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March 15, 2007

**Testimony of Sheldon Toubman before the Human Services Committee
In Support of Bills 7322, 1425 and 7375
To Improve Access to Health Care Under Medicaid**

Good afternoon, Members of the Human Services Committee. My name is Sheldon Toubman and I am a staff attorney with the New Haven Legal Assistance Association. I am pleased to be here today to testify in support of bills which will increase access to care for Medicaid recipients, particularly under the Medicaid managed care system, as a followup to the eye-opening informational forum the committee held on January 18th which called attention to access problems under that system.

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 failing Medicaid managed care system which is enriching HMOs mostly at the expense of poor children. Bills 7322, 1425 and 7375 together accomplish all of these important goals. I will primarily speak today about the last three goals.

First, I think it is important to understand that the problems with Medicaid HMOs are the problems with managed care generally, **except magnified**. 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 folks. This is 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.).

Second, the evidence of access problems under the CT Medicaid managed care system is extensive. Some samples of that evidence are listed in an attachment to my testimony, but I note particularly that the October 2006 "secret shopper" survey of providers listed by the HMOs as current participants in their plans, commissioned by DSS, 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. All of these problems continue, although mercifully the legislature did remove behavioral health responsibilities from the HMOs after the DSS Commissioner was

forced to admit, after years of denial, that behavioral health services under them was a failure. See Letter from Patricia Wilson-Coker dated May 5, 2005 (attached).

Third, because of endemic lack of access to information from the HMOs, Senator Looney last year 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 legislature'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 legislature's direction, let alone to hold the HMOs accountable for providing the services required under their contracts.

With this background as to how the program is currently failing, the proposals in these bills to increase Medicaid provider rates are most welcome. The language in section 3 of Bill 7375 (as opposed to the language in section 12 of Bill 7322) will ensure the appropriate level of payment. We 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 actually get **paid**, once a provider has stuck it out long enough to actually 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.

I believe it is time to work toward replacing the entire failing Medicaid managed care system, as provided in Bill 7322. However, the pilot program of PCCM set forth in bill 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 Bill 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; it also is the model that the legislature and DSS followed in developing the mental health carve-out program.

Also, I would urge the Committee to improve upon the PCCM section (section 7) of Bill 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 Bill 7322, and section 7(b) of Bill 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.

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 Bill 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 15 days (which is still less than the 30 days that 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. Substitute language with explanations for the proposed changes is attached to my testimony.

Finally, both 7322 and 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 are not 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 we fully expect the Connecticut Supreme Court to affirm that ruling. Indeed, there could not be a stronger case for state contractors performing a governmental function than the Medicaid HMOs.

Thank you for the opportunity to speak with you today.

Some of the Evidence of Access Problems under Medicaid HMOs

1. On May 5, 2005, the DSS Commissioner wrote to legislators acknowledging that, with regard to behavioral health services under the HMOs, “[t]he failings of the current system are numerous,” with “decisions driven by dollars, and a system of services that is confusing and difficult to navigate,” and so behavioral health services were taken back from the HMOs on January 1, 2006 (memorandum attached).
2. An October 2006 Mercer “secret shopper” survey of providers listed by the HMOs as participants in their plans, commissioned by DSS, concluded “[a]ccess to care is found to be *deficient across all health plans and provider groups*”
3. The last time Health Net was required (in a court case) to provide pharmacy drug denial data it showed that, for just this one HMO, about 3,000 denials of covered drugs occurred each month, with only about 3% getting temporary supplies either at the time of the denial or within 24 hours.
4. Despite a long-standing contract provision which explicitly has required that the HMOs meet a goal of providing well-child screenings for 80% of children, the MCOs have never come close to the goal (latest data for 2005 shows screening of 57% of kids) (<http://www.ctkidslink.org/publications/h06ambulatorycare.pdf>)
5. Access to required dental services is abysmal under all four Medicaid HMOs- a recent VOICES study of the dental care actually received by children in HUSKY A in 2005 found that only 41% of children received any preventative dental care while only 48% received **any** dental care (http://www.ctkidslink.org/pub_detail_316.html)
6. Although the HMOs are required under their contracts to provide and coordinate care for all children, Child Advocate Jeanne Milstein testified before the Human Services Committee on January 18th that a “continued concern for child recipients of [HMO] services involves case management and coordination;” in the case of children with special health care needs, i.e., those most in need of coordinated care, “[o]ur investigation ... revealed care described as fragmented and poorly-coordinated.”
7. Medicaid HMO enrollees are routinely denied access to medical treatment on the basis that the services are not medically necessary, despite the broad definition of that term in state regulations which are required to be followed by the HMOs in their contracts. We see these cases at legal services all the time, but what is most alarming is that the HMOs have recently admitted in the context of a pending FOIA request that they are using private medical necessity criteria and even claiming that these criteria can be kept secret from both the consumers it denies and the taxpayers who pay them.

