



Office of The Attorney General
State of Connecticut

*TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL
BEFORE THE HUMAN SERVICES COMMITTEE
MARCH 15, 2007*

I appreciate the opportunity to support the provisions for reforming Medicaid managed care that are contained in House Bill 7322, An Act Concerning Medicaid Managed Care Reform and Senate Bill 1425, An Act Concerning Managed Care Organizations Contracting with the Department of Social Services.

This legislation improves the accountability and the delivery of services under our Medicaid and HUSKY health care programs by:

- requiring that rates paid by state contractors to health care providers be subject to the Freedom of Information Act;
- mandating monthly reports on funds used under these contracts for preventive and primary care, administrative costs and other non-medical costs;
- initiating an annual 'secret shopper' survey on Medicaid managed care effectiveness and responsiveness to consumers;
- implementing a pilot program of primary care case management for certain HUSKY Part A and Part B recipients;
- creating pay for performance rewards for excellent service by a Medicaid managed care company;
- establishing minimum rates for health care providers in the Medicaid managed care system;
- appointing a medical director within the Department of Social Services to review disputes on medical necessity;
- consumer protections for prior authorization denials by Medicaid managed care companies;
- requiring the Healthcare Advocate to assist in consumer outreach and oversight of the Medicaid managed care companies; and
- requiring Attorney General review of Medicaid managed care contracts to ensure they benefit residents in those programs.

Lack of access to appropriate health care is due substantially to low reimbursement rates offered by MCOs for services under the HUSKY and Medicaid programs. The reimbursement levels are so low that health care providers reportedly cannot or will not participate.

This legislation would clarify in statute recent superior court and Freedom of Information Commission decisions requiring disclosure of reimbursement rates. Astonishingly, no one knows for sure what those reimbursement rates actually are -- which is the reason I went to court seeking such vital information necessary to hold the MCO's accountable. I have fought, along with health care advocates, for information from the Department of Social Services and the private companies paid to provide this public program. Despite the clear language of the Freedom of Information Act, the MCOs have refused to disclose this information. Although the Freedom of Information Commission ruled that the MCOs are organizations operating a public program on behalf of a state agency and must make this information available to the public, the MCOs refused and appealed the decision. Even after the Connecticut Superior Court upheld the FOIC's determination, the MCOs continue to stonewall, appealing to the Connecticut Appellate Court.

Both proposals would establish a pilot program within the Medicaid managed care system based on primary care case management, as an alternative to the managed care companies. Provider case management would be more responsive to patient needs and more cost effective. Under the primary care case management system, the patient's physician determines the medically necessary treatment or may make a referral to another health care provider and the state pays the cost of any prescribed treatment. The primary care physician is paid an administrative fee to be the gatekeeper and decision maker. Unlike the HMO model, the physician bears no liability to pay for the services being prescribed. The state monitors the physician's decision to ensure accountability, and pays a fee for service established with the doctors openly and accountably. A pilot program would provide significant evidence of its benefits to those receiving HUSKY Part A or Part B health care.

House Bill 7322 would require appointment of a medical director within DSS to monitor medical necessity disputes. This position would greatly assist in resolving such disputes and prevent the state HMO contractors from unduly restricting Medicaid coverage for doctor prescribed health care services.

My office receives frequent calls from confused and concerned citizens desperately seeking assistance from denials of insurance coverage for health services or a prescription drug by a HUSKY or Medicaid managed care company -- services or medications prescribed by their physicians as medically necessary.

Although the state has very clear statutory requirements that the MCOs pay for all medically necessary services, and defines what is medically necessary, there is mounting evidence that the MCOs are using their own definitions of medical necessity to restrict coverage. Several of the MCOs refuse to disclose their rules used to deny coverage and care.

On June 5, 2006 I wrote to Governor Rell urging her to suspend negotiations on rate increases for MCOs while they continued to withhold records in violation of the Freedom of Information Act and their contractual obligations. On November 8, 2006, I wrote to Governor Rell requesting her to require the MCOs to disclose the criteria they use to determine whether a medical treatment or prescription drug prescribed by a health care provider is medically

necessary. Regrettably, Commissioner Wilson-Coker answered my letter stating that she would not request that critical information.

In addition to the appointment of a medical director, the committee should consider requiring disclosure of information regarding medical necessity denials to the Medicaid Managed Care Council.

House Bill 7322 would require my office to review Medicaid managed care contracts to ensure that they will benefit those receiving health services under these programs. This review is clearly necessary as citizen complaints to my Office have revealed many problems with MCO administration of the Medicaid benefit. Problems frequently occur with coverage for prescription drugs. For example, the parents of children enrolled in HUSKY sought my help when Health Net, serving as a Medicaid managed care administrator, tried to force the children to switch to generic psychiatric medications without considering whether the brand-name medications the physicians had prescribed were medically necessary, and could not be safely replaced. While we were able to secure medically necessary drugs for many families, our success was on a case-by-case basis. I am sure there were many children who may not have received the appropriate medication. These HMO contracts should require closer state supervision of Medicaid HMO performance.

Senate Bill 1425 would provide basic protections to patients who are denied prescription drugs because the Medicaid managed care company did not issue a prior approval for the prescribed drug. These protections include a maximum 5 day supply of the prescription drug so the patient can receive the prescription drug benefits during the time the insurer and the patient's physician can resolve the dispute.

Prior authorization may save dollars in prescription drug costs. Under the prior authorization process, the state contracts with a pharmaceutical benefit manager to seek the best price, based on the promise of a certain volume of sales.

Not all drugs are equal in safety and efficacy for every individual. A physician who prescribes a drug that is not on the list of preferred drugs must seek authorization from a state contractor for the patient's insurance to pay. If the physician fails to obtain prior authorization, patients receiving state assistance do not receive their prescriptions, becoming innocent victims of miscommunication or non-compliance by health care providers.

House Bill 7322 requires the state to provide an annual secret shopper survey of Medicaid HMO performance, especially regarding their responsiveness to beneficiary health care coverage needs. An October, 2006 Mercer secret shopper survey found that access to health care in the Medicaid HMO system was deficient across all health plans and provider groups. Annual surveys will help document areas where we need to improve this system.

I urge the committee's favorable consideration of the concepts contained in House Bill 7322 and Senate Bill 1425.