authorities, state oversight and administration, legislative authorization and funding, and IT/analytics infrastructure.
7. **Begin program implementation.**

Intensive stakeholder engagement would inform each stage of HCBS innovation strategy development.

5. Areas to Explore and Next Steps

Areas to Explore and Next Steps

In each area, Connecticut will need to clarify vision and further analyze data before designing and implementing new programs.

Areas to Explore	Next Steps
Explore new care delivery and integration models for **HCBS users**.	1. Articulate DSS goals and objectives for HCBS innovation strategy. 2. Analyze HCBS service area by program and population. 3. Evaluate program models based on defined criteria. 4. Select program model(s) and develop implementation workplan (slide 41).
Explore care management and payment models to improve acute/chronic disease management, reduce avoidable hospital utilization, improve behavioral health outcomes and beneficiary care experience.	1. Analyze utilization and reimbursement by sub-population, service and disease state. 2. Review CT Medicaid's current care management delivery models. 3. Identify key areas of opportunity based on current state performance and existing care management models. 4. Identify relevant care management and payment models in other states. 5. Evaluate potential models, including but not limited to the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model in which Connecticut is participating. 6. If DSS chooses to move forward, select model(s) and develop implementation workplan, including program design, federal authorities, funding needs, and procurement approach.
Explore additional levers to manage increases in **pharmacy** spending based on best practices in other states, while ensuring beneficiaries maintain appropriate access to prescription drugs.	1. Identify cost drivers within pharmacy service area by reviewing detailed spending across categories of drugs. 2. Evaluate current state policies related to preferred drug lists, prior authorization, drug utilization review, and other strategies. 3. Evaluate best practices in other states, with a focus on managing "blockbuster" drugs (e.g., GLP-1s) and high-cost therapies for rare diseases (e.g., sickle cell disease). 4. If DSS chooses to move forward, identify strategies appropriate for CT Medicaid and develop implementation workplan.

Rate Study Implications: DSS is currently completing a Medicaid rate study, comparing CT Medicaid payment rates for specific services to Medicaid rates in other states and Medicare. Phase I (complete) focuses on behavioral health services, dental services, and physician and other professional service providers. Phase II (forthcoming) will focus on all other aspects of the Medicaid program (e.g., FQHCs, specialty hospitals, and complex nursing care). After completion of rate study, DSS should consider how changes to payment rates could address system challenges identified in this report, in conjunction with the potential strategies outlined above (e.g., if payment rates are low for specialists treating certain acute/chronic diseases, increasing rates could improve provider participation in Medicaid and access to/satisfaction with specialty care, which could complement new care management models designed to improve outcomes).

6. Appendix

a. Managed Care Analysis Details
b. HCBS Analysis Details
c. Quality Measure Details
d. Acronym Reference List

6a. Managed Care Analysis Details

Evidence on Managed Care Cost Impacts

Key Takeaways

- **Evidence on service costs is positive, managed care typically reduces service costs, while impacts on overall state Medicaid costs and budget predictability are mixed.**
- Evidence points to a positive association between MMC and **lower service costs**.
- Evidence points to **no correlation** between MMC and state budget predictability.
- A study of one state found that MMC **lowers** overall state Medicaid spending after accounting for **increased administrative costs related to MMC.**

Evidence Review

Current State	Managed Care Opportunity

Performing Well:
• CT Medicaid per-enrollee **service costs** are low compared to Northeast states.
• CT Medicaid per-enrollee **administrative costs** are low compared to MMC states.
	• Of nine studies exploring the impact of MMC on service costs, eight **(89%)** found **positive** results (i.e., decreased costs).
	  • There is evidence of MMC's **positive** impact on inpatient and outpatient (IP/OP) hospital spending. Specifically, five studies on IP/OP spending under MMC identified **cost savings**.[34, 47, 76, 78, 94]
	  • There is **mixed** evidence of MMC's impact on drug spending.[11, 25, 47]
	• One national study found **no significant effect** of MMC on budget predictability.[79]
	• One study from Texas estimates that state Medicaid costs were approximately **10% lower** over a five-year period under managed care than if services had been delivered through Medicaid FFS.[32]

Opportunities for Improvement / Exploration: CT per-enrollee spending on those with disabilities and older adults is substantially higher than Northeastern states.	• Two studies found a **positive** cost impact of managed care for LTSS users (see Section 6a., Evidence on Managed Care LTSS Impacts, for detail).[32, 94]

Evidence on Managed Care Access & Member Experience Impacts

Key Takeaways

- **MMC has a mixed impact on beneficiary access and no impact on patient experience.**
- When measured directly through survey data, **managed care has little to no impact on a member's overall satisfaction with care.**
- Studies are **mixed** on whether care coordination, an indirect measure of patient experience, is more effective in MMC vs. FFS.

