

Testimony of WellCare of Connecticut, Inc.

Delivered by Robert Caione, Chief Operating Officer

**Joint Committee on Human Services in Opposition to SB 1425
and HB 7322**

March 15, 2007

Good afternoon Senator Harris, Representative Villano and members of the Human Services Committee. My name is Robert Caione and I am the Chief Operating Officer of WellCare of Connecticut. I would like to thank you for the opportunity to testify before this committee to respectfully oppose **SB 1425** and **HB 7322**.

Introduction

The four Managed Care Organizations (MCOs) offering care through the HUSKY program combine a number of strategies to provide cost-effective, high-quality care to our members. We deliver an array of access enhancement, outreach and education services while providing a meaningful and accountable system of coverage where multiple aspects of the program's performance can be tracked. This system provides a seamless and coordinated system of care that has consistently controlled escalating costs in the HUSKY program while simultaneously receiving high satisfaction marks from our members.

Today, you will hear testimony from proponents who favor moving the HUSKY Medicaid population into a primary care case management (PCCM) model. I am here to respectfully request that you reject both proposals before you that would establish a PCCM system of care in Connecticut. The current delivery model is an experienced, tested system that provides financial accountability at a time when healthcare costs continue to grow exponentially. A PCCM model will provide less oversight and less accountability, at a much higher cost to the state.

Quality, Accountability and Outreach

In a decentralized PCCM model, there is less accountability, as reporting requirements are often too burdensome and difficult for individual providers to aggregate. Currently, the MCOs provide DSS with over 100 cost, access, and quality reports. MCOs offer real-time data query capabilities, not to mention encounter-specific data for every instance a member accesses care through the program. This data is critical in evaluating access and quality outcomes, and can alert the state (and the MCO) to any weaknesses or problems within the system. In a centralized system of care, the MCOs respond immediately to resolve issues and provide corrective action within the program, something that a PCCM model cannot guarantee.

Under PCCM, the primary care provider (PCP) will be responsible for coordinating care and paid an additional administrative fee by the state. However, the PCP does not have a capable system or process to deliver the same results as an MCO. A physician's office lacks the ability to effectively channel patients to the most cost-effective facility, lacks the claims data and software to efficiently check a patient's medical and pharmacy records for potentially harmful drug interactions, and lacks the incentives to reduce unnecessary and duplicative utilization of services. While the PCP means well and is good intentioned, most offices are simply not capable of offering the same degree of care coordination, disease management, and quality improvement initiatives as an MCO.

Furthermore, MCOs reinvest administrative dollars into numerous services that benefit members including outreach, education, quality and customer service initiatives.

For example:

- Providers and members receive communications after an enrollee uses the emergency department for non-emergency care to ensure all prescriptions are filled, follow up treatment occurs and to reduce the likelihood of a return trip to the ER. In the PCCM environment, the primary care physician is unlikely to even know their patient visited the ER and appropriate follow-up and patient education opportunities are missed.
- An MCO Member receives telephone and mail reminders to obtain mammography screening, diabetic retinal exams and vaccinations. This does not typically occur in a Medicaid PCCM program and would result in less effective and more costly care.

We recognize that members in the HUSKY program often face challenges and different stressors compared to enrollees in a commercial plan. They require a highly coordinated system of care including:

- Assistance with appointment and transportation scheduling.
- At times help with other issues affecting their quality of life and health such as heating, housing and food assistance.

MCOs provide a platform which allows the state to cover non-medical costs like transportation and housing assistance that are critical to members' well-being—but not reimbursable under federal law in a PCCM model.

MCOs are also better equipped to partner with the state to offer innovative new programs which improve our members' lives and reduce preventable medical costs.

For example:

“Easy Breathing” Program:

- Improves the quality of life for children with asthma by ensuring compliance with medicine regimens and reducing hospitalizations.
- Decreases direct and indirect costs to the state.
- In December, the Governor authorized an additional \$500,000 for the Easy Breathing program.

The state, through the Department of Public Health, has recently invested in some new programs to coordinate care for children with unique medical situations.

Medical Home Pilot Program:

- Coordinates and enhances a multi-layered system of care for children with special health care needs.
- Enables children and families to receive assistance through their primary care provider.
- Providers work with other health professionals to identify necessary medical and non-medical care to aid children in their development.

This session, much time, effort and debate has been focused on finding a way to ensure health care coverage for all residents of Connecticut. Numerous proposals have suggested expanding eligibility under the HUSKY program—and in fact you are hearing testimony on two such proposals today. At a time when we are working to strengthen the existing program and even considering expanding eligibility to more people under HUSKY, a PCCM pilot would divert scarce and much needed resources away from the program. We fear that this would delay the progress and stability of the program by undermining its very structure. Simply put, a PCCM model—even a pilot—erodes cost savings and makes the HUSKY program unsustainable.

Proponents of PCCM have characterized the above mentioned programs and the administrative costs associated with them as “waste” that represents dollars being taken out of the Medicaid program. The balanced reality however is that these are highly valuable programs which create an integrated system of care delivery, access, and patient education. Non-medical costs in the MCO environment create exceptionally valuable and cost-effective programs that represent “spending-to-save” initiatives which simultaneously improve a member’s health while saving state dollars.

