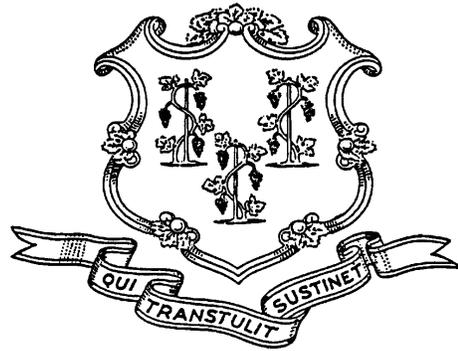


**Connecticut Access:**  
Report on the Implementation of  
Medicaid Managed Care  
*to the Medicaid Managed Care Council*



**February 2, 1996**

**Joyce A. Thomas**  
*Commissioner*  
State of Connecticut  
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## I. THE MEDICAID MANAGED CARE PROGRAM

In testimony presented to the Human Services and Appropriations Committees of the Connecticut General Assembly one year ago, the Department described the arguments for managed care as contained in the waiver application:

- The fee for service system that we have operated for the past 30 years has failed to either promote access or contain costs.
- Managed care offers the last best hope to enhance recipients' choices and access to the mainstream health care system in our state while limiting the rate of increase in per capita costs.
- Managed care will bring accountability to a program where assurances of quality and access have been beyond the reach of the Department.

Before the advent of managed care, we had open enrollment of providers. With the exception of certain procedures that required prior authorization by our medical staff, we did not control service volume. There was no system in place to assure continuity of care with a primary care provider. Recipients had the right to choose providers from the list of those who were willing to serve as providers. There was no system in place to measure either access or quality. Savings were achieved through the regulation of reimbursement rates. When rates would languish without regular increases, access suffered. We are committed to an approach which reverses these trends away from a program which failed to meet the needs of recipients, providers, and taxpayers in our state.

Within the parameters of the goals set forth, the Department has delivered the program we were charged to implement. There have been problems and there are still issues that need to be resolved. Many of these issues have been raised by providers who have traditionally served the Medicaid population. We need to separate the operational and policy issues that are specific to this Medicaid Managed Care Program from those issues which are general issues about managed care.

We have adopted a managed care approach that incorporates the same general features of cost containment as are practiced in the private sector. We have encouraged, and in some cases required, the inclusion of traditional Medicaid providers in managed care networks but ultimately there is a limit on those networks. We do not have any willing provider legislation in this state for either the public or the private sector. We have made a contract with managed care organizations where we agreed to

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share risk. In exchange for that risk we allowed them to define provider panels as long as necessary services are provided. That is not unique to Medicaid managed care. That is managed care. We are certainly open to comments and criticisms that speak to whether those services are being provided by the participating health plans. But as for the fundamental concepts of provider panels, actuarial rates, shared risk - these represent the essential features of the program we are charged to implement.

In so doing, it is inevitable that some providers will not serve the Medicaid population. Some never did. Some providers who did not serve this population are now treating them for the first time. There is an enormous sea of change occurring that will result in improved access for less cost. But part of that equation is necessarily the reduction of inefficiencies or redundancies in the system. Take away that, and you have no cost containment. Take away that, and you cannot position the state for wider reform. Take away that, and you do not have managed care.

## **II. MEDICAID MANAGED CARE ENROLLMENTS**

The enrollment of recipients into health plans of their choice is a key measure of success for the program. The Department has put in place an educational and enrollment plan which gives Medicaid recipients many opportunities to learn about the program and their plan options. We took a multi-pronged approach in our efforts to educate clients about Medicaid managed care. Our approach includes multiple mailings; one-on-one meetings at the local Department office; group presentations in the Department offices and at community sites and the toll-free phone line.

The mandatory enrollment into managed care is being phased in. Clients are being targeted for mandatory enrollment at the time of their review for Medicaid eligibility or upon application for Medicaid. The enrollment process gives client ample time in which to make a choice. This will be evident as we discuss the enrollment process.

