PRIMARY CARE CASE MANAGEMENT:

AN ALTERNATIVE FOR MEDICAID IN CONNECTICUT

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EXECUTIVE SUMMARY

The purpose of this report is to explore policy alternatives for Connecticut's Medicaid Managed Care program. The focus will be on states and their agencies, which administer Primary Care Case Management (PCCM) as a mechanism for implementing managed care within the Medicaid population.

PCCM programs offer the attractive promise of improved access to care while promoting cost efficiency and quality control. This is accomplished by channeling access to care for Medicaid enrollees through a primary care provider (PCP), also known as a "gatekeeper." The PCP is usually not at financial risk, but is responsible for providing primary care with around the clock availability, care coordination and authorization for services.

This report examines 22 states that administer a PCCM program. Most of these states have a combination of PCCM program and a Managed Care Organization (MCO) for delivering Medicaid managed care. In addition to improved access to care, cost efficiency and quality control, study results indicate that some of the states report better continuity of care, improved provider and enrollee satisfaction, and increased provider participation.

The experience of PCCM in the states reviewed lends support to the fact that alternative strategies are necessary for the operation of the current Medicaid Managed care system in Connecticut. It is beyond the scope of this study to exhaustively describe all intricacies of the state PCCM programs. What it does offer, is an overview of how geographically diverse state Medicaid programs have dealt with the challenges of implementing the PCCM program in their states in order to improve access to services and promote cost effectiveness.

INTRODUCTION

Approximately fifteen percent of the health care spending in the United States is associated with Medicaid (Levit, 2000). In 1998, Medicaid spending totaled $170.6 billion, an increase of 6.6 percent from the previous year, and up from $75.4 billion from 1990 (Levit, 2000). The General Accounting office reports five main reasons for the high growth rate. These include: an increase in disproportionate share hospital payments; an increase in the average cost per enrollee related to medical price inflation; declining reimbursement levels; and increasingly stringent quality assurance standards; and finally the overall growth in the number of enrollees (GAO, 1997).

As a result, many states have implemented managed care models to contain cost. All states except Wyoming now have some form of managed care for their Medicaid population. There are two primary mechanisms for implementing managed care in Medicaid, primary care case management (PCCM) and full-risk capitation. "Under fully capitated arrangements, a managed care organization assumes full financial risk for a defined set of services in exchange for a fixed payment per enrollee per month. Under primary care case management arrangements, the state pays a small [commonly $3] monthly fee per enrollee to "gatekeeper" physicians who are not at financial risk, but who control access to specialist care or hospital services" (Schneider, 1997).

The state of Connecticut initiated a full-risk capitation plan in 1995 with mixed results. During the initial phase of the reform, Connecticut's Medicaid spending increased, followed by a period of savings. Recently, however, this cost saving trend has reversed and Connecticut's Medicaid spending is now exceeding the traditional fee-for-service model costs. The state has also struggled to maintain health plans from which beneficiaries can chose. Only four of the original eleven plans are available today.

Nationally, the outlook is similar. The Congressional Budget Office projects that federal Medicaid spending on fully capitated managed care organizations will grow, on average, by fifteen percent annually for the next five years (as cited in Schneider, 1997). Current trends also suggest that while Medicaid managed care enrollment has continued to grow, recent analysis has shown that the number of commercial plans entering the Medicaid market has begun to slow, and the number leaving has increased (Kaiser, 1999).

A review of Medicaid managed care literature by Rowland, Rosenbaum, Simon, and Chait highlight the diversity of managed care arrangements state by state, but note

some important common themes. Most studies indicate a decline in the use of emergency and specialty services since the advent of Medicaid managed care, but do not find a clear picture on the use of physician visits, inpatient care, or preventative services. Studies about cost effectiveness are also inconsistent ranging from tremendous savings to higher expenses under managed care.

In light of these obstacles and the persistent problem of reducing Medicaid cost while maintaining quality, choice, and access Connecticut is now considering the primary care case management model as an adjunct to the full-risk capitation model.