In other words, meaningful medical costs savings cannot occur without an organized and integrated system of care which is held accountable to deliver care on-time and under budget. The MCO system provides the only model which aligns incentives to promote innovative cost-effective care that holds the Medicaid program accountable for both high-quality care and cost-effective results.

Cost Containment

Introducing alternative delivery systems—even in pilot form—erodes system-wide cost controls and exponentially increases avoidable and unnecessary medical costs. With fewer cost-containment tools, fragmented treatment and claims data and no incentives to reduce unnecessary and preventable utilization, PCCM programs are significantly more expensive than the MCO model. In Connecticut, the introduction of a less efficient PCCM model could cost the state between \$37 and \$67 million dollars more annually based on medical utilization data available from other states.

In comparison, MCOs agree to a discounted annual premium which provides budget predictability and locks in and guarantees savings to the state. The MCOs in the HUSKY program are projected to save \$250-\$300 million dollars in costs to the state over the next five years – and are financially held accountable if they fall short of those goals.

Recommendations

Let me take the opportunity to acknowledge there is room for improvement in the current HUSKY program. By now you've heard the results of the mystery shopper survey commissioned by DSS, and they were unsatisfactory. Each plan is working diligently to improve access for members, new and old. There are areas that we can and would like the opportunity to improve upon. Therefore, we would like to support the recommendations for improving the current HUSKY model that were enumerated in the Lewin Group Report, including the following:

- Requiring MCOs in the HUSKY program to develop a monitoring plan to proactively and regularly track the status of their physician network, especially for providers accepting new patients.
- Imposing additional reporting requirements (HEDIS) for MCOs to standardize data assessments for comparison with other states.
- Requiring each MCO to obtain national accreditation by a recognized quality assurance body by 2009.
- Increasing Medicaid physician and dental fee schedules to encourage more providers and specialists to join HUSKY and improve patient access.

We believe these recommendations will improve upon the current program and help to resolve some of the issues surrounding access. We ask you please not to throw out the good in search of the perfect.

Both bills propose instituting a pay-for-performance program for MCOs that achieve favorable quality outcomes in the program. We are supportive of this initiative and would like to work with legislators and DSS on developing a system that is both fair and effective.

Conclusion

As in everyday life, there are times when it is appropriate to try something new. However, based on the information and the facts regarding PCCM, this is not the right time, nor the right place for a pilot program. There have been numerous incremental enhancements to the program that have achieved significant improvements in health outcomes over the years. The four MCOs are committed to this program and have invested considerably in improving quality, access and care for HUSKY members. Abandoning the current system in favor of a model that has traditionally experienced higher medical cost trends, lower quality of care and spotty accountability could be a costly mistake not only for the state budget, but for our HUSKY members as well.



WellCare Health Plans, Inc. Select Facts

WellCare Health Plans, Inc. – A Proven Leader in Government Sponsored Programs

- Government Sponsored Programs Only (no Commercial business) with almost 2.2 million Members nationwide.
- Medicaid and SCHIP Participation in 7 States: Connecticut, Florida, Georgia, Illinois, Missouri, New York, Ohio. Total Medicaid and SCHIP Enrollment (as of 9/06) – 1,167,000.
- Medicare Advantage Participation in 6 States and 57 Counties: Connecticut, Florida, Georgia, Illinois, Louisiana, New York. Total Medicare Advantage Enrollment (as of 9/06) – 87,000.
- Medicare Private Fee-For-Service Plans in over 700 Counties in 38 States (as of 1/07).
- Medicare Prescription Drug Plan Offered in 50 States. Enrollment (as of 9/06) – 911,000.
- One of the leading managed care providers nationwide of managed care services to SSI/ABD Medicaid recipients. In Florida, we serve over 57,000 aged and disabled enrollees.

WellCare of Connecticut – Longstanding Partner Committed to Success of the HUSKY Program (data as of 12/06)

- Participation in HUSKY since 1995. HUSKY Product Name: Preferred*One*.
- Enrollment: HUSKY A – 33,953. HUSKY B – 2,245.
- Medicaid Providers: Primary – 1,200. Specialist – 3,000. Ancillary – 183. Hospitals – 23 (out of 31).
- Office – North Haven. Number of Employees – 77.
- Medicare Advantage in 3 Counties. Enrollment: Coordinated Care: 1,619, Dual-eligible: 1,278.
- Medicare Prescription Drug Plan Enrollment – 13,200.
- Total WellCare members in Connecticut: 52,547.

WellCare of Connecticut – Rob Caione – Experienced Health Plan Executive

- Full responsibility for the plan's performance in the provision of HUSKY A & B health care services.
- Oxford Health Plans, Norwalk and Trumbull, CT (1992-2000) – Vice President (Medicaid, Medicare and Commercial and various functional area experiences).
- Touchstone Health Partnership (Medicare), New York City, NY (2002-2006) – Chief Operating Officer/Chief Financial Officer.