Evidence Review

Of 24 studies exploring the impact of managed care on access and patient experience, **ten (42%)** found **positive** impacts on access, **eight (33%)** found **negative** or **mixed** results, and **six (25%)** found **no impact**.

Current State	Managed Care Opportunity
Performing Well: Average levels of access across different service types.	While the overall evidence is **mixed**, MMC in some cases decreases access to primary care. • Of **twelve** studies on primary care or outpatient visits, seven (58%) had **negative**[31,41,46,52,55, 76] or **mixed**[21] conclusions, while three (25%) had **positive**[22,54,74] conclusions (the remaining two[37,51] showed **no impact**). • Some studies specifically suggest that MMC may have a **positive** impact on access to certain types of preventive services, including asthma medications and cancer screenings.[8,44]

Opportunities for Improvement / Exploration: Health care experience, including ratings of specialists are low compared to national benchmarks.	• Measured **directly,** national survey data finds **no impact** of managed care on satisfaction overall – factors like provider supply and PMPM spend may be more strongly associated with satisfaction than managed care versus FFS delivery system.[6]
	• When measuring patient experience **indirectly** by evaluating intensity or receipt of care coordination, the evidence is **mixed.**
	  • One study found a **negative** association between managed care and access to or receipt of care coordination services for children compared to FFS and Primary Care Case Management (PCCM) models.[28]
	  • Another found a **positive** association between managed care and greater spending on care transition services for those with high-needs.[66]

Evidence on Managed Care Acute and Chronic Disease Management Impacts

Key Takeaways

- Evidence of MMC Impact on acute/chronic disease management is **mixed.**
- CT Medicaid's quality performance is strong in areas such as primary care, with room for improvement in acute/chronic disease management (specifically measures on pediatric ED visits and adult hospitalizations for asthma) – **studies suggest that MMC has mixed effects on these areas.**

Evidence Review

- Of 31 studies exploring the impact of MMC on quality across a variety of measures, **8 (26%)** found **negative** impacts**, 7 (23%)** found **mixed** impacts, while **12 (39%)** found **positive** impacts and **4 (13%)** found **no/unclear impact**.

Current State	Managed Care Opportunity
Performing Well: Overall performance and maternal health, dental and oral health, and primary and preventive care measures.	There is **mixed** evidence that MMC improves quality measures related to maternal and perinatal health, primary care, or preventive care (e.g., screenings). • For example, one study found that CT Medicaid had **lower**[90] early-stage cancer diagnosis before the transition to FFS, while another found that mandatory MMC **increased**[44] diagnosis for late-stage cancers in Pennsylvania.
Opportunities for Improvement / Exploration: Quality performance on behavioral health and acute/chronic disease measures, specifically measures related to pediatric ED visits and adult hospitalizations for asthma or chronic obstructive pulmonary disease (COPD).	There is **mixed** evidence that MMC improves outcomes associated with **acute/chronic disease management,** CT Medicaid's most substantial area for improvement. • One study suggests a **positive** impact on pediatric diabetes-related readmissions (not a CT Medicaid weakness).[34] • A study in South Carolina shows a **negative** impact on the ***outcomes*** for children with ADHD and asthma (e.g., increase in ED visits), *despite increased access* to treatment through managed care.[22] • Looking at *preventable ED visits* only – as a proxy for effectively managing acute or chronic disease – four studies found **positive** impacts[39,54,91,94] and three found **negative** or **mixed** impacts.[5,22,83] • Evidence review identified **no studies** that managed care improves behavioral health outcomes and researchers have found that managed care **does not** reduce behavioral health disparities.[10,49]

Evidence on Managed Care Provider Impacts

Key Takeaways

- **Evidence on provider impact is negative.**
- CT providers are highly satisfied with the state's Medicaid program administration. A study from one state (Missouri) found that providers were **less satisfied** with managed care compared to FFS.
- Evidence review identified **no studies** evaluating whether MMC impacts provider participation in Medicaid, and evidence points to **no correlation** between MMC and physician acceptance of new Medicaid patients.