The federal Health Care Financing Association (HCFA) gives states the option of offering Medicaid beneficiaries the choice of enrolling in managed care, including the PCCM model, as an alternative to fee-for-service. The first PCCM program was started by the state of Massachusetts in 1979. Between 1992 and 1994, nineteen states initiated PCCM programs (Horvath, 1996). By mid-1995, thirty-five states had PCCM in place accounting for 31% of all Medicaid recipients in managed care programs (HCFA, 1995). Currently, thirteen states use PCCM exclusively as the mechanism to deliver services to their Medicaid population, however many of these are in largely rural states (Schneider, 1997).

States are able to offer PCCM through the Section 1915(b) waiver of the Social Security Act. According to Schneider, the 1915(b) is most commonly used by states to require Medicaid beneficiaries to enroll in a managed care organization, and was not greatly impacted by the Balanced Budget Act of 1997 for states offering beneficiaries the option of voluntary enrollment (1997). For states that want to require mandatory enrollment a new Section 1932 waiver was established. This permits states to require PCCM enrollment as long as the beneficiary has at least two physicians or case managers to choose from and may access services from any other provider in appropriate circumstances (Schneider, 1997).

In either case, if the state elects to offer PCCM services they must be provided under a contract with the state Medicaid agency. This contract is not the same as one in which the state would enter with an HMO, however Schneider reveals there is substantial overlap in the areas of accessibility, adequate capacity, emergency services, discrimination on the basis of health status, and marketing practices (1997).

Although the primary care case manager has less financial incentive to deny medically necessary care, and therefore may improve quality of care, Schneider cautions that the model is not subject to the new requirements on other managed care organizations to establish an internal grievance procedure and external quality reviews.

As a result the state's or a beneficiary's ability to determine if they are receiving quality care may be greatly reduced.

Medicaid has many challenges. Most of its beneficiaries are "economically disadvantaged, frequently reside in medically underserved areas, and often have more complex health and social needs than do higher-income Americans" (Kaiser, 1999). It operates under tight budget constraints that threaten to compromise access and quality of care. The Balanced Budget Act of 1997 has established basic federal standards to assure plan capacity and enforce consumer protections, however each state is developing its own standards to meet the needs of its own Medicaid population. The Kaiser Commission on Medicaid and the Uninsured notes that "assuring access and quality of care in a managed care environment will require fiscally solvent plans, established provider networks, education of providers and beneficiaries about managed care, and awareness of the unique needs of the Medicaid population" (1999). The purpose of this report is to review the experience of PCCM in other states, present an analysis of the findings relative to the current Connecticut Medicaid Managed Care environment, and propose the potential benefits and shortfalls of PCCM to consider before implementing such a program in the state.

The first section of the report is a description of the study's methodology, the second is the experience of PCCM by state, and the final sections are devoted to results and recommendations. Appendices include a table of comparison, a resource list, and references.

METHODOLOGY

To gain a better understanding of how states across the country manage their PCCM programs currently and historically, a telephone survey of various professionals from 22 states was conducted. States utilizing PCCM were identified using a HCFA table found on the HCFA website. This table lists Medicaid managed care plans and enrollments by state as of June 1999. Each of these states was geographically grouped. A survey developed by four Yale University School of Nursing graduate students was conducted to identify and highlight specific information concerning the use of the PCCM model within each state's Medicaid population. The major focus of the survey was to identify and highlight specific information concerning the use of the Primary Care Case Management model within each state's Medicaid population. The survey participants included those individuals who possessed specific knowledge regarding their respective state's program(s). Examples of these individuals include; Medicaid directors, bureau directors, program managers, policy analysts, social workers, and others. The questions were designed to gather information about each PCCM program such as; the extent, age, historical background, name(s), eligibility, PCP designation and availability, per member per month costs, methods of program evaluation, existence of perceived benefits, and any known clinical outcomes.

Initial contact with each state was preceded by a search of the state's website where applicable. This was done for the purposes of obtaining baseline information of each program, as well as to ascertain the names and phone numbers of offices that administer or oversee each program. Once this basic information was obtained, states were contacted directly with requests for more detailed information. In order to obtain the desired information on a wide variety of topics, it was often necessary to contact more than one individual from each state. This was accomplished in several ways. Some states preferred to answer questions only after written requests via facsimile or mail were sent to individuals or offices. The majority of states agreed to interviews after messages were left at various offices requesting information through personal telephone contact.

