

# **ISSUE BRIEF**

May 2011

# Fixing Medicaid: Healing Connecticut's largest health care program

### **Summary**

Connecticut's public coverage programs, Medicaid, HUSKY and the former SAGA program, provide care to one in six state residents. Consumers enrolled in these programs encounter significant challenges accessing health care, mainly due to difficulty finding participating providers. As enrollment in these programs grows due to health reform and economic forces, the shortage of providers will become more acute. The most commonly cited reason by providers for unwillingness to participate is inadequate payment rates, but there is evidence to suggest that other barriers are also significant. In 2008, Connecticut's Medicaid fees averaged 44% higher than the US average, but our provider participation rates are far behind states with lower payment rates.

In January 2008 Connecticut implemented the largest Medicaid, HUSKY and SAGA provider payments rate increase in the state's history. We surveyed Connecticut physicians about their participation in public programs before, during and after the rate increases were implemented. Unfortunately, the rate increases made little difference in providers' willingness to accept public program patients.

To identify other provider barriers to participation we conducted focus groups,

surveys and interviews with practices across the state. Respondents outlined a multitude of disincentives to participation including administrative hassles, poor communications with the state, and unreceptive provider relations.

In developing recommendations to improve Connecticut's recruitment and retention of providers, we interviewed stakeholders from states with demonstrated success.

Recommendations include reorienting agency attitudes toward practices, redesigning systems

The bottom line is it's about rates, but that's not nearly all of it.

- practice manager

from the perspective of providers, using outside consultants to serve providers, overhaul communications, adopt fair and transparent compensation models, and patient education. The most important recommendations are to engage providers as equal partners in policy development and program monitoring at every stage and recognize their essential value in the programs in meaningful ways.

### Introduction

Connecticut health care consumers in public coverage programs, as in many other states, experience a great deal of difficulty accessing services. Connecticut's state-administered public coverage programs include Medicaid and

HUSKY, between them covering low income children, families, people with disabilities, and seniors, and the former SAGA program, covering very low income adults, which was integrated into Medicaid in 2010. One out of six state residents is covered by these programs<sup>i</sup>. In 2009 only 65% of children in the HUSKY

program received a well-child screen. Lack of access to care forces many Medicaid recipients into emergency rooms. In 2009 Connecticut Medicaid patients made up 35% of emergency department visits that did not require inpatient admission, but only 13% of our state's population. The greatest barrier to accessing care is often finding providers willing to take patients covered by public programs.

Physician participation in public programs is voluntary. The number of physicians participating in Medicaid nationally has decreased over the last decade. Unfortunately, the introduction of managed care has been associated with a decrease in primary care physicians in the program. Family practice and internal medicine physicians are twice as likely as pediatricians to refuse all Medicaid patients. This is especially troubling for the expansion of eligibility to 140,000 new Connecticut residents, mainly adults, in 2014 under national health reform.

While Medicaid rates paid to providers are a significant barrier to accepting patients ix, there is evidence that other influences are also important. Connecticut's Medicaid fee-forservice rates are relatively generous compared to other states. In 2008, Connecticut's Medicaid fees averaged 44% higher than the US average, paying 99% of Medicare rates compared to the US average of 72%. Between 2003 and 2008, Connecticut raised Medicaid provider rates by 28%, while general inflation was only 20% and other states' rate increases averaged 15% over the same time period. Studies have shown little, if any, improvement in access to care with increases in Medicaid rates, particularly for more generous states such as Connecticut.<sup>x</sup>

There is growing evidence that other barriers, beyond low reimbursement rates, are significant in deterring physicians from participating in Medicaid. \*i Reimbursement rates have a relatively modest effect on provider participation nationally. A national

study found that a 10% increase in rates resulted in only a 2.1% increase in Medicaid acceptance rates among primary care providers.xii Billing and insurance activities are a significant drain on medical practices, both in staff time and in revenues.xiii In a national physician survey, among those taking only some or no new Medicaid patients, the largest concern cited as important in that decision was inadequate reimbursement (82.6%), but billing issues (70.1%) and delayed reimbursement (68.3%) were also important barriers. The clinical burden of Medicaid patients (50.7%) and capacity constraints (43.7%) were less important barriers. xiv There is evidence that Medicaid reimbursement delays across states can offset the impact of higher rates, lowering participation rates to the level of states with lower payment rates.xv

We have looked into participating at least twice, but it was too burdensome.