Evidence Review

Current State	Managed Care Opportunity
Performing Well: Providers have been consistently satisfied with CT Medicaid and provider participation in Medicaid has modestly increased overall.	There is some evidence from Missouri that, following the transition from FFS to managed care, physicians were **less satisfied** with their Medicaid experience.[27] • *"Physicians participating in Medicaid managed care were less likely to be satisfied or very satisfied with Medicaid managed care (28.6%) than…their previous experience with traditional Medicaid (39.7%)."*
Opportunities for Improvement / Exploration: PCP participation decreased slightly from 2021 to 2022.	• Evidence review identified **no studies** evaluating whether MMC increases provider participation relative to FFS. • Evidence points to **no correlation** between a state's level of MMC penetration and physician acceptance of new Medicaid patients.[35]

Evidence on Managed Care LTSS Impacts

Key Takeaways

- **Limited number of studies evaluating MLTSS have found positive impacts on costs and access, with mixed impacts on quality.**
- Evidence suggests MLTSS could potentially improve CT Medicaid's LTSS rebalancing from institutional to community-based services and reduce HCBS waiting lists.

Evidence Review

Category	Current State	Managed Care Opportunity
Service Cost	• Per-enrollee costs for individuals with disabilities and older adults are **much higher** than other Northeastern states.	**Two studies found a positive cost impact of managed care for LTSS users.** • In Illinois, managed care reduced inpatient hospital utilization for older individuals (defined as ≥46) with early-acquired physical disabilities compared to a FFS delivery system, leading to cost reductions of >$600 per-person, per-month.[93] • In Texas, managed care for older adults and individuals with disabilities produced state cost savings of around 4% compared to a FFS delivery system.[31]
Member Access and Experience	• Access to Medicaid for individuals with disabilities **exceeds** national benchmarks for several key measures. • CT Medicaid's LTSS rebalancing ratio is **slightly worse** than the median state. • Member experience for individuals using HCBS is around **average**.	**Four studies found a positive association between MMC and access for LTSS users.** • Medicaid beneficiaries enrolled in Virginia's MLTSS program were more likely to be enrolled in 1915(c) waivers for home and community-based services, compared to Medicaid FFS.[64] • Across a survey of 18 states, MLTSS enrollees were 28% more likely than FFS beneficiaries to respond favorably on beneficiary experience (NCI-AD) survey questions.[93] • Among seven states that had waiting lists for HCBS waivers before the start of the MLTSS program, two states eliminated the wait for services and four states decreased the number of people on their waiting lists after the MLTSS programs began. Authors note that waiting list improvement was likely tied to both MLTSS and other factors (e.g., increased waiver funding).[86] • Members enrolled in managed care in a midwestern state reported a positive impact of managed care on care coordination, with beneficiaries reporting fewer unmet health care needs.[9]
Health Care Quality and Outcomes	• CT's potentially avoidable hospitalization rate among full benefit dual-eligible beneficiaries—who use most HCBS in the state—was **average** compared to national benchmarks.	**Among four studies on quality, one was negative[26] and three were mixed.[30, 80, 93]** • There is **mixed** evidence of MLTSS' impact on hospital utilization. One study found that MMC reduced avoidable hospital utilization among enrollees,[93] while another study found MMC led to increased ED utilization and mortality.[26]

6b. HCBS Analysis Details

Program of All Inclusive Care for the Elderly (PACE)

PACE is a capitated, provider-led model for delivering integrated care to dual-eligibles meeting nursing facility level of care.

