

NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.

426 STATE STREET
NEW HAVEN, CONNECTICUT 06510-2018
TELEPHONE: (203) 946-4811
FAX (203) 498-9271

February 26, 2008

**Testimony of Sheldon Toubman before the Human Services Committee
in Support of HB 5617 and 5618, and In Opposition to Sections 1 and 2 of SB 34**

Good morning, members of the Human Services Committee. My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association, mostly working on matters of access to health care. I am submitting testimony in support of HB 5617 and 5618, which are designed to improve access to health care under the HUSKY program, as well as under the Charter Oak Health Insurance Plan, and in opposition to sections of the Governor's bill, SB 34, which would gut the Medicaid definition of medical necessity and eliminate coverage for medical interpretation services.

Reject the Elimination of Medical Interpretation Services Under Medicaid

First, I urge you to reject the Governor's proposal in Section 1 of SB 34 which would eliminate the provision for medical interpretation services, as passed last year, before this critical benefit is even implemented. A large barrier to racial and ethnic health equality is difficulty communicating with health care providers because of limited English proficiency. This barrier also ends up costing our health care system because of the inevitability of more costly interventions being needed due to delayed or inaccurate diagnoses.

DSS should include payment for medical interpreting as a Medicaid cost, since it would then be a cost which is federally reimbursable at 50%. Last year, the Office of Fiscal Analysis, and researchers commissioned by the Connecticut Health Foundation, estimated that the cost to the state to provide these services would equal \$4.7 million annually. But after the 50% federal Medicaid match, the state's cost would be only \$2.35 million. Most of Connecticut's hospitals and clinics already provide interpretation services, most likely out of funds provided by the state.

I urge you to reject the Governor's proposal to eliminate this critical service, and instead allow us to maximize federal dollars available to Connecticut for providing it, while increasing access to care.

Preserve the Medicaid Definition of Medical Necessity

Second, I urge you to reject Section 2 of SB 34 which would gut the current Medicaid definition of medical necessity by making it the same as the definition under the SAGA program, which is the same proposal put forth and rejected by this committee last year. Everyone should understand that the SAGA program was largely gutted over the last several years, under successive cuts by the Rowland Administration, with more and more

basic services taken away. The regulatory gutting of the medical necessity definition was the last bit of dismemberment of that program before the further cutting stopped.

By contrast, the state's long-standing Medicaid DSS definition of medical necessity has worked well for the fee-for-service Medicaid population, and is also the definition long applied to HUSKY A recipients. It is based on broad federal law requirements specific to needy Medicaid recipients who lack independent resources to pay for health services.

Although the proposal says it is based on a desire to innocuously "update that long-standing definition, and to incorporate "clinical standards of practice, the reality is that it would restrict access to treatment, as reflected in the fact that the proposal is presumed to save \$4.5 million. Placing the burden on the prescriber to demonstrate that a requested treatment meets clinical standards established through controlled scientific studies, which rarely exist, would also be in contravention of the long-established rule in the Medicaid case law (based on Congressional legislative history) that the treating provider's judgment is entitled to great weight. It also would conflict with the federal statutory requirement that states cover under their Medicaid programs services needed to maximize independence and self-care, under 42 U.S.C. §1396.

Ultimately, the proposed definition change will result in higher hospital costs for individuals unable to get the appropriate treatment when they need it. Please reject this harmful change this year, as you did last year.

Protect HUSKY Enrollees From an Intolerable Double Disruption in Access to Health Care and Improve the Charter Oak Health Insurance Plan

I also urge you to pass favorably on HB 5617 and HB 5618. Both of these bills address the frightening prospect which about 330,000 low income HUSKY recipients are facing that they will **twice** -- in a matter of weeks-- be required to go through substantial turmoil under the HUSKY program, because of DSS' unilateral decision to link contracting with HMOs under the HUSKY and Charter Oak Health Plans. HB 5617 will also improve access to care under the Charter Oak plan.

No responsible policy-maker would intentionally restrict access to health care for 330,000 poor children and their parents to advance an untested program that *might*, in three years, provide about 33,000 people with limited insurance coverage. Nevertheless, this will be the effect of the Governor's Charter plan on the low-income children and families enrolled in HUSKY if a course correction is not made -- and quickly.

Last fall, in contract negotiations with the HMOs which have run the HUSKY program for the state, the Governor required that the HMOs agree to be subject to the state Freedom of Information Act (FOIA). When the two largest HMOs refused to accept this requirement, the Governor announced the termination of their contracts. As a result, two HMOs are scheduled to leave the program on March 31, 2008 (one of the refusers, Anthem Health Plans, has since signed a FOIA commitment but another HMO, though having previously signed it, is leaving anyway). Since January 1, 2008, all HMOs are

operating as administrative agents only; DSS is now making all policy and medical decisions.