For several reasons, not all of the states that utilize some form of PCCM were able to provide data in a timely manner. Some states were uncooperative; some were unavailable, while others simply did not have the ability to provide the requested information. As a result, the survey includes data obtained from 22 states nationwide. These states are Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New York, North Carolina, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington, and West Virginia.

States were compared using a variety of information including; per member per month (PMPM) costs, provider experiences and feedback, total program size, clinical outcomes, and important verbatim comments. All data was gathered not only from personal interviews, but also from available printed media. This includes published independent studies or reports, as well as 1915(b) "program" waiver applications. Because these waivers are granted for two year time periods (but may be continued indefinitely through renewal), states must track, document, and report certain outcomes during that period. Of significant importance is the PMPM cost data. However, for different reasons, not all states were able to supply these waivers.

In retrospect, some approaches to the gathering of data were more effective than others.

The more effective techniques include:

-The use of states websites as an initial encounter.

-The use of office personnel in the various states as resources.

-The use of telephone and voicemail as the primary mode of communication.

-The use of a standardized table and survey questionnaire.

Less effective techniques include:

-The faxing of questionnaires, which generally produced low response, rates and extended the period of data collection.

- Sending written requests for information via mail.

-Limited space on questionnaires restricted the respondent's information.

RESULTS

Driving Forces

The reasons for the adoption the Primary Care Case Management (PCCM) model varies by state, but only slightly. Reports of its use as a method of reducing overall health care costs for Medicaid recipients is unanimous. For example, Maine's program started out as a three county program and was expanded over a four-year period because it showed such impressive cost savings. Georgia's model started out as pilot project and eventually expanded statewide over a three-year period. Massachusetts adopted its PCC model mainly because costs were out of control, as Massachusetts was considered one of the 'easier' states in which to receive Medicaid assistance. In Pennsylvania, the state adopted the model to reduce costs it recognized were largely from the use of the emergency room as a treatment of choice.

Another reason for the adoption of PCCM was the lack of alternatives that existed in some states. Managed Care Organizations (MCOs) were either scarce or non-existent in many locales such as reported by New York and Indiana. In "frontier" states like Kansas, Iowa, and South Dakota, MCOs were unable to sustain operations in light of low population density in large, rural areas of the states. A smaller, individual primary care provider practice, federally supported rural health clinic or Indian Health Service clinic was more suited to serve these areas.

Some states reported having a less than ideal relationship with some MCOs and thus developed PCCM models for that reason. Access to a PCP was also a great motivator in the adoption of the PCCM model. All states report increasing consumer access to a PCP (medical home) in as cost effective a manner as possible, as a major goal in PCCM implementation.

Overall, the states feel their Primary Care Case Management programs are working well and as expected. Massachusetts has a Primary Care Clinician (PCC) program and they report that it is successful and growing year after year. In addition to its PCCM Medicaid model, New York utilizes a PCMP or Physician Case Management Program that is similar to its PCCM program but slightly larger. Through customer satisfaction surveys, Tennessee has demonstrated greater satisfaction among beneficiaries in its' PCCM model when compared to the former straight FFS model. This improvement was seen in three successive surveys. Florida, Virginia, and Indiana specifically report favorable patient satisfaction ratings as being in the 80^{th} to 90^{th} percentile.

Most of the PCCM models have been in existence since the early 1990's with the exception of New York whose 1915(b) waiver originates from 1987 and Kentucky whose waiver originates from 1985. Maine, Massachusetts, Indiana, Georgia, Louisiana, North Carolina, West Virginia, and Iowa use the PCCM model for 50% or more of their total Medicaid populations. (PCCM in both Pennsylvania and New York consist of much smaller percentages of Medicaid recipients at 12% and .4% respectively.) In the study, the largest PCCM models exist in Georgia and North Carolina with 675,000 and 579,119 enrollees respectively. Massachusetts with its PCC program consists of 500,000 enrollees, and 3,000 physicians in 1600 sites. The smallest programs exist in Washington which consists of 4,065 Native Americans, and New York with 5,182 in its' PCCM program and 7,000 in its' PCMP program.