TO: The Honorable Toni Nathaniel Harp, Senate Chair
The Honorable Denise Merrill, House Chair
The Honorable David Cappiello, Senate Ranking Member
The Honorable Arthur O'Neill, House Ranking Member
Members of the Appropriations Committee

The Honorable Mary Ann Handley, Senate Chair
The Honorable Peter F. Villano, House Chair
The Honorable John A. Kissel, Senate Ranking Member
The Honorable Lile R. Gibbons, House Ranking Member
Members of the Human Services Committee

FROM: Patricia A. Wilson-Coker, Commissioner

RE: **CONNECTICUT MEDICAID MANAGED CARE 1915(b) WAIVER AMENDMENT /
BEHAVIORAL HEALTH CARVEOUT / COMMUNITY KIDCARE**

DATE: May 5, 2005

In accordance with the provisions of Section 17b-8 of the Connecticut General Statutes, I am pleased to submit to the Human Services and Appropriations Committees of the Connecticut General Assembly the Department's proposed Medicaid Managed Care 1915(b) Waiver Amendment to create an integrated system for the administration of behavioral health services for HUSKY A enrolled parents and children. The waiver amendment is faithfully submitted in accordance with the Connecticut Community KidCare enabling legislation, Connecticut General Statutes 17a-22(a)-(f).

I am particularly pleased to submit this proposed waiver amendment in collaboration and partnership with Commissioner Darlene Dunbar of the Connecticut Department of Children and Families (DCF) as the proposed waiver represents a shared vision and commitment to build an integrated, family driven, behavioral health system that combines the broad range of services and supports funded by the two Departments. Our commitment is demonstrated in our longstanding agency partnership begun more than 5 years ago and in the devotion of extensive agency resources and recommended appropriations to achieve the purpose of the reforms we seek to implement.

Behavioral health services have been administered by the HUSKY Managed Care Organizations (MCOs) since the advent of the Medicaid managed care program in 1995. The purpose of this waiver amendment is to carve out the behavioral health services from the capitated portion of the HUSKY program and to return these services to a fee for service model managed by an administrative services organization (ASO) under contract with the two Departments. This reform is intended to address fundamental deficiencies in the current system that limit the provision of timely, appropriate, and effective care to children with special behavioral health needs. The failings of the current system are numerous. There are extraordinarily long and unnecessary stays in inpatient psychiatric facilities and excessive reliance on emergency departments with discharge delays resulting in overnight stays for children. There are long delays in accessing outpatient services and uneven service quality and outcomes. Under the current system, children fall through the cracks and end up in the child

protection or juvenile justice system. There are gaps in essential services, care decisions driven by dollars, and a system of services that is confusing and difficult to navigate. As importantly, the Departments lack the information that would otherwise allow us to research and improve the performance of the system and its services as well as to inform policy.

The amendment itself acknowledges that the design of the existing Medicaid Managed Care program may undervalue behavioral health and that creating a discreet behavioral health benefit under the joint management of our Departments and an ASO is the means by which we can address the shortcomings in the current system. As the most recent *Health Care Reform Tracking Project, 2003 State Survey* has made clear, carve out reforms such as this one are more likely to involve multiple stakeholder groups, provide for family involvement, have discreet planning processes for special populations (e.g., child welfare, juvenile justice), enroll specialty providers within their networks, and provide education and training about home and community-based services and about the needs of specialized populations. Such reforms are more likely to cover a broad service array such as home and community-based services (respite, family support, intensive in-home, day treatment, after school programs, behavioral aides, case management), and provide flexible funding and individualized services. Carve outs also better promote the use of evidenced based practices, facilitate and support the development and operation of local systems of care and incorporate those values and principles in the managed service system.

Commissioner Dunbar and I have no doubt that the essential elements to the reforms we seek are contained in this proposed waiver amendment. There is strong leadership and concurrence from Governor Rell and from Secretary Robert Genuario in the full implementation of Connecticut Community Kidcare. It is demonstrated in the strong policy statement reflected in the recommended state appropriations in the Governor's proposed biennial budget now before the Appropriations Committee. There is strong support from the families of children who will benefit from the reforms we seek and from the advocacy organizations who represent their interests. This model of reform addresses a range of provider issues and proposes new investments in rates and services. The HUSKY MCOs are prepared for the transition of their responsibilities to the ASO. There is a clear vision shared by the partnering agencies through which we will guide the program. A rigorous legislative and community oversight structure is in place in the Behavioral Health Oversight Committee. There has been unprecedented public deliberation and debate in dozens of collaborative meetings and presentation to legislative committees and workgroups. And we are further committed to community based meetings with families, providers and other interested parties as we move ahead with our implementation schedule.