- physician

There is strong evidence that excessive paperwork and administrative hassles in Connecticut's Medicaid program is a significant deterrent to provider participation. A 2000 survey of private, office-based Connecticut pediatricians found that 50% cited low reimbursements as reasons for limiting Medicaid participation, 33% cited missed appointments, 35% cited unpredictable payments, 26% felt that Medicaid patients were less compliant, 24% each cited payment delays and paperwork, 23% cited increasing state managed care requirements, 20% cited regulations that interfere with quality medical care, 19% said the program was too complex, and 16% cited high emergency room use.xvi Maine's Medicaid rates are 47<sup>th</sup> among states

(Connecticut is 5<sup>th</sup> highest), but 85% of Maine's physicians participate in their Medicaid program. \*Vii A 2008 study found that it took on average 73.6 days for a Medicaid bill to be reimbursed compared to only 36.4 days for commercial insurers. \*Viii Connecticut's Access projects, federal community-based programs to connect the uninsured with health care resources, have found it easier to recruit physicians to serve the uninsured without any compensation than to accept Medicaid even at 99% of Medicare rates. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound. \*Xix Stories of excessive paperwork and even persecution in Connecticut's Medicaid program abound.

Pressures on access to care in Connecticut's public programs are expected to grow in the next several years. In addition to the estimated 140,000 new members expected to join Connecticut's Medicaid program in 2014 under national health reform, current enrollment in Medicaid, HUSKY and SAGA grew by 8% in the last year with no expansion of eligibility. \*xii\* To address concerns about access to care, national health reform includes increases in Medicaid primary care provider rates up to Medicare levels, paid for by the federal government, for 2013 and 2014. \*xiii\* However, there is growing concern that this may not be sufficient to meet the need. \*xxiiii\*

### This study

In 2008 the Connecticut General Assembly appropriated the largest Medicaid rate increases for physicians and hospitals in the state's history; the first significant rate increases in the programs since 1989. \*\*xiv \$54.6 million was appropriated across those two years to increase provider rates in the Medicaid fee-for-service, HUSKY and SAGA programs. Capitated rates to HUSKY health plans were also increased to reflect higher provider rates. \*\*xv The rate increases were effective January 1, 2008 but implementation was not complete for several months. \*\*xvi However the increases were not evenly applied across categories. Shorter

visits received fee cuts (after adjusting for inflation) and longer visits received increases. \*\*X\*VIII\* General preventive pediatric rates were 80 to 120% higher than non-pediatric rates before the increase and were not

A: We're actually closing the practice in about a month.
Q: Do HUSKY, SAGA, and Medicaid make up a significant percentage of your practice right now?
A: Yes, they did. That's why we're closing.

increased further.xxviii

To assess the impact of the rate increases, we surveyed Connecticut physicians about their participation in Medicaid, HUSKY and SAGA before and after the rate increases, in the summers of 2007, 2008 and 2009. To collect more detailed information on the sufficiency of rate increases as well as the contribution of other factors to provider participation in Connecticut's public programs we held focus groups, in-depth surveys, and interviews with Connecticut practice managers, administrators, physicians and other clinicians. To gather best practices, we interviewed key stakeholders from other states with success in engaging providers in their Medicaid programs. Based on this research, we offer targeted recommendations to improve provider engagement and participation in Connecticut's public coverage programs.

### **Methods**

Interviewers called 850 physicians randomly sampled from the 4,970 Connecticut State Medical Society membership list (2007). Calls were made to the same set of physicians at the

phone number listed in the CSMS database in June/July 2007 (before the rate increases), June/July 2008 (during and immediately after the rate increases were implemented) and June/July 2009 (a year after implementation). Physician offices were asked about each physician's participation in HUSKY, Medicaid and/or SAGA, specifically whether they are taking new patients for appointments within the next two weeks. Across all three years, the response rate was 71.4%.