Description	Prevalence	Evidence	Implications for CT
• **Overview:** Provider-led, HCBS service delivery model for individuals age 55+ meeting nursing facility level of care.[68] • **Care Model:** Interdisciplinary Team (IDT) coordinates and delivers care. PACE organization must operate a center that provides services, but some services can be provided at home or other community settings. • **Financing:** PACE organizations receive a blended, capitated rate from Medicare (Parts A, B, and D) and Medicaid. Rates must be less than the "amount that would otherwise have been paid" (AWOP) under Medicare and Medicaid.	In 2023, more than 72,000 Medicare beneficiaries were enrolled in 155 PACE programs across 32 states and the District of Columbia (most were dually eligible for Medicaid).[61]	• **Service Costs:** Among three studies evaluating impact of PACE on Medicaid costs, two found PACE was associated with **lower** Medicaid spending, and one found PACE was associated with **higher** Medicaid spending.[85] • **Member Access and Experience:** Three of four studies found PACE was associated with a **lower** likelihood of long-term nursing facility placement.[85] • **Health Care Quality and Outcomes:** Of four studies evaluating the association between PACE and hospital admissions or ED visits, two studies found a **reduction** and two found **no impact**. Additionally, one study found PACE programs were associated with **lower** mortality, while two found **no impact**.[85]	• Evidence suggests PACE program could support CT Medicaid's efforts to further transition LTSS from institutional-to-community based settings, with potential opportunities to improve beneficiary health outcomes and reduce costs. • PACE provides the benefit of integrated care for dual eligibles under a capitated model but is **provider** rather than managed care plan driven, which may be better aligned with CT Medicaid's FFS delivery model.

Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)

FIDE-SNPs provide integrated Medicare and Medicaid services to dual-eligible individuals.

Description	Prevalence	Evidence	Implications for CT
• **Overview:** FIDE-SNPs cover all Medicare and Medicaid benefits—including LTSS—through a single MCO. A FIDE-SNP contracts with the federal government for Medicare services and the state Medicaid agency for Medicaid services.[61,62] • **Care Model:** FIDE-SNPs must use "aligned care management and specialty care network methods" to meet the needs of high-risk enrollees. • **Financing:** FIDE-SNPs hold capitated contracts for both Medicaid and Medicare services. FIDE-SNPs may also receive additional Medicare payments through a frailty adjustment if CMS determines beneficiaries enrolled in a FIDE SNP have an average level of frailty similar to those enrolled in PACE.	FIDE-SNPS enroll about 419,000 beneficiaries in 14 states,[20] or about 3% of the dually eligible population.* **Note:* 3% figure calculated by multiplying 40% of dual-eligible beneficiaries enrolled in D-SNPs (March 2023)[62] by 7% of D-SNP enrollees in FIDE-SNPs (November 2024)[20]	• **Service Costs:** No studies evaluating the association between FIDE-SNPs and Medicaid spending are available. • **Member Access and Experience:** Three of five studies found FIDE-SNPs were associated with a **lower** likelihood of long-term nursing facility placement, while two found **no impact** or **mixed** results. One study found that beneficiaries in FIDE-SNPs were **more satisfied** with their care.[85] • **Health Care Quality and Outcomes:** Findings on hospital admissions and ED visits were mixed. Two studies found FIDE-SNPs were associated with **lower** mortality.[85]	• A limited body of evidence suggests FIDE-SNPs could encourage greater use of HCBS and improve health outcomes. • Connecticut already has 15 "coordination-only" D-SNPs operating in the state which—although they have a much lower level of Medicare-Medicaid coordination than FIDE-SNPs—represent a starting point for greater integration. D-SNPs currently serve ~105,000 dual-eligible individuals in the state[20] (~50% of dual-eligibles in the state).** • **CT Medicaid could implement a FIDE-SNP strategy to provide integrated care for duals under a capitated contract without implementing an MLTSS model for its broader Medicaid program (beyond duals)**. Under this approach, which has been implemented in Idaho, the state contracts directly with FIDE-SNPs for the provision of Medicaid services. ***Note:* Percentage calculation leverages the number of dual-eligibles in CT in 2021, from MACPAC.[56]

Comprehensive Care Management for HCBS Users

Massachusetts and Alabama provide comprehensive care management for individuals using LTSS through FFS delivery systems.

