



Ensuring Access to Care for Children and Parents in HUSKY A: Alternatives to Managed Care

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Background on Medicaid Managed Care

In 1995, Connecticut changed the way Medicaid services for low-income families are financed and delivered. To try to achieve cost savings for the state and to increase access to primary care, Connecticut created a Medicaid managed care program for children and families whose care previously had been covered on a fee-for-service basis. Medicaid benefits did not change, but the way in which families accessed care did. Under “managed care,” the Connecticut Department of Social Services contracted with managed care organizations, paying them a fixed amount per member per month (capitation) to provide all medically necessary services required under Medicaid, including medical and behavioral health care, dental care, vision and hearing care, and prescription drugs; assistance with appointment scheduling; transportation as needed; and case management. In January 2006, behavioral health services were “carved” out of the managed care program and are now provided on a fee-for-service basis, with support for beneficiaries and mental health care providers from an administrative services organization that contracts with the Department of Social Services but without financial risk for providing services.

Problems with Access to Care

Despite some improvements in health care utilization in the past 10 years, access to care remains problematic, especially for dental care and specialty care. In 2005, just 57 percent of children 2 to 19 who were enrolled for the entire year had a well-child visit.¹ Forty-one percent of children 3 to 19 had preventive dental care.² Nearly 16,000 children (i.e., 10 percent of children enrolled) in 2005, did not have

a single health service during the year. While some managed care plans do better than others, depending on the measure, no plan has shown dramatic improvements in preventive care since the program began. At the HUSKY Program’s current rate of improvement, it will be 2027 before all children receive well-child care and 2044 before all children receive preventive dental care.

Further, in November 2006, the Connecticut Department of Social Services released results of a “mystery shopper” survey showing system-wide problems with obtaining appointments for care.³ Just 26 percent of 1,851 calls to pediatricians, dentists, dermatologists, neurologists, and orthopedists resulted in timely appointments for newly enrolled “children” in HUSKY A.

One factor that has contributed to problems in getting care is that the Medicaid fee-for-service reimbursement schedule has not been increased since the early 1990s. While managed care organizations can and do occasionally negotiate with providers to pay fees that are higher, especially in relatively underserved geographic areas or specialties, the very low Medicaid fee schedule is likely to be the starting point for those negotiations. For some office-based procedures, the Medicaid reimbursement rate under the fee schedule is just 40 to 45 percent of the Medicare reimbursement rate for a visit of comparable length and complexity.⁴ Dental reimbursement rates on the fee schedule are generally less than the 10th percentile of the fees paid in New England.⁵

In addition, managed care organizations are at financial risk for all the care that a member might need, even when it exceeds the amount paid up front

per member per month. Likewise, if the cost of the health care that is provided is less than the amount the managed care plans are paid, they keep the difference. Under this system of care, there is a financial incentive to limit or deny care, either by erecting administrative barriers such as prior authorization or deciding against a provider's determination that the care is medically necessary.

Recommendations

For these reasons, we believe it is time to raise provider reimbursement and to develop alternatives to the current risk-based system of managed care for families in Connecticut's Medicaid program:

1. The Medicaid fee-for-service reimbursement rates for medical care should be raised across the board to rates equaling the Medicare reimbursement rate for the corresponding procedures.
2. The Medicaid fee-for-service reimbursement rates for dental care should be raised for preventive care and treatment to equal the 70th percentile of dental fees in New England.⁶
3. The Medicaid fee-for-service reimbursement rates for medical and dental care should be adjusted annually in accordance with adjustments made to Medicare fees.
4. Contracts with managed care organizations should stipulate that provider reimbursement should be at or above the Medicaid fee-for-service rates.
5. As an alternative to care managed by for-profit entities that contract with the State of Connecticut, care managed by primary care providers should be offered, especially in those parts of the state with relatively low provider participation in the existing managed care program. Primary care practices that can demonstrate a willingness and capacity for providing primary care, working with families who use the emergency department for non-urgent conditions, helping families obtain other needed services, and coordinating care with specialists should be paid either an enhanced care management fee (per member per month in addition to fee-for-service reimbursement) or at enhanced rates for primary care services. The

success of this managed care alternative is dependent on:

- a. Increased provider reimbursement;
 - b. Increased provider participation;
 - c. Management of primary care services by an administrative services organization, under contract to the Department of Social Services for building and maintaining an adequate network of primary care providers; assisting families with information, referrals, and support services; monitoring services; and reporting to the Department and the Connecticut General Assembly on performance on indicators such as preventive care, emergency department utilization, and referrals; and
 - d. Management of dental and specialty care provider networks and services by the Department of Social Services or its contractor.
6. Alternatives to the existing managed care program should be developed with input from primary care providers, beneficiaries, and child health advocates.
 7. The Department of Social Services, working with its program contractors and key stakeholders, should design and implement a plan to monitor care and to evaluate the impact of any program change on access, utilization, and satisfaction with services

Further, the Connecticut General Assembly should consider ways to reduce costs in the Medicaid program to offset -- at least in part -- the fiscal impact of a significant increase in Medicaid provider fees. Other states have cut costs in their Medicaid programs by moving from fee-for-service reimbursement to care managed by primary care providers, especially for the most costly beneficiaries. Since the costs of care for the elderly and blind or disabled in Connecticut far exceed the national average and are more than ten times higher than the costs for children and their parents, Connecticut should consider this managed care alternative for those whose care is currently reimbursed on a fee-for-service basis.⁷ Improving the management of care for these people should achieve some cost savings.

¹ Connecticut Voices for Children. Ambulatory Care for Children in HUSKY A: 2005. New Haven, CT: CT Voices, 2006.

² Connecticut Voices for Children. Dental Care for Children in HUSKY A: 2005. New Haven, CT: CT Voices, 2006.

³ Connecticut Department of Social Services. Mystery Shopper Project. Hartford, CT: DSS, November 2006.

⁴ Connecticut Voices for Children analysis of Medicaid reimbursement rates for problem-oriented evaluation and management services provided in a physician's office for a new patient. Data available upon request.

⁵ Beazoglou T, Douglass J. HUSKY A dental care: financial strategies (policy brief). New Britain, CT: Connecticut Health Foundation, January 2006. Available at: www.cthealth.org

⁶ The Connecticut Health Foundation recommends that reimbursement should be raised to the 70th percentile of dental fees in New England to increase provider participation in Medicaid. Source: Beazoglou T, Douglass J. HUSKY A dental care: financial strategies (policy brief). New Britain, CT: Connecticut Health Foundation, January 2006. Available at: www.cthealth.org

⁷ Average annual costs per beneficiary by type of beneficiary in Connecticut: \$21,105/year/elderly beneficiary, \$21,274/year/blind or disabled beneficiary, compared to \$1,859/year/child beneficiary, \$1,967/year/adult beneficiary. Average annual costs per beneficiary by type of beneficiary in US: \$10,971/year/elderly beneficiary, \$11,547/year/blind or disabled beneficiary, compared to \$1,400/year/child beneficiary, \$1,782/year/adult beneficiary. Based on analysis of 2004 Medicaid data by the Kaiser Commission on Medicaid and the Uninsured. Available at: www.statehealthfacts.org.

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