In October 2009 in-depth surveys were sent to all 340 members of the Connecticut Medical Group Management Association. Respondents could respond by mail or in an identical online survey and were offered a gift certificate for their participation. Responses were collected through March 2010; the response rate to this survey was 26%. An email invitation to a different online survey was sent to Connecticut community health center clinicians in March of 2010. We held three focus groups with practice managers, physicians, and with community health center chief financial officers. The practice manager and physician groups included

some participants who accept public coverage patients, some who never had, and some who had ceased participation. We conducted focused interviews with stakeholders in Connecticut's public programs including physician, nurse practitioner, practice administration, hospital, community health center, and social service leaders as well as current and former Medicaid state agency staff. We interviewed practice management consultants, medical societies and Medicaid administrators representing forty states to collect experience in maximizing provider participation.

### Results

The phone survey found that about half of Connecticut physicians participate in HUSKY and Medicaid; about one in three participates in the SAGA program. Those participation rates varied little over the three years, despite provider rate increases.

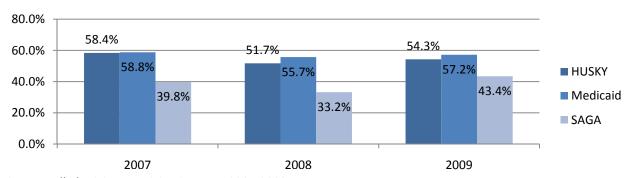


Figure 1: All physicians participation rate, 2007-2009

Slightly more than half of primary care physicians participate in HUSKY or Medicaid; about one in three would take new SAGA patients. Both HUSKY and Medicaid

participation rates decreased over the three years for primary care physicians, but the drop was not statistically significant. SAGA participation rates were relatively stable.

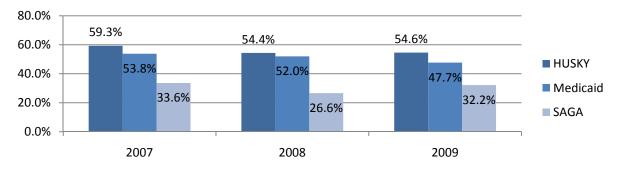


Figure 2: Primary care physicians participation rate, 2007-2009

While primary care physicians were more likely to accept HUSKY than Medicaid patients, the reverse was true of specialists. Specialists were slightly more likely than primary care physicians to take Medicaid and SAGA patients but slightly less likely to accept new HUSKY patients. It is possible that this is related to primary care

shortage issues and a general shift from specialty to primary care across Connecticut's health care system. There was a small but not statistically significant increase in specialist participation in all three programs after the rate increase.

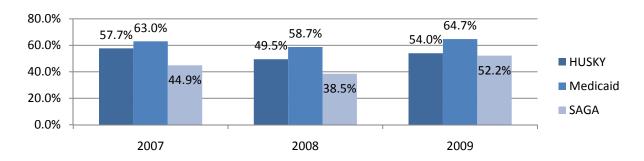


Figure 3: Specialist participation rate, 2007-2009

We also compared physician retention in the programs with paired sample correlations. We found that the rate increases had little impact on physician retention, in fact, retention in HUSKY and Medicaid was lower after the rate

increases than before. Physicians who participate in SAGA, while the smallest percentage, are the most likely to remain in the program. Overall physician retention in all three programs is about half.

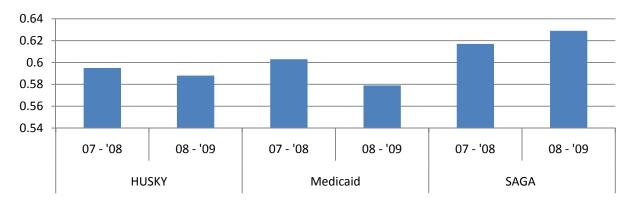


Figure 4: Participation correlation between years, all physicians

Most respondents to the survey of practice administrators participate in Medicaid (77%) and HUSKY (55%). Fewer accept SAGA (43%) and 17% take none of the three programs. One third of participating practices are not sure if they will be participating in five years; 11% either definitely or likely won't be. Of those who do not participate, reasons included insufficient rates and too many hassles. The most commonly reported problem in all three

programs was insufficient rates, followed by claims processing, customer service, communication with the state, provider credentialing, eligibility verification, prior authorization, policy changes within the programs, and communication with managed care companies, in that order. More respondents reported problems with Medicaid, closely followed by HUSKY and fewer in SAGA.

