



**Saint Raphael
Healthcare System**

Sponsored by The Sisters of Charity of Saint Elizabeth

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**WRITTEN TESTIMONY OF
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SAINT RAPHAEL HEALTHCARE SYSTEM**

**HUMAN SERVICES COMMITTEE
Thursday, March 15, 2007**

RE: H.B. 7322, AN ACT CONCERNING MEDICAID MANAGED CARE REFORM

Thank you for the opportunity to submit written testimony regarding House Bill 7322, An Act Concerning Medicaid Managed Care Reform. I would like to commend the Human Services Committee for raising the managed care reform bills and addressing many of the inadequacies of the current Medicaid managed care program.

Saint Raphael's supports many of the recommendations in House Bill 7322 and would also like to offer some suggestions to strengthen and clarify the bill's language:

- Sec. 5 (d) line 84 – the words “allocated for” should be substituted with “annually expended on” so that the contracts between the Department of Social Services ("DSS") and managed care organizations ("MCOs") would require the MCOs to provide an accounting of where the funds were actually spent.

Sec. 5 (d) line 87 – we suggest adding another sentence, such as “Contracts between the department and a MCO shall also include the total dollar value of “withholds”, if any, that are not paid to healthcare providers.” A "withhold" is a percentage of the payment to primary care providers that is held back to incent them on the appropriate referring of patients for diagnostic tests and specialty providers. Because of the economic consequences for practitioners, you may not be aware that “withholds” result in some healthcare providers limiting access to specialty and other types of care.

Sec. 5 (d) lines 90-91 – since MCOs may receive other rebates beyond those from pharmaceutical companies, you may want to consider changing the language to report "any rebates provided by a manufacturer, vendor, and/or distributor to a managed care organization."

- Sec. 7 requires the DSS to hire a medical director to determine medical necessity. Since this hinders the relationship between physicians and their patients, we suggest the following change in line 112:
“...the DSS shall hire a medical director , whose prescribed duties shall include reviewing MCO denials and assisting HUSKY beneficiaries with appeals.” Physicians and other providers need help with the MCOs’ denial instead of adding another layer of approval prior to treatment.
- Sec. 9 – since the primary care case management (PCCM) model has succeeded in some states and failed in others, we suggest that **the PCCM model should first be limited to a pilot program**. A pilot program would allow the State to test the model while working out the details of this new system of care.

If the PCCM model is implemented in any capacity, it is extremely important that hospital clinics are not left out of the definition of a primary care provider. For this reason, lines 148-150 should be changed to, “The network of primary care providers utilized by the department shall include but not be limited to healthcare professionals employed by community health centers and school-based health centers.” This requested change is critically important in the urban centers where it is extremely difficult to attract private primary care providers. We understand the goal of the proposed managed care reform legislation is to improve access and expand the number of primary care providers – the language change is essential to continue to allow Medicaid patients to receive care through hospital-based primary care clinics.

- Sec. 11 – this section allows DSS to implement a MCO pay-for-performance system. Since this section states that no additional appropriations will be made for bonus payments, **we are concerned that a pay-for-performance bonus system will result in reduced payments to providers and will create even less access for Medicaid patients.**
- Sec. 12 – since the language in this section is somewhat restrictive, we suggest substituting this section with Section 3 from proposed H.B. 7375, AAC Health Care Access and Expansion of the Husky Program. Section 3 from H.B. 7375 requires reimbursement to providers at the Medicare rate or, if not available, at the usual and customary rate paid to private providers.

We appreciate the opportunity to comment on H.B. 7322, An Act Concerning Medicaid Managed Care Reform, and, again, commend the Human Services Committee for raising this important issue. You have identified and recommended changes that will not only streamline the system and improve efficiency but, more importantly, may result in improved access for Medicaid recipients. A substantial increase in Medicaid and Medicaid managed care provider rates would also expand access and would assure that the current “healthcare safety net”, such as the Hospital of Saint Raphael would be able to continue its outreach and primary care programs to serve our community’s needs.

Thank you for your consideration of our testimony.