Redetermination clients are given at least 60 days prior to the Eligibility Management System (EMS--the Department's eligibility computer system) cutoff for their mandatory effective date in which to make a choice. Two notices, spread 30 days apart, are issued before the default assignment takes place. Clients have at least two weeks to change from the assigned default plan into a plan of their choice before the EMS cutoff date.

Example: 4-1-96 mandatory effective date (based on 3-31-96 certification end-date). The redetermination interview is scheduled for the month of February.

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- The first managed care mandatory notice is mailed between the 22nd and 25th of January (around the same time as the redetermination appointment notification).
- The second notice (a reminder for those who have not yet chosen) is mailed between the 21st and 24th of February.
- The enrollment broker makes three attempts, by phone, to reach the clients who have been mailed reminder notices. These calls are made over approximately a 30 day period (between 2-25-96 and 3-26-96).
- The default assignment would be run on 3-11-96 for those clients who have still not chosen a plan. A notice is mailed to clients to notify them of the default assignment.
- Clients still have until 3-26-96 to switch from the default plan into a plan of their choice before being locked into the default plan for the month of 4/96.
- For clients that make a choice, enrollments are processed on a daily basis throughout the month.

Applicants receive managed care information at the local DSS office at the time that they file their application.

- A choice of plan can be made while the application is pending. Enrollment would then become effective the first of the month following the eligibility determination.
- If no choice is made while eligibility is pending, the client will receive a mandatory notice at the time that the eligibility is granted and be given 30 days in which to make a choice. If no choice is made by the 30th day, a default assignment is made effective the first of the following month. This time frame also applies to individuals who apply by mail (i.e. 30 days from the eligibility determination to make a choice).

Please see the Appendix for a detailed chart regarding this process.

Our goal has been to have a low default rate. The overall default rate (percentage of mandatory clients that were assigned into a default plan) has been low. As of today that rate stands at 11%. For more information, please see the attached enrollment and default enrollment charts.

### III. CLIENT EDUCATION AND ENROLLMENT

The Department decided to pursue an enrollment strategy that included a diverse array of fully capitated and partially capitated options for our clients. In order to implement this complex approach, the Department contracted with Benova/HealthChoice, a national leader in health decision support. The Department elected an approach that would provide a wide array of enrollment opportunities for our recipients. Clients may enroll in person at our regional offices, at community presentations, by mail, or over the phone. This last option was unique to Connecticut and represents a significant innovation in enrollment technology. We are planning to pilot an automated enrollment information kiosk in one of our sub-offices in the near future.

When we began the project in August, our phone capacity was overwhelmed. We did not anticipate the number of clients who would choose to enroll over the phone and we underestimated the number of informational calls our recipients would place as part of the plan selection process.

We have now increased the number of lines into the HealthChoice call center to deal with the volume. We also have shifted resources from our regional offices to the community presentations in order to meet the demand for outreach and client education. Between November, 1995 and January, 1996, despite the fact that we received between 15,000 and 20,000 calls each month, the call abandonment rate each month remained below 8%.

In addition to the call center activity, HealthChoice has conducted over 6,000 one on one counseling sessions in our regional offices. They have conducted almost 400 community presentations in conjunction with subcontracts with community based organizations.

Has the operation been perfect? Certainly not. But the Department and HealthChoice have demonstrated a willingness to work together to improve the project. We have not yet reached a 0% default rate. However, our overall choice rate of 89.7% is among the highest in the country. Out of over 27,000 recipients targeted for enrollment for the month which began yesterday, only 1,704 or 6.1% were assigned to default plans. We feel that in combination with the large number of voluntary enrollments which occurred prior to the date of mandatory choice, nearly 25,000, this speaks to the success of the program.

The enrollment process has worked and will continue to work to meet the needs of our recipients. We have accomplished this with a HealthChoice staff of which nearly 50% are former recipients of public assistance. We are certainly open to other options, such as primary care provider assignment, which will improve client service delivery.

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#### IV. CLIENT SATISFACTION

One of the most important components to measuring the success of the Connecticut Access program is in gauging the degree to which clients are satisfied with the services that the program delivers. At this early stage in the process, any preliminary data won't tell us everything we have to know, but feedback from the client's perspective is a significant source of information and one that will help us with decision making in the program.