Model	Description	Evidence	Implications for CT
LTSS Community Partners (MA)	• **Overview:** Massachusetts' MCOs and Accountable Care Organizations (ACOs) – provider-led risk bearing entities – are required to contract with **Community Partners** (CPs), community-based entities such as Area Agencies on Aging (AAAs) that provide specialized wraparound care coordination supports to members with complex behavioral health and LTSS needs. *The CP program excludes duals, who are served by two other integrated care programs.*[3] • **Care Model:** MCOs/ACOs refer beneficiaries with complex LTSS needs to community partners, who provide assessments, care plan development and coordination across care settings and providers. • **Financing:** CP funding is authorized through "MassHealth" 1115 waiver authority.[14] CPs receive funding for capacity building and for delivery of care coordination services.	Between 2018-2021, patients enrolled in the BH and LTSS CP programs had a 19% **lower** risk-adjusted total cost of care (TCOC) upon discharge from the program, compared to TCOC during the 12 months prior to enrollment. The study does not separately evaluate BH vs. LTSS CP performance, nor does it include a comparison group.[53]	• While CT Medicaid's 1915(c) waiver enrollees access case management as part of waiver benefit packages, there is no comprehensive care management strategy to support beneficiary access, utilization and quality across care settings. • CT Medicaid could consider a more integrated care management strategy for beneficiaries utilizing HCBS, based on examples in other states.
Integrated Care Network (AL)	• **Overview:** Alabama's Integrated Care Network (ICN) uses a PCCM model to coordinate care for LTSS. The statewide program represents a collaboration across nursing facilities and AAAs, which coordinate care across both institutional LTSS and HCBS. The model also seeks to promote LTSS rebalancing. • **Care Model:** The ICN provides overall care coordination (for all health needs, not just LTSS) to enrollees, in addition to providing education to providers. The AAAs that contract with the ICN provide HCBS case management services. • **Financing/Structure:** Alabama procures the ICN (currently owned/governed by a nursing facility network), which then contracts with entities responsible for aging services, behavioral health and LTSS, including AAAs, state agencies, and providers such as nursing facilities and community providers. The AAAs receive PMPM payments through the ICN; the ICN's payments are subject to a 10% withhold each year based on meeting the state's LTSS rebalancing goals.	No publicly available evidence of impact.	

Managed Long-Term Services and Supports (MLTSS)

States can implement MLTSS to improve coordination, service delivery, and costs for LTSS users.

Description	Prevalence	Evidence	Implications for CT
• **Overview:** MMC programs that cover either all Medicaid LTSS users (duals and non-duals), or Medicaid LTSS users with exclusions. • **Care Model:** Depends on program design. Programs can be combined with integrated benefits for duals (e.g., with D-SNP). Note: in limited cases, MLTSS organizations are provider-owned. • **Financing:** MLTSS plans receive capitated payments for defined set of services (usually most or all Medicaid benefits).	Enroll about 365,000 beneficiaries in 24 states.[13,63]	• **Service Costs:** Two studies found a **positive** cost impact of managed care for LTSS users.[31,93] • **Member Access and Experience:** Four studies found a **positive** association between MMC and access/experience for LTSS users.[9, 64, 86, 93] • **Health Care Quality and Outcomes:** Evidence is **mixed** on the impact of MLTSS on quality. Among four studies on quality, one was negative and three were mixed.[26, 30, 80, 93]	• Evidence suggests MLTSS could potentially improve CT Medicaid's LTSS rebalancing from institutional to community-based services and reduce HCBS waiting lists. • Would accelerate full integration of benefits for HCBS users (HCBS, behavioral health, physical health, etc.); could be combined with FIDE-SNP for duals integration. • Despite mixed evidence on quality, there is opportunity for CT to make contract choices that incentivize MCOs to provide high quality care.