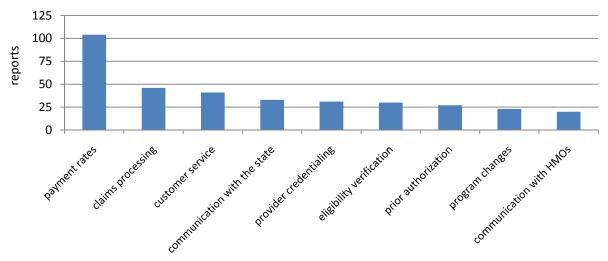


Figure 5: Practice management problems reported

Forty three percent of respondents were aware of the rate increases but reported that they had minimal impact on their practice. Seventeen percent felt that the rate increases had a very positive impact. Twenty four percent reported

that the rate increases had no impact on their practice. Seventeen percent did not notice the increases. Survey respondents were generous with ideas to improve the program. Repeated themes included:

- Rate increases
- Better communication -- One suggested etiquette training for customer service staff; another suggested that staff should be more helpful when called.
- Better information for consumers –
   Patients are confused navigating the
   programs and rely on providers for
   help.
- Recruit more physicians, especially for referrals
- Make prior authorization processes easier
- Update program information more frequently
- Quicker payments to providers

It's extraordinarily time consuming to get a straight answer out of them (DSS).

- practice manager

The survey of community health center clinicians raised overlapping issues with practice managers. Half reported that participating in the programs is getting more difficult over time but half expect to still be participating in five years. Reported administrative problems centered on payment rates, prior authorization, and communication with the state. No problems were reported interacting with the SAGA program by community health center clinicians. The most commonly reported patient issues were not showing up for appointments, non-compliance with treatment plans and inappropriate emergency department use. Ideas to improve the program included:

- Offer care coordination in the office
- Truly support and expand HUSKY Primary Care (Primary Care Case Management)
- Make the rules simpler and standardize across programs
- Increase payment rates, especially for specialists for referrals
- Faster prior authorizations
- Give providers better information on patients, addresses, contact information, current and prior use of other services, etc.
- Pay for translators
- Public service announcements on patient-centered medical homes
- Better patient education systems
- Free language courses for staff
- Get more input from providers into proposed policy changes – Some reported that by the time they hear about a change from the state and from managed care organizations, it has already been decided.

Poor communications were a constant theme in focus groups and stakeholder interviews with private practice managers and physicians. Staff and clinicians spend a great deal of time interacting with the state and managed care organizations wasting hours on the phone. We heard several times that state Department of Social Services (DSS, Connecticut's Medicaid agency) staff will not answer questions in writing, creating concerns that the guidance will not be honored later. Several reported getting different answers on different days from different DSS staff. Many complained about DSS staff attitudes, lack of courtesy, and not returning calls. There is a strong perception that the rules are not applied fairly or evenly – some practices left the program when they felt "targeted" by DSS staff. There was a strong feeling that practices to be audited are not selected fairly. "There's almost a perception of guilt if a provider is doing a lot of Medicaid

business." Participants felt they were hassled for no reason. There is a pervasive perception that the system is not a partnership, that providers who participate in the programs are not respected.

Three stories from focus groups and interviews highlight the problems.