Legislation

The state legislatures have had differing roles in the evolution of the various PCCM programs. The majority of states report solid legislative support for PCCM. For instance, Maine was mandated by its legislature to start the PCCM model because it couldn't attract HMOs to participate in Medicaid. The state feels that the PCCM model is much easier to oversee than MCOs/HMOs because data and feedback is much easier to obtain. Strong legislative support, affecting development of the PCCM model was present and greatly needed as reported by Idaho, Montana, Oklahoma, and Mississippi. New York reportedly likes PCCM/PCMP because unlike the HMO model, local control is maintained. Indiana on the other hand, reports continued lack of solid legislative support. The state is not known as a 'managed care friendly state' and subsequently had to struggle in order to develop a managed care model.

Eligibility and Access

Generally speaking, the Primary Care Case Management programs are mandatory for Medicaid recipients who do not choose capitated managed care programs. This includes those who receive TANF or Temporary Aid for Needy Families, CHIP or Children's Health Insurance Program, pregnant women and children at or slightly above the poverty level, foster children, SSI or Social Security Income recipients not receiving Medicare, and blind and disabled individuals. Among those usually included in PCCM programs are not people receiving Long Term Care (LTC), Medicare, residents of institutions, as well as hospice and medically needy populations. Interestingly, Tennessee reports that it "insures nearly everybody".

PCCM is available countywide in Maine, Pennsylvania, New York, Idaho, Mississippi, Oklahoma, Louisiana, North Carolina, and Iowa with plans to expand statewide in Maine. The remaining states operate statewide programs. Most states report

that growing or expanding their current PCCM programs are priorities, except for New York who encourages expansion only in rural areas, which have limited Medicaid penetration. Indiana, Idaho, Mississippi, Oklahoma, Washington, Florida, Georgia, Kentucky, Louisiana, Tennessee, Virginia, West Virginia, Iowa, Kansas, Texas, and South Dakota describe their programs as stable. Pennsylvania reports the phasing in of its' PCCM model in some counties and the phasing out of it in other counties as a result of the expansion of capitated managed care models.

Who is can be a Primary Care Physician (PCP) within the different PCCM programs varies only slightly. Most states recognize general and family practitioners, internists, pediatricians, obstetricians, gynecologists, and nurse practitioners as PCP's. Not only may individual caregivers serve as PCPs, but physician groups, community health centers, community hospitals, out patient departments, rural health clinics, and other federally qualified health centers may participate. Physician assistants are recognized as PCPs in Maine, Florida, Louisiana, North Carolina, Oklahoma, Tennessee, Washington, Virginia, and West Virginia. In many cases this is due to the lack of alternatives. In states with large Native American populations, provider selection is tailored to the needs of the population. This is clearly evident in Washington, where only Native Americans are eligible for PCCM.

The ratio of provider to patients is an important indicator of access to care. Estimated average ratios within these states range from 1 to 53 in Montana, to 1 to 2,000 in North Carolina, Tennessee, and Virginia. The average provider to patient ratio for New York and Mississippi is not known. Provider flexibility within the PCCM Medicaid model is granted as long as certain guidelines/protocols are abided by, such as around the clock availability and ongoing communications with appropriate state agencies. Providers are mandated to stay in touch with the various state agencies that administer each program. This is accomplished in several ways. There is heavy use of monthly/quarterly reports, report cards, and patient/provider satisfaction surveys. Massachusetts utilizes a Network Management Services Department whose only job is to communicate with PCPs very closely. Indiana stresses its use of provider relations representatives as well as the states extensive website. Louisiana utilizes random sampling in its mailing of surveys to recipients and evaluation of their program is based upon survey results.

Costs

Primary care physicians in PCCM are reimbursed on a fee-for-service basis with an additional monthly case management fee. The average fee among the various states is $3 per member per month (PMPM). Interestingly, Maine pays its' PCPs a quarterly bonus (based on performance) in addition to the management fee. Whatever the arrangement, the PCCM model has suppressed PMPM costs. For instance, Indiana,

which has reported a large cost savings, has saved approximately 20% PMPM in its PCCM program in comparison to straight FFS for the year 1998. For the same time period, Maine has reportedly decreased PMPM costs by 3.5% in PCCM versus non-PCCM models. Maine mentions PCCM costs as growing considerably less than they would if there was no physician oversight. South Dakota estimates it has saved $16.5 million for fiscal year 1998 with its' PCCM model. In an assessment of its PCCM model, Virginia has shown a 9% cost savings over their former FFS program. Florida reports cost savings ranging from 8.5 % to 19 % over a 27-month period between its PCCM model and straight FFS model. Massachusetts estimates for 1999, its PCC (FFS gatekeeper) model and its capitated MCO model have shown a 3% cost savings PMPM over the straight FFS model. Pennsylvania with its countywide PCCM model has evidently saved 13.7% in 1996 as compared to 1995.