Toward this end, the Connecticut Access program has been committed to various efforts designed to measure the program's success from the viewpoint of the customer. Principally through the work of the Children's Health Council, we have learned a great deal about how clients feel about the program.

A recent survey of 1,500 Medicaid managed care recipients completed by the consulting firm Maximus for the Children's Health Council sought and obtained some very important information from the clients served under Connecticut Access. The survey sought information on whether clients are satisfied with the services they have received under managed care in comparison to the fee for service system; information on problems with the disruption of health care services for recipients in the program; information on whether clients understood the materials they have received from the state and the health plans; and information on whether clients have ready access to care in the managed care setting.

The results of the survey indicate the following:

- over 90% of the clients stated that their children were receiving the services that they need under the managed care program;
- 71% of the recipients that have used services in the new managed care setting reported no problems with the services;
- over 89% of the clients feel that the doctors and other medical services are located in a very convenient or somewhat convenient location;
- of the 64% of clients are receiving care from the same provider as in the fee for service system, and that 84% reported that they were at least as satisfied or more satisfied in the managed care setting;
- of the 36% that have new medical service providers under managed care, 73% said they were at least as satisfied or more satisfied compared to the fee for service system:

- 75% of the clients thought the material they received from DSS was clear and useful and 82% of the clients thought that the material they received from the health plans was clear and useful.

While we recognize the information does not tell us everything we need to know and must be considered with other measures being developed by the Children's Health Council, we nevertheless view the results as very promising and look forward to more positive feedback from clients experiencing success with the new managed care program.

#### V. MEDICAID MANAGED CARE PERFORMANCE MEASURES

DSS is planning to release a competitively bid RFP and enter into a contract with an External Quality Review Organization (EQRO). This will help to provide a comprehensive assessment on the quality of care provided to Medicaid recipients and health plan performance. The EQRO is scheduled for implementation in Spring 1996. Elements of the EQRO will include the following:

- **REVIEW AND STUDY DESIGN** -- Development of an organized, integrated plan to evaluate the performance of participating health plans including the collection of baseline data.
- **ONGOING MONITORING** -- Focus on evaluating data collected by DSS to identify problems or potential problems regarding access to care, quality of care and utilization (or under-utilization) of care. Data to be evaluated include member surveys, focus groups, health plan reports, complaint data from DSS and discussions with the enrollment broker.
- **MEDICAL RECORD REVIEW** -- The medical record review will consist of a retrospective audit of all care provided to selected Medicaid eligible clients. The review will provide an independent assessment of the quality of care and identify substandard and superior performance.
- **ON-SITE REVIEWS** -- Site visits to health plans performed in order to monitor compliance with contractual obligations and to confirm that sites, facilities, staffing and other operational elements are satisfactory. The visits will enable us to compare actual health plan practices to proposed practices described in their applications.

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- **SPECIAL EVALUATION OF DESIGNATED PLANS --** Includes the aforementioned on-site functions plus program and outreach activities. Again, actual practice will be compared to proposed practices.
- **FOLLOW-UP --** Post review activities including follow-up on plan strategies for improvement, creation of detailed final report and conducting forums to determine and disseminate “best practices.”
- **OPTIONAL TASKS --** The EQRO will be asked to provide an additional 400 hours for various medical review and audit investigations.

The Department has provided the health plans with provider specific reports listing Medicaid providers to assist in network development. DSS has also encouraged the plans through meetings and written communication to include historic Medicaid providers in their networks. DSS is monitoring and working with the plans to meet the requirement that managed care organizations contract with school based health centers. For children’s mental health and substance abuse services, we also require the managed care plans to contract with child guidance centers and other organizations which meet the benchmark requirements, i.e., family service agencies, community mental health centers and clinics, and qualified substance abuse providers, or demonstrate equal or superior alternatives.

The Department has established for each county plan-specific enrollment capacity levels. The enrollment caps are intended to assure that access to health care in the managed care program, as measured by a ratio of enrollees to providers, must be equal to or better than fee-for-service Medicaid. We continually monitor plan enrollment ceilings and will enforce these caps through such measures as suspensions of new enrollment into a plan.