6c. Quality Measure Details

MY 2022 Quality Measures Below Median

Domain	Rate Definition	State Rate	Median	Delta
Behavioral Health Care	Percentage with Two or More Antipsychotic Prescriptions that had Metabolic Testing for Blood Glucose: Ages 1 to 17	52.0	53.1	-1.1
Behavioral Health Care	Percentage with Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test: Ages 18 to 64	75.6	77.1	-1.5
Behavioral Health Care	Percentage of New Episodes of Opioid Use Disorder with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	58.7	60.9	-2.2
Behavioral Health Care	Percentage of New Episodes of Other SUD with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	41.2	41.6	-0.4
Behavioral Health Care	Percentage of New Episodes of Total SUD with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	44.3	44.5	-0.2
Behavioral Health Care	Percentage of Current Smokers and Tobacco Users Discussed or Provided Other Cessation Methods or Strategies: Ages 18 to 64 Years	42.5	43.3	-0.8
Care of Acute and Chronic Conditions	Emergency Department Visits per 1,000 Beneficiary Months: Ages 0 to 19*	42.6	36.5	-6.1
Care of Acute and Chronic Conditions	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5 to 11	63.8	75.9	-12.1
Care of Acute and Chronic Conditions	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 12 to 18	62.0	68.7	-6.7
Care of Acute and Chronic Conditions	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5 to 18	63.0	71.6	-8.6
Care of Acute and Chronic Conditions	Percentage of Episodes for Beneficiaries with a Diagnosis of Acute Bronchitis/Bronchiolitis that did not Result in an Antibiotic Dispensing Event: Ages 18 to 64	38.9	43.6	-4.7
Care of Acute and Chronic Conditions	Percentage with Concurrent Use of Prescription Opioids and Benzodiazepines for 30 or More Cumulative Days: Ages 18 to 64*	14.5	13	-1.5
Care of Acute and Chronic Conditions	Ratio of Observed All-Cause Readmissions to Expected Readmissions: Ages 18 to 64*	1.3	1.01	-0.28
Care of Acute and Chronic Conditions	Hospitalizations for Chronic Obstructive Pulmonary Disease (COPD) or Asthma per 100,000 Beneficiary Months: Ages 40 to 64*	27.6	27	-0.6
Care of Acute and Chronic Conditions	Hospitalizations for Asthma per 100,000 Beneficiary Months: Ages 18 to 39*	5.4	2.8	-2.6
Care of Acute and Chronic Conditions	Percentage of Adults Without Cancer who Received Prescriptions for Opioids with an Average Daily Dosage Greater than or Equal to 90 Morphine Milligram Equivalents (MME) for a Period of 90 Days or More	9.0	5.9	-3.1
Maternal and Perinatal Health	Percentage of All Women at Risk of Unintended Pregnancy Provided a Most Effective or Moderately Effective Method of Contraception: Ages 15 to 20	23.2	23.8	-0.6
Maternal and Perinatal Health	Percentage of All Women at Risk of Unintended Pregnancy Provided a Long-Acting Reversible Method of Contraception: Ages 15 to 20	2.6	3	-0.4
Maternal and Perinatal Health	Percentage of Nulliparous, Term, Singleton, in a Cephalic Presentation Births Delivered by Cesarean*	27.7	24.2	-3.5
Primary Care Access and Preventive Care	Percentage who had Appropriate Screening for Colorectal Cancer: Ages 50 to 64	29.2	36.4	-7.2

Note: * means lower-than-median score for this measure is better.

Source: 2023 Adult and Child Medicaid Core Measures for Connecticut (MY 2022)[12]