Utilization

The popularity and extensive use of the PCCM models across the states is due in large part to the savings that each state has achieved. These savings are a result of closely managing utilization rates that appear to be decreasing. Most states report emergency room (ER) use has decreased since the adoption of PCCM. Maine, for example, has reduced ER costs by 9% PMPM as compared to straight FFS. Georgia reports that PCCM has dramatically cut back on "ER abuse". Louisiana stresses the importance PCPs have in educating recipients and discouraging unnecessary ER use. Prior to the implementation of PCCM, Tennessee's ER utilization rates were double what they were in 1997. However, Massachusetts and Indiana report continuing struggles with the management of their ER utilization in this population. Similar struggles are reported in Florida, with 73% of recipients continuing to use the ER for inappropriate reasons. Interestingly, in Indiana, 68% of patients report better health since joining PCCM, another 85% report their medical care as either very good or good.

As a result of the PCP acting as the case manager, not only has access to care increased but the use of preventative medicine has as well. For many Medicaid recipients, the PCP is a new concept that allows them to take advantage of information and services aimed at prevention. Many states stress the relationship with one's primary doctor as essential, and it is highly encouraged. With the continuity of care fostered by PCCM, PCPs are able to increase both patient education, and the use of important services/projects that target various diseases and ailments such as asthma, diabetes, and cancers. Maine reports that PCCM has decreased the utilization rates of specialist services because diseases are diagnosed earlier and thus treated more effectively.

Challenges

The challenges inherent in the PCCM model as seen by the states, differ somewhat. While some states express more than others, most challenges are not directly related to the model itself, but related to other issues. For example, Massachusetts reports that a disadvantage to its' PCC model is that it sometimes frustrates clinicians. Many times unassigned patients appear at provider offices randomly. The clinician is then responsible for contacting the patient's assigned physician for direction as to the level of care (if any) to be given. Other problems in the state are the lack of availability of providers in certain areas, and the fact that some members still do not show up for appointments or follow treatment plans. Georgia mentions operational challenges. For example, some PCPs complain that they do not have enough Medicaid patients while others state they have too many. Therefore, there is competition among providers for patients. Pennsylvania reports that PCPs may not possess the wealth of knowledge nor the resources to case manage. They stress that PCPs devote much of their time establishing resources to ensure patients are placed with available services. In essence, it requires them to make changes in behavior as reported by Louisiana. In New York, some feel PCCM is a "pain in the neck" to administer. They report that under this model the clinician is forced to construct his/her own network (who to refer to, who accepts Medicaid, etc), has lots of paperwork, must be available 24 hours a day 7 days per week, and that reimbursement is "God awful". Availability of PCPs was a big challenge in Florida. Providers originally were not complying with the 'around the clock availability' rule until the state began stringent enforcement of this requirement. The state reports that it is in a better position to be more selective of PCPs. The most frequently cited challenges in Tennessee were access to needed medications, inadequate reimbursement, and confusing or complex rules. Indiana clinicians complain of low reimbursement rates, but little else.

IMPLICATIONS FOR CONNECTICUT'S MEDICAID PROGRAM

In review of previous PCCM studies, little is known about how PCCM models affect the complex and fragile Medicaid Managed Care environment, which brings to light the need for ongoing systematic and comprehensive PCCM data collection. The information obtained from this study provides only a fraction of information regarding PCCM programs. None-the-less, it establishes a benchmark from which future change can be tracked and most importantly, this study will serve as a resource to Non-PCCM states exploring the option of primary care case management.