Staff also review and resolve complaints and inquiries about the health plans from recipients and providers on issues related to enrollment and eligibility, covered benefits etc. The Department through its computer system is able to verify a recipient's eligibility for Medicaid and the health plan in which the person is enrolled.

We are also performing extensive network audits to verify information supplied by the plans on the participation of providers. The Department will also review the participation of high-volume Medicaid providers in health plans and will survey enrollees with high mental health usage. Dentists in plans with dental capacity constraints will be contacted to obtain their views and information will be tracked on appointment availability.

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## VI. DESIGNATED PROVIDERS

The Department adopted the designated provider strategy in order to facilitate the movement of our AFDC population into managed care on a mandatory basis. We have done all we could to encourage our recipients to choose a health plan, and for the most part, they have. Unlike other states, we do not lock recipients into their plan for more than 30 days so they are free to select an alternative once their assignment is effective. However, we needed a mechanism to assign those recipients who fail to make a choice once the process is completed.

We chose to assign recipients based on their county of residence and divided the state into an eastern and a western region. We have heard suggestions that assignment could be rotated among the plans, or that assignment could be done on a proportional basis, or that assignment could be based on the recipient's primary care provider.

All of these would be viable strategies. However, each of these alternatives would add greatly to the administrative complexity of the program. In addition, a rotating assignment process would abandon two of the attributes which we sought to incorporate in our designated provider process - quality and price. Through a competitive process we feel that we have secured the services of health plans which are experienced and fiscally sound and that provide a network of care for our recipients that is more than adequate to meet their needs.

We are continuing to monitor the performance of these plans and we have cooperated fully with all investigations about the selection process. The Comptroller's report, copies of which are available here for you today, exonerated the Department from any hint of impropriety about the selection process. Moreover, the State Comptroller, Nancy Wyman, in her review of the bidding procedures used for the designated provider selection, found that the Department's course of action was well designed and fully complied with.

We have also listened to numerous complaints that provider networks were misrepresented in the proposals submitted by the designated provider plans. We continue to monitor the networks of all the plans in order to limit enrollment, when necessary. However, these criticisms of the designated provider applications were of particular significance to the Department.

Therefore, our Quality Assurance division will complete an audit of our designated providers to determine whether any misrepresentation had, in fact, occurred. Our Quality Assurance division began with Oxford Health Plans. A copy of that audit is attached. They will complete a similar review of Blue Cross in the near future.

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The results of the Oxford audit speak for themselves. While we did identify that there is some confusion among providers about the Connecticut Access Program, the overwhelming majority of providers surveyed understood their obligation to serve Medicaid recipients and were prepared to do so.

Of the hospitals included in the Oxford proposal, only two - (Yale New Haven and Meriden-Wallingford) had not signed contracts at the time of the audit. Oxford was able to demonstrate to our satisfaction that recipients are able to access these providers and other out of plan services when necessary.

We are concerned about Yale's reluctance to sign a contract with Oxford. We have met with both Oxford and Yale to convey this concern. Beyond that, I think we all have to realize that these are business decisions. Yale-New Haven Hospital is a unique facility that is a partner in two health plans. It is their position that it is against their interests in a competitive environment to contract with potential competitors. The health centers which founded their own plans have also chosen not to contract with the other HMOs. Both Yale and the health centers are free to contract or not contract with whomever they wish. That is not our decision. But neither are we obligated by their position in making our decision on the designated provider plans.

## **VII. CAPITATION RATES**

The purpose of the rate setting effort is to produce a valid estimate of the fee-for-service (FFS) costs that the Connecticut Access target population would incur in the absence of the managed care initiative. This estimate drives the baseline payment rates which are set at 95% of the expected FFS per capita costs for all participating health plans (except the designated plan contractors, which are paid at their bid rate or at 95% of FFS, whichever is lower).

Rates are developed for DSS by its contractor Lewin-VHI. These rates are set on a global capitation basis which for a full risk plan covers virtually all inpatient and outpatient Medicaid benefits and services. Actual capitation rates paid to health plans are based on enrollee age, sex and county of residence.