Over ten years ago a large pediatric practice realized that many of their patients were going to hospital emergency departments in the early evening, as schools and daycares were ending and just after the practice closed. Often these visits were for small problems that could have been dealt with more easily for parents and more economically for payers in the office. In response the practice decided to stay open a few hours in the evening; the added hours were only for urgent care, no appointments were scheduled during those hours. The practice arranged modest additional payment to compensate for extra staffing with all their payers under a billing code for after hours care. Most payers were thrilled at this development as the charge was far less expensive than an emergency department visit. DSS's payment for the billing code was smaller than other payers (\$4 compared to \$11 to \$12 for the same code). The practice communicated with DSS staff about the code several times during those years and were always reimbursed by the HUSKY managed care organizations for the code. Staff never stated that billing under the code was not allowed. An audit of the practice found the payments and denied them. Rather than thanking the practice for saving the state significant funds and for improving access to care for families, they were assessed triple damages back ten years, which is the maximum allowed. The complaint involved only a few thousand dollars per year in billing. (Practice managers from other states stated that if this happened elsewhere, the worst that would likely happen is that the practice would be asked to stop billing under that code.)To avoid a lengthy and costly legal battle, the practice

settled the complaint and paid back \$74,644 to the state for the last ten years in addition to \$35,000 in legal fees. The practice has stopped allowing Medicaid families to come in afterhours – doubtless sending patients to the emergency department, costing the state far more – and are seriously considering leaving the program altogether. The practice reported getting no help from DSS, and felt that they were treated as if they had committed intentional fraud. The practice received no assurance that there will be changes to policy guidance warning practices about billing for the code to ensure nothing like this happens again. (Edmund Mahony, Medical Practice Fined, Hartford Courant, 4/7/10)

Q: Why did you stop taking the programs?

A: Too many regulations. We lost a lot of money on each patient we saw. It's not worth it.

- Practice manager

In May 2008 advocates, physicians, hospitals, and other providers in the Bridgeport area were concerned about the low rate of Medicaid provider participation in the community and scheduled a meeting with DSS personnel. The meeting resulted in a set of five very modest recommendations that DSS staff promised to take back to the department. The recommendations included:

- Establishing a "guest privilege" system to expand the number of participating providers available to care for patients
- Allow facilities to be credentialed as their own entity

- Ensure that providers have direct access to managed care organization medical directors
- Ease HUSKY credentialing for providers already credentialed by those same managed care organizations for commercial patients
- Identify physician champions to help recruit their colleagues into public programs

While advocates followed up after the meeting, they received no response from DSS. We could not confirm that the Medicaid Director or anyone in DSS leadership was informed about the meeting or the recommendations. (June 4, 2008 B Edinberg, BCAC letter)

In another instance, a practice manager sent in a stack of paperwork "inches thick" to credential a new provider in the program. She eventually got the stack of documents returned to her with a cursory memo stating that there were one or more errors in the paperwork. There was no indication on which page or what type of error was made. She had to make many calls for over a month to find the DSS staff person responsible. The physician placed one of the numerous initials required on a line below where he was supposed to sign. She suggested that DSS get Post-It arrows to indicate where changes need to be made. She stated that this was only one recent example of the many unique hassles in the Medicaid program that serve as a barrier to participation. She commented, "You would think they don't want doctors to join Medicaid."

Focus group participants' suggestions to improve the programs included

- treating providers and practice staff with respect, as equal partners in caring for patients, with consideration for the pressures on practices
- improve communications, with clear answers in writing available online

- better transparency in policies, rates, rate setting, and developing/monitoring new policies
- ensure the system is fair, that everyone is treated equally, and rules are applied evenly and consistently

Most providers are scared that if they ask too many questions, that will invite scrutiny. You have to trust the person you're calling.

Practice manager

In sharp contrast to the experience of private practices, community health centers reported excellent relationships and communications with DSS staff. They reported getting timely updates on policy, being solicited for input on policy development, and identified staff to call with questions. DSS staff regularly visit the Community Health Center Association of Connecticut (CHCACT) offices to meet with community health center administrators and staff. Community health center staff reported feeling respected and appreciated by DSS staff for the care they provide to patients.

Community health center respondents proposed several reasons for their better treatment by DSS staff including:

- Recognition by DSS of the large patient volume treated at community health centers –"We have a bigger population so we have a bigger voice. They have no choice but to deal with us."
- Community health centers are organized – CHCACT staff spend a great deal of time working out common issues with DSS staff. Even though the efforts are labor intensive and it is a "struggle", the resulting guidance is shared across all clinics. Respondents

- noted that this effort is not feasible for even large private practices acting alone.
- Personal relationships developed over years between DSS and community health center staff
- Lawsuits have been necessary at times

This administration bent over backwards not to alienate physicians.