The Governor was right in taking this action in favor of transparency, especially given the history of serious problems under the HUSKY HMOs, from inflated provider lists to routine denials of covered services. However, this positive transformation, effective April 1st, will necessarily involve substantial confusion.

Notices are going out now to all families in HUSKY instructing them to enroll in either CHNCT or Anthem (the two remaining HMOs) or in traditional "fee-for-service Medicaid, by April 1st. To avoid changing doctors, families must ensure that their providers participate in the plan they pick, or convince their providers to enroll in that plan. DSS is working with advocates and providers to try to reduce the disruption, but, inevitably, it will take at least a few weeks to straighten out all of the glitches.

DSS also is required by state law to implement a pilot program of primary care case management (PCCM) for HUSKY by April 1st. PCCM is a well-tested alternative to HMOs that was adopted in last year's legislative session. In 2003, Oklahoma terminated HMO contracts in its Medicaid program and quickly implemented a statewide program of PCCM, which both improved access to care and saved \$4.3 million in the first year. As in Oklahoma, PCCM can help address the disruptions caused by the departure of the HUSKY HMOs.

Unfortunately, DSS is not seriously looking for alternative ways to manage HUSKY in the long run. Instead, if DSS has it way, just after the dust settles from the major changes on April 1, families in HUSKY, and their providers, will receive another notice saying they have to make yet another change, to one of several **different** HMOs, just three months later. This second disruption results directly from DSS' decision to combine HUSKY with Charter Oak. DSS has issued a joint request for proposals on which HMOs must bid to begin operations under both programs on July 1st.

Requiring such a major upheaval **twice** over such a short period of time will cause severe disruption in access to care for HUSKY enrollees and will undermine efforts to enroll new providers in HUSKY by April 1st. The linkage of these two programs is not required (or even authorized) by the legislature-- nor even logical. The two programs serve different populations with different benefits and costs. Medicaid is an entirely government-funded entitlement; Charter Oak is modeled on private insurance, with a limited state subsidy.

In fact, in combining the two programs, DSS may be violating its obligation under federal law to operate its Medicaid program in the "best interests of the recipients, as required under 42 U.S.C. §1396. DSS officials have for months acknowledged that the reason that HUSKY and Charter Oak are linked is concern that, standing alone, the Charter Oak plan will not attract HMOs as carriers because it is too risky a "product. But forcing vulnerable kids and parents on HUSKY to make two major changes in three months, in order to further an unrelated program for other people, is clearly not what is best for them. Moreover, one HMO has specifically declined to bid on Charter under the joint

RFP, based in part on DSS' decision to bid Charter Oak in "combination with the HUSKY Program," indicating the opposite of the intended effect has resulted from the decision to combine the two programs.

Since the Governor does not appear to be willing to delay the return of HMOs to HUSKY or to separate Charter Oak from HUSKY, and thus avoid this double turmoil after the April 1st changes and allow the HUSKY program to stabilize, it is necessary for the legislature to step in now to do so.

HB 5618 will require DSS to maintain the status quo by not contracting with risk-based HMOs under HUSKY until July 1, 2009, while a study is done of the relative quality and cost of delivering health care to this population under the previous system, the current system and PCCM. It also will restore continuous eligibility.

SB 5617 will make substantial improvements to Charter Oak and delay its implementation for one year to allow for this. Among the substantial improvements made possible by 5617 are:

- Mental health parity is required
- Drug and durable medical equipment caps are removed
- Cost-sharing is reduced
- Comprehensive dental and vision care is required to be covered
- Six-month waiting period is removed
- Authorization to provide more limited "alternative" benefits is removed
- Lifetime maximum benefit cap is removed
- External appeals are required

The removal of the authorization for a more limited "alternative" benefits package is particularly important in light of DSS' recently stated willingness to let the HMOs have free reign on benefit design- commitments at the 12/5/07 legislative forum and in DSS' January 3, 2008 follow-up letter to legislators notwithstanding. DSS has made clear to potential bidders that, if they cannot come in with a premium of \$250 to do that which DSS is asking of them, then they are free to submit a bid to **change** the benefits in any way they wish so as to meet the premium target— making a mockery of the commitments which DSS has made over the last few months to include most of the insurance mandates and make other changes.

Finally, I note that if the Charter Oak plan is as good as it has been represented to be by DSS, it should be able to stand on its own two feet, without needing to be supported by the vulnerable children and parents on HUSKY. 5617 therefore wisely requires that any contracting under it and under HUSKY be done separately. I

I urge you to pass favorably on both 5617 and 5618, and, in the case of the separation of Charter Oak from HUSKY and the delay in contracting with HMOs under HUSKY, that this be passed by the full legislature promptly, before DSS commits the state to moving forward with a return to HMO-run care under HUSKY on July 1, 2008. Thank you for the opportunity to speak with you today.