The 1995 capitation rates were developed using FFS claims data from July 1992 through June 1993. Capitation rates scheduled to go in effect in 1996 were developed using 1994 claims data.

It is important to note that the 1915(b) waiver obliges the Medicaid agency to meet upper payment limit (UPL) requirements. This means that state spending under a managed care program may not exceed what would have been spent under fee-for-service for an actuarially equivalent population. The state would face penalties on the rate of federal financial participation if it exceeds the UPL.

Currently DSS has eleven health plans under contract with a potential for several more organizations being included. The contracts are for two year periods. There is no guarantee that the players in Connecticut Access will not change. The market is highly competitive and market forces may change the nature and number of plans participating. Some managed care organizations may make business decisions to leave the program for a variety of reasons including inability to achieve sufficient market share, redirection of strategic priorities or financial losses. Such changes will not impair the effectiveness of the Connecticut Access program since we anticipate that there will be a number of viable plans willing to continue. There may also be other organizations participating based on potential new procurements.

## VIII. CONNECTICUT ACCESS STAFFING

The Connecticut Access program is overseen by the Director of Medical Administration Policy at the department who reports to the Deputy Commissioner of Administration. A Medical Assistance manager is accountable for the day-to-day operation of the Medicaid managed care program. Five staff report to the Medical Assistance manager and are dedicated solely to the Connecticut Access program. Additionally, staff from our other Medicaid divisions are assigned to managed care activities as are staff from other related divisions in the department including management information systems, contract administration and financial management. This brings the total staff involved in some feature of the Medicaid managed care program on a full-time or part-time basis to over fifteen individuals and that number continues to grow.

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*"The Connecticut Access staff must be considered from a qualitative as well as quantitative perspective."*

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The Connecticut Access staff must be considered from a qualitative as well as quantitative perspective. Our Director of Medical Administration Policy, David Parrella, is widely and deservedly considered to be a national expert in Medicaid and health care policy. We consider him a tremendous asset to the State of Connecticut. We consider ourselves very fortunate to have an expert in Connecticut's health care delivery system in our managed care program manager, James Gaito. Jim's expertise and private sector experience are well known to the Medicaid Managed Care Council. Rose Ciarcia is a long time employee with the Department who consistently demonstrates a spirit of dedication and compassion in working with our recipients. All of our staff work well as a team and are committed to the success of the program.

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*"The Department is holding firm to the fundamental goals of the managed care initiative..."*

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As we move forward with our managed care programming, more and more Medicaid Division staff will become dedicated to managed care activities. We are in a situation now where we must continue to operate two versions of the Medicaid program and meet our obligations in both a fee for service and a managed care environment. When Medicaid managed care is expanded to other populations our goal is to have virtually all Medicaid staff assigned to managed care functions.

#### **IX. THE FUTURE OF MEDICAID MANAGED CARE.**

We are committed to a Medicaid managed care program that is the best in the nation. The Department is holding firm to the fundamental goals of the managed care initiative: (1) improved access, continuity and coordination of health care for recipients; (2) reducing Medicaid expenditures vis-a-vis the unmanaged, fee for service program; and (3) fostering the growth of an organized health care delivery system for Medicaid recipients based upon the principles of quality, efficiency, accessibility and accountability.

Implementation of the Connecticut Access program has not been without problems. The Department has recognized the deficiencies in our implementation plan and taken remedial steps in all instances. We will continue to modify the program as warranted in the future.

Our managed care program is one where various and competing interests converge. There are many stakeholders in a health care system that will deliver health care services to 230,000 Medicaid recipients. The Commissioner of Social Services has the responsibility to balance the competing interests inherent in our program and to implement a program true to the goals established under the framework of the program.

As we move forward, we need to be mindful that no decision in the program is not without consequences for other stakeholders; that an accommodation in one area of the program may come at the expense of other elements in the program. Indeed, there is potential conflict in the very goals of the program--saving scarce dollars may not always easily reconcile with other fundamental goals of the program. Our commitment is to do the best we can in assuring that our decisions fairly balance the issues.