AARP Scorecard Selected Measures Definitions

Category	Measure	Definition	CT Rank
Affordability and Access	ADRC/NWD Functions	This composite indicator draws from a voluntary, self-reported survey fielded by AARP for each state's Aging and Disability Resource Center/No Wrong Door (ADRC/NWD) System. Survey asked state administrators to describe their progress toward developing fully operational NWD Systems using 41 criteria. ADRC/NWD Functions | Long-Term Services and Supports State Scorecard	**9**
Affordability and Access	Medicaid for Low-Income People with Disabilities	The percentage of people ages 21+ with a self-care difficultly (difficulty dressing or bathing; a reasonable approximation to activities of daily living disability) at or below 250% of the poverty threshold who have health insurance through Medicaid, medical assistance, or any kind of government assistance plan for those with low incomes or a disability. We chose 250% of poverty in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300% of Supplemental Security Income. Medicaid for Low-Income People with Disabilities | Long-Term Services and Supports State Scorecard	**8**
Affordability and Access	Medicaid Buy-In	The percent of state policies governing Medicaid Buy-In programs that promote enrollment. AARP Public Policy Institute analyzed the data on eligibility policies for state Medicaid Buy-in programs for working people with disabilities, and scored states based on eligibility policies related to individual income limits, individual asset limits, spousal asset limits, and premiums. Those scores are the numerator with a top possible score as the denominator, to derive a percent value for the indicator. Medicaid Buy-In for Working People with Disabilities | Long-Term Services and Supports State Scorecard	**13**
Affordability and Access	Medicaid LTSS Balance: Spending*	The percentage of Medicaid LTSS spending for programs used primarily by older people and adults with physical disabilities going to HCBS programs as opposed to facility-based services. Medicaid LTSS Balance: Spending | Long-Term Services and Supports State Scorecard	**19**
Choice of Setting and Provider	Self-Directed Program Enrollment	The number of people receiving LTSS through one of several self-directed programs per 1,000 people with any disability. Self-Directed Program Enrollment | Long-Term Services and Supports State Scorecard	**25**
Choice of Setting and Provider	Home Health Aide Supply	The number of personal care, nursing, psychiatric, and home health aide direct care workers currently in the workforce per 100 population ages 18+ with need for assistance with an activity of daily living (ADL). Home Health Aide Supply | Long-Term Services and Supports State Scorecard	**9**
Choice of Setting and Provider	Adult Day Services Supply	The maximum number of participants, per 10,000 population ages 65+, allowed at any one time at licensed adult day services centers in each state. Adult Day Services Supply | Long-Term Services and Supports State Scorecard	**27**
Choice of Setting and Provider	LTSS Worker Wage Competitiveness	The dollar amount shortfall between the average hourly wage rate paid for direct care jobs and the average hourly wage rate paid for other comparable jobs in each state. LTSS Worker Wage Competitiveness | Long-Term Services and Supports State Scorecard	**31**

Note: *"Medicaid LTSS Balance: Spending" measure uses data from 2020 – older data than used within Section 3b. showing Medicaid LTSS expenditures

Source: AARP LTSS Choices Scorecard for Connecticut.[1]

Acronym Reference List

- AAA: Area Agencies on Aging
- AARP: American Association of Retired Persons
- ACO: Accountable Care Organization
- ADHD: Attention-Deficit/Hyperactivity Disorder
- ADL: Activity of Daily Living
- ADRC/NWD: Aging and Disability Resource Center / No Wrong Door
- ASO: Administrative Services Organization
- AWOP: amount that would otherwise have been paid (for PACE rates)
- BH: Behavioral Health
- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- CFC: Community First Choice
- CHIP: Children Health Insurance Program
- CMS: Centers for Medicare & Medicaid Services
- COPD: Chronic Obstructive Pulmonary Disease
- CP: Community Partner
- CT: Connecticut
- CY: Calendar Year
- D-SNPs: Dual Eligible Special Needs Plans
- DSS: Department of Social Services
- ED: Emergency Department
- FFS: Fee-for-Service
- FIDE-SNPs: Fully Integrated Dual Eligible – Special Needs Plans
- FY: Fiscal Year
- HCBS: Home-and-Community-Based Services
- I/DD: Intellectual/Developmental Disability
- ICN: Integrated Care Network
- IDT: Interdisciplinary Team
- IP/OP: Inpatient and Outpatient
- KFF: Kaiser Family Foundation
- LTSS: Long-Term Services and Supports
- MACPAC: Medicaid and CHIP Payment and Access Commission
- MAPOC: Medical Assistance Program Oversight Committee
- MCO: Managed Care Organization
- MLTSS: Managed Long-Term Services and Supports
- MMC: Medicaid Managed Care
- MSP: Medicare Savings Program
- MY: Measurement Year
- NCQA: National Committee for Quality Assurance
- PACE: Program of All Inclusive Care for the Elderly
- PCA: Personal Care Attendant
- PCCM: Primary Care Case Management
- PCP: Primary Care Provider
- PMPM: Per Member Per Month
- PP: Percentage Point
- SUD: Substance Use Disorder
- TCOC: Total Cost of Care

Medicaid Landscape Analysis – Works Cited

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