Commissioner Dunbar and I welcome the opportunity to meet with you at your earliest convenience to discuss our ongoing vision and commitment to developing an integrated behavioral health system, the merits of combining our expertise and vision, and the importance and value of building a new system with and for parents and consumers.

We will be calling on you in the days ahead to request a meeting for this purpose. In the meantime, please do not hesitate to contact our agency legislative liaisons, Matthew Barrett (306-3727) or Debra Korta (550-6317), should you have any questions or concerns.

Thank you.

cc: The Honorable M. Jodi Rell, Governor
Robert Genuario, Secretary, OPM
M. Lisa Moody, Governor's Chief of Staff
Darlene Dunbar, Commissioner, DCF

(d) In all cases where a Medicaid, state-administered general assistance or ConnPACE recipient presents to a pharmacist a prescription for a drug requiring prior approval, but for which prior approval has not been obtained by such recipient, the Department of Social Services or any entity that administers a Medicaid managed care health plan shall:

(1) Ensure the immediate electronic authorization of up to a [five-] FIFTEEN day supply of the originally prescribed drug and require that the initial response to a pharmacist requesting authorization for the drug include confirmation of the availability of payment for dispensing such a temporary supply;

[Explanation of Change: 5 days is not enough to ensure that the PA process is actually completed before the temporary supply runs out. Also, if the drug was previously provided to the individual without PA and now this requirement will be imposed, a 10 day advance written notice of termination is required prior to termination of payment for lack of PA; 5 days after a post-PA requirement temporary supply is authorized would not be sufficient for a 10-day termination notice which would comply with these federal law requirements to be issued.]

(2) Ensure that [contemporaneous]written notification, in a format that has been developed and created by the department or such entity, is [provided by the pharmacy] MAILED to such recipient WITHIN 24 HOURS OF THE ELECTRONIC AUTHORIZATION OF THE TEMPORARY SUPPLY, ADVISING THE RECIPIENT that (A) [informs the recipient that] the drug ORIGINALLY PRESCRIBED IS [may be] covered but [that] prior approval from the prescriber is first required in order to obtain the prescribed drug, BEYOND THE TEMPORARY SUPPLY AUTHORIZED [and] (B) [instructs such recipient that] he or she should contact [their] HIS OR HER prescriber to obtain such prior approval OR TO DISCUSS POSSIBLE ALTERNATIVE DRUGS THAT DO NOT REQUIRE PRIOR APPROVAL; and (C) HE OR SHE HAS A RIGHT TO A HEARING IF A MISTAKE IS BELIEVED TO HAVE OCCURRED.

[Explanation of Change: Pharmacists, who generally have people waiting in line at the counter, cannot be expected to have and hand out proper notices in each case and are not equipped to issue individually-tailored notices detailing the specific drug and dosage, reason for rejection, legal authority and appeal rights, as required by federal law. The Department or its contractor, which will have complete information, is in a far better position to methodically issue such notices in all cases, upon electronic issuance of a temporary supply and the collection of the data concerning such issuances. Recipients should be told to talk to their doctors about possible alternative drugs which may be just as effective but cheaper, and information about appeals rights is required by federal law in the event of a mistake, like prior authorization having already been obtained.]

(3) Provide notification to the prescriber, not later than twenty-four hours after [receipt] ELECTRONIC AUTHORIZATION of the prescription by the [pharmacy] DEPARTMENT OR SUCH ENTITY, by facsimile transmission, telephone or electronic mail, that prior approval is required in order for the recipient to receive the prescribed drug. OF THE PROCESS FOR OBTAINING SUCH APPROVAL AND OF POSSIBLE ALTERNATIVE DRUGS THAT DO NOT REQUIRE PRIOR APPROVAL.

[Explanation of Change: The Department or its contractor cannot know when a prescription was "received"; they only can know when they electronically authorized payment for a supply of the drug, so the timing of notice to the prescriber should be tied to that event. Prescribers should be told about possible alternative drugs which may be just as effective but cheaper, thus saving taxpayer money; DSS already does this under its Medicare Part D wraparound program, and CHNCT already does it under its Medicaid managed care and SAGA plans.]