Maine Medical Association

Interviews with Medicaid stakeholders from states with better participation rates, many with lower provider rates, offer more guidance to improve Connecticut's program. Providers and Medicaid agency staff from successful states regularly refer to the program as a "partnership" with mutual respect, shared goals and trust. Providers believe they are recognized as the "core" of Medicaid system by state agencies. Practice managers noted the importance of "listening to provider concerns, answering their issues, acting on them and following through." (stated with emphasis)

Both providers and agency staff in successful states describe policymaking as a collaborative process. Quality incentive and bonus programs are developed together. Providers in one state remarked that the agency had been very active in advocacy efforts to increase provider rates. While the advocacy was not successful, the effort was appreciated and added to provider trust in the agency. The medical societies in some states regularly include Medicaid agency articles in their newsletters.

"Very open lines of communication" between Medicaid agencies and providers was a common theme across successful states. Providers report feeling that their input is valued and are confident that issues raised will be addressed. Agency staff understand that participation in Medicaid has its challenges and is voluntary. Staff are responsive, agency contacts for each issue are clear, questions are answered quickly, in writing, and answers are shared with the entire provider community. Agency staff and provider groups both take responsibility to both update providers on policy changes, collect input from providers to monitor programs, and solicit input on proposals before they are adopted. Maine hires consultants to survey providers and practice managers regularly. Results from the surveys drive policy and operational changes. Successful states have user friendly websites with clear policies, updated often. Providers also get weekly emails with updates and online portal for claims and adjustments. Providers reported that it is critical that agency staff "admit what doesn't work and fix it" and "act on the feedback you get or they'll never trust you again."

Successful states also report that the state's provider culture includes an expectation that they will participate in Medicaid. Several noted that Medicaid patients can be challenging everywhere, but there is a strong history of participation in the program. Seventy three percent of Maine physicians and 64% of office managers report that their favorite thing about participating in MaineCare is the program's commitment to increasing access for low income populations. \*\*xix\*\*

If it's hard to get paid, they won't do it.

- Multi-state practice management consultant

A very important feature of successful states is prompt payment. Practice managers in Connecticut and other states stated that being paid quickly is often more important than raising rates. At one point Vermont's program had a six to seven month backlog of payments. They heard from practices in focus groups that this was a serious disincentive to participation and addressed it. Staff travelled out to practices, updated the eligibility verification system, and instituted regular monthly meetings with provider associations at their offices. Vermont now promises to pay bills within at least 14 days; most often within four days for large practices.

Advice from providers and Medicaid agency staff in successful states included:

 Make it as easy as possible for practices to get paid – "In too many states, the money left on the table unpaid is greater than the Medicaid

- underpayment" reported a large practice management consulting firm.
- Meet with physicians when it is convenient for them, usually 7am or 6pm, and feed them
- Reach out to practice managers' groups
- Ensure it is clear who to call at the agency for each issue, with a name, number and email
- Ensure agency contact staff are friendly
- Attend provider meetings -- buy a table or booth at provider organization conferences
- Find champion doctors to help recruit colleagues into the program. Solicit their input often.
- Create standing meetings with provider and practice management organizations at their offices with open agendas.
- Collaborate on all policy development, including small issues.
- Consider incentives to providers for participation

### Recommendations

Providers are very eager to engage in improving the program. As soon as we explained why we were asking, very busy providers and practice managers took time to share their thoughts with us. By and large, people seemed very pleased to be asked for their input and the input was largely constructive.

### Reorient agency attitudes toward providers

Providers are looking for a true partnership of equals with the Medicaid administration. DSS must work to re-build trust with individual providers currently participating, and the larger provider communities in Connecticut. It is critical that providers and practice staff be treated with courtesy as respected professionals. DSS must solicit and welcome complaints from providers and must rigorously

follow through to resolve them – both for the individual making the complaint and improvements to the system to avoid future problems. DSS should demonstrate in meaningful ways that they value practices that

There's almost a presumption of guilt if a provider is doing a lot of Medicaid business.

