



# State of Connecticut

## SENATE

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Good morning Senator Harris, Representative Villano and members of the Human Services Committee I am pleased to be here today to testify in support of three bills which will increase access to care for Medicaid recipients, particularly under the Medicaid managed care system. These bills are SB 1425, An Act Concerning Managed Care Organizations Contracting With The Department Of Social Services, HB 7322, An Act Concerning Medicaid Managed Care Reform, and HB 7375 An Act Concerning Health Care Access and Expansion of the Husky Program.

I urge you to (1) increase income eligibility for all adults under Medicaid to 185% of the federal poverty level, matching children's Medicaid income eligibility; (2) reinstate "continuous eligibility," (3) raise provider rates for all Medicaid providers, (4) implement strong consumer protections under preferred drug lists run both by DSS and by its contracting HMOs; and (5), most importantly, require at least a pilot program of primary care case management ("PCCM") as a real alternative to the Medicaid managed care system.

The problems with Medicaid HMOs are simply a magnified version of the problems with managed care generally. Under capitation (fixed payment per member per month), there is a direct financial incentive to deny care. But as problematic as capitated managed care is for patients generally, it is particularly problematic for low-income residents because they have no ability to pay out of pocket when the HMO says "no," and because they often lack the practical resources to fight HMO denials (lack of writing skills, time off from work, transportation, etc.).

The evidence of access problems under the Connecticut Medicaid managed care system is extensive; I am particularly disturbed by the results of the October

2006 "secret shopper" survey of providers listed by the HMOs as current participants in their plans. This study was commissioned by DSS, and concluded that "[a]ccess to care is found to be **deficient across all health plans and provider groups.**" And the HMOs have now admitted that they are using private medical necessity criteria in denying care, which they are withholding as "confidential," notwithstanding an explicit contractual requirement that both the HMOs and their subcontractors must use the official DSS regulatory definition of medical necessity in deciding all requests for services.

In addition, because of endemic lack of access to information from the HMOs, last year I proposed, in a letter that also was supported by the Attorney General, that the HMOs not get **any** increase until they agreed to be publicly accountable, including under the FOIA. But despite all of the access and accountability problems, and the General Assembly's specific authorization of an increase for these HMOs for fiscal year July 2006-June 2007 of 2%, DSS nevertheless negotiated to give the HMOs a 3.88% increase, almost **twice** what was authorized. This happened because the agency is simply too dependent upon these private contractors to act in accordance with the General Assembly's direction, let alone to hold the HMOs accountable for providing the services required under their contracts.

With this background regarding the deficiencies in the current system, the proposals in these bills to increase Medicaid provider rates across the board are most welcome. I strongly support this long over-due proposal.

Unfortunately, however, for HUSKY, any increase in these low rates will be for naught if there is not an enforceable mandate that 100% of the increases actually go to the providers, which is very difficult as long as we pay capitated HMOs. This is because, in the words of the recent FOIA court decision, based on testimony of HMO and DSS officials, "the MCOs' unilateral authority to set provider fees goes to the essence of Medicaid managed care."

In addition, even if increased rates for HMO providers could be mandated to actually get through to the providers, this would hardly solve all of the access problems under HMO-managed care. This is because many providers do not want to participate in the HUSKY plans because of the extraordinary administrative burdens imposed by the HMOs, both to get prior authorization and to get **paid**, once a provider has stuck it out long enough to get prior approval. These administrative obstacles require the besieged providers to hire costly administrative staff just to deal with the HMOs.

After eleven years of failure, it is time to get serious about pursuing alternatives to the dysfunctional HMO-managed system. DSS should be **required** to implement an alternative system of non-HMO care, through a program of primary care case management (PCCM), now used by 30 other states. Under the PCCM model, there is still management of the services, but the management is

provided by the treating doctor who knows the patient, not a corporate entity with a financial incentive to deny needed care, and there is direct policy setting by the state (including of provider rates).

Having PCCM work in tandem with the HMOs will allow for an honest comparison with the performance of the HMOs, and if it does a better job while controlling costs, it can be adopted for the whole state. At the very least, it will finally break the mentality at DSS that they cannot hold the HMOs accountable for fear that they will leave the Medicaid program when there is nothing else in place.

While ultimately we may decide to replace the entire failing Medicaid managed care system, as provided in HB 7322, the pilot program of PCCM set forth in SB 1425 is an excellent start. But I urge the committee, if it is going to adopt the pilot program in that bill, to also take section 9(d) of HB 7322, which has excellent provisions concerning public input in the design of the PCCM program. This type of input is essential if the pilot program is going to have a real chance of success and it also is the model that the General Assembly and DSS followed in developing the behavioral health carve-out program.

Also, I would urge the Committee to improve upon the PCCM section (section 7) of SB 1425 by clarifying that the pilot program must be applied to both HUSKY A and HUSKY B recipients, both sets of whom have serious access problems under the HMOs. And the language in section 9(b) of HB 7322, and section 7(b) of SB 1425, should be clarified to provide that the primary care providers under the new PCCM program "shall include, **but not be limited to**, health care professionals employed and community health centers and school-based health clinics," to make sure private and hospital-based providers also are included.

Senate Bill 1425 also has excellent provisions which will finally address the crisis of medications being denied at the pharmacy by the HMOs, through their imposition of prior authorization (PA) and through their computers' programmed responses to pharmacists denying payment where PA has not been obtained. The current contractually required system for issuing temporary supplies is close to useless, as it requires multiple phone calls to be made by busy pharmacists who have neither the time nor the inclination to make them.

Section 5(d) of SB 1425 will guarantee the electronic authorization of a temporary supply in all cases where PA is required but has not been obtained, and the prompt issuance of a written notice to both recipients and prescribers advising them of the next steps to take. However, there are a couple of changes which I urge the committee to make, particularly to expand the temporary supply provision from 5 days to 30 days (which CHNCT is already providing), and to require that DSS or the HMO mail the written notice to recipients, since it is unreasonable to ask the pharmacists to do this, and they lack the complete information necessary to issue the required individually-tailored notices.

Finally, both HB 7322 and SB 1425 have provisions explicitly subjecting the Medicaid HMOs to the Freedom of Information Act. These are good provisions but I should point out that they should not be necessary: the broad language in the current FOIA defining "governmental function," the performance of which subjects a state contractor to the FOIA, clearly encompasses the Medicaid HMOs, which collectively are paid over \$700 million/year and have taken over the administration of a huge program previously administered directly by DSS. The FOIC so ruled, the Superior Court affirmed that ruling, at least in the two areas where documents were sought, and I believe the Connecticut Supreme Court will affirm that ruling.

Thank you.