Historically, Connecticut's experience with Medicaid spending is comparable to other states. Increased beneficiary enrollment and uncontrolled health care costs is a

national problem. However, Connecticut enjoys several advantages which suggest that a PCCM program would be successful. According to many key Medicaid administrators, strong legislative support is critical to the viability of a PCCM program. Legislation passed by the Connecticut General Assembly in 2000 requires the state to conduct a study of alternative delivery models for Medicaid Managed Care, including PCCM. Connecticut is home to several strong PCCM advocates and policymakers, at the local and state levels, who are willing to begin planning initiatives to establish a strong PCCM program in this state. Additionally, the absence of urgency allows for adequate planning. Currently, four health plans participate in Connecticut's Medicaid system. However, given the dynamic trends of the Medicaid system, the risk of HMO's withdrawing from the Medicaid system is a constant concern. If this happens, important decisions are less likely to be efficient when made under pressure.

Another advantage Connecticut offers is better access to care. There are 31 Acute-care hospitals in CT (http://www.chime.org/, 2000) and 3.7 primary care physicians to 1,000 residents (http://state.ct.us/ohca/, 2000). Also, the population density in Connecticut is less extreme compared to other areas studied, which eliminates a common challenge reported by many states. In other states, long traveling distance seem to seriously compromise PCP accessibility. Of the 8 counties in Connecticut, Litchfield is the largest (920 sq. mi) and least densely populated area (196 persons per sq. mi), with a population of 181,227 (http://state.ct.us/, 2000).

Naturally, with the implementation of any new program, Connecticut will encounter a multitude of challenges unique to this state. However, like other states, with appropriate planning, legislative support and creativity, PCCM offers the flexibility to accommodate the needs of both private and public sectors.

Implications of the issues revealed in this study are important for Connecticut's policy makers to consider in making decisions affecting health care services to vulnerable populations. Policy makers will need to appraise the efforts of those PCCM states that continue to make important contributions in the Medicaid arena. In light of the information gathered in this study, it is safe to say that implementing a PCCM model offers Connecticut an alternative strategy to improving access to health care, controlling Medicaid program costs, and offering beneficiaries the freedom to choose between health plans. The experiences of PCCM states, as documented in this study, has helped to create a "PCCM" template for Non- PCCM states. The following template is designed in respect to the Medicaid system in Connecticut.

- Demographic/Geographic Needs Assessment. Collect baseline of state vital statistics regarding logistical, cultural, and medical needs for each county (Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham).

- Pre-PCCM Planning. Contract with an outside agency to conduct this phase or independently dedicate professionals to begin PCCM program planning and designing to establish a solid PCP network and organizational infrastructure. Include all stakeholders, private and public, in each stage of planning (regulation, administration oversight, etc.) to ensure continued survival within the changing political context.

- Pilot Program. Implement a PCCM pilot program in two counties for comparison purposes.

- Marketing. Educate policy makers, the general public, eligible PCCM member and other individual affected by using the Internet, letters, brochures, and other areas of media advertising directly

- Organizational Structure. Designate one person or agency to oversee and coordinate the satellite offices in each region. Each regional office will coordinate private and public sector initiatives and strictly reinforce PCCM rules and regulations according to the needs for that region.

- National PCCM Association: Establish a local chapter of PCCM Advocates and participate in a national PCCM Association.

- Electronic centralized database. Design a quality assurance system that will systematically and continuously collect, critically analyze data, and generate valid and reliable feedback, in a timely and consistent fashion, to providers and consumers. Mandate one Independent Assessment every two years.

CONCLUSION

This report demonstrates that data collected from PCCM programs and centralized at one location can be useful in monitoring trends in PCCM programs and provide an alternative source for a multi-level analysis (i.e., regional, state, and national) of the PCCM program participants. While the results presented here should not be solely used for decision-making purposes, they are a valuable complement to the existing PCCM studies. Future legislative questions to think about:

- What factors would influence the decision to implement a PCCM program in Connecticut?
- What degree of dissatisfaction by Medicaid recipients will be tolerated before changes in the current Medicaid system are made?
- How much longer can Connecticut's Medicaid healthcare spending continue to be out of controlled?

- What other alternatives currently exist that will decrease Medicaid healthcare spending, while improving access to medical care and consumer satisfaction?

These questions will remain in the forefront as implications for healthcare policy change. As more states move towards evolving and expanding their PCCM programs, comprehensive data collection and analysis will become still more important. It can only be beneficial for Connecticut to continue collecting such critical health care information in order to develop a PCCM program tailored to the needs of its low-income population. Connecticut's Medicaid recipients deserve a healthcare delivery system that will provide access to quality care.

APPENDIX.

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