Practice manager

continue to participate in this critical program.
Regular provider surveys, by independent
consultants, are essential to identify problems
and get honest feedback. It is critical to create a
system to identify when a practice or provider

has reduced their Medicaid business, reach out to them, and make genuine efforts to remedy any problems. A practice management consultant working in other states noted that if a practice leaves Medicaid, it takes fifteen years for them to give the program another chance and get them back. If capacity issues are a problem, identify government and private resources and policy changes to assist.

### Redesign systems from the perspective of providers

DSS must perform a detailed assessment of internal and external systems from the practice/provider viewpoint. The audit must not simply assess compliance with current policies, but assess whether those policies and procedures are serving a purpose, are as efficient with practice staff time as possible, are timely, are responsive, constructive and integrate with commonly accepted standards used by other payers. We recommend that this audit be performed by outside consultants rather than internal DSS staff to ensure robust findings and credibility. Systems and functions to audit include, but are not limited to:

- provider enrollment and credentialing
- prior authorization
- eligibility tracking
- claims processing, including timeliness and resubmission processes
- billing practices

It is strongly recommended that the state move as much provider relations, including recruitment, billing, claims processing, contracting and credentialing, out of DSS as possible, ideally to consultants with demonstrated success in building positive relationships with providers.

It is critically important that DSS completely overhaul the current auditing process. All respondents support legitimate investigation of fraud and abuse, but many practices believe the current process does little to further those goals. The current audit process is widely perceived as punitive rather than constructive. Respondents do not believe that the design of the current audit process is effective at

## Lots of good hearted souls are getting hammered.

- Practice manager

### identifying true waste, fraud or abuse. **Overhaul communications**

Good communications are critical to building trust, quality control and ensuring compliance with and developing good policies. DSS needs to listen more and talk less. There should be regularly scheduled meetings with provider organizations with open agendas. DSS staff should come to providers at their site, as they do for community health centers. DSS must arrange meetings at practices' convenience rather than expect busy professionals to come to them. Providers should receive regular, userfriendly updates/newsletters with information on policy changes and proposals being considered. Each communication should include multiple methods for submitting feedback or questions. DSS's provider website should be overhauled and updated often. Contact information with names, phone numbers and emails for each issue area are critical.

DSS phone staff should be courteous, responsive and follow up on questions or complaints in writing. We heard that staff are rushed on the phone and too quick to refer callers to the website which often does not have the answer. Those answers should be shared not only with the practice that asked, but also more broadly through the website and newsletters. Phone staff should receive training and DSS must take efforts to ensure quality; we

heard numerous complaints that DSS staff gave different, inaccurate answers to different people on different days.

It is critical to consult with providers and practice managers on proposed policy changes and regularly after implementation to ensure each policy is performing as intended.

### Fair, transparent compensation models

Rate setting is a constant complaint from providers. Not only are rates too low, but there is a perception that rate setting is arbitrary or worse, that resources are directed to favored groups. Some respondents stated that they could accept the low rates, but not understanding how rates are set process is a greater disincentive to participation. Other states and systems face similar challenges but thoughtful rate setting models exist. xxx

### **Patient education**

Productively engaging patients in their own care and strong patient-provider relationships are critical to making the system work. Patients are often confused about program policies and turn to their providers as trusted sources for information. Many practices noted that better

information both directly to patients and for them to give patients when asked would ease that burden.

Providers also mentioned the burden of patients who do not show up for scheduled

## Participating in these programs is like charity work for the doctor.

- Practice manager

appointments as a barrier to participation. Some Connecticut practices have had success in reducing missed appointments and there is a growing literature on effective methods to reduce missed appointments. Some methods are practice-specific but some could be supported by DSS. Options include orientation statements and videos, phone prompts, mailed reminders, automatic appointments, patient contracts, and sharing best practices among providers. An important role for DSS is to make expectations clear at enrollment and to explain to patients the financial burden of no-shows on providers and the impact on access to care, causing overbooking and longer waiting times.

### **Authors**

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