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January 31, 2007

Testimony of Sheldon Toubman before the Public Health Committee Regarding Improving Access to Health Care for Medicaid HMO Enrollees

Good morning, Members of the Public Health Committee. My name is Sheldon Toubman and I am a staff attorney with the New Haven Legal Assistance Association, mostly working on matters of access to medical care for Medicaid recipients. Thank you for allowing me to speak with you today in favor of Senate Bill 1, which is designed to increase access to affordable, quality health care. Specifically, I am here to testify about the needs of Medicaid recipients and about the problems with access to care under the Medicaid managed care system for individuals theoretically already entitled to comprehensive care-- but in fact routinely blocked from access to it under HMO administration of the program—crying out for a real alternative.

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, which is particularly a problem with for-profit entities (3 of the 4 Medicaid HMOs are for-profit). 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 an October 2006 Mercer “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.*”

Third, because of lack of access to information from the HMOs as to how well they are performing, Senator Looney last year proposed that they not get **any** increase until they agreed to be publicly accountable, including under the FOIA.

Fourth, despite all of these access problems 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. How could this be? The answer is that 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, Sen. Williams' excellent health care reform proposals, including specifically a recognition that HUSKY provider rates need to be increased across the board, are most welcome. Advocates have for years been up here trying to get the severe access problems due to low reimbursement rates fixed. Unfortunately, however, any increase in these low rates will be for naught if there is not some mandate that 100% of the increases actually go to the providers, which is virtually impossible as long as we pay capitated HMOs. This is because, in the words of the judge in the Freedom of Information Act decision holding the HMOs subject to the FOIA, based on the extensive 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 provider rates for HMO providers could be mandated to actually get through to the providers, this would not solve all of the access problems under HMO-managed care. This is because many providers simply 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.

Thus, 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). 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 under capitated payments to deny needed care, and there is direct policy setting (including of provider rates) by the state.

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 know that it is difficult to think about major restructuring. On the other hand, the former DSS Commissioner finally admitted in May 2005 that, under HMO-managed behavioral health, "[t]he failings of the current system are numerous," and that, "[u]nder the current system, children fall through the cracks and end up in the child protection or juvenile justice system." Those services were therefore taken back by DSS. But that was after years of denials by DSS that there were any serious access problems regarding mental health services. The sad thing is that the eventual carve-out came years too late for many kids, who could not get the mental health treatment when they needed it.

Do we really want to put kids through more years of deprivation for their **physical** ailments, with some of them suffering permanent effects as a result, while waiting for DSS to make the eventual statement, also years too late, that the rest of the system is a failure as well? I hope that you will recognize that the time to act is now.

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 behavior 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