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**TESTIMONY OF SHELDON TOUBMAN BEFORE THE APPROPRIATIONS
 COMMITTEE IN OPPOSITION TO CUTS CONTAINED IN GOVERNOR RELL'S
 PROPOSED DEFICIT MITIGATION PLAN**

Members of the Appropriations Committee:

My name is Sheldon Toubman and I am an attorney at New Haven Legal Assistance Association working to preserve access to health care for Connecticut's low-income populations. I am here to testify, along with many other advocates and recipients, in opposition to the proposed cuts to state medical assistance programs contained in the Governor's proposed mitigation package, including, among other things

- **ending intake to the critical SAGA medical assistance program**
- imposing unaffordable cost-sharing
- ending dental and eyeglass coverage for adults
- cutting payments to medical providers already paid way below Medicare (driving more of them out of the Medicaid program), and
- subjecting individuals stable on psychiatric medications to prior authorization-- which will inevitably result in some of them having access to their needed medications blocked.

Other cuts, which indirectly will harm access to health care for our most vulnerable populations, also are contained in the deficit mitigation package, such as cutting the funding for the Office of the Child Advocate, which has been critical in advocating for access to care for children, particularly those in the state's custody.

The Governor's proposed cuts are on top of the severe cuts to the medical assistance safety net **already** passed in August and which are now quite painfully being put into place. As just a few examples, the budget passed at that time:

- Ended medical assistance for 3400 low-income, tax-paying non-citizens who are **legally** present in the United States, even though the Attorney General specifically warned that ending this assistance would raise "serious constitutional issues"
- Ended coverage for non-formulary drugs unavailable to elderly and disabled Medicaid enrollees under the restrictive Medicare Part D plans they must now turn to for drug coverage because they are "dually eligible"

- Imposed restrictive prior authorization for psychiatric medications under Medicaid, HUSKY and SAGA, even for children (though grandfathering those enrollees already stabilized on particular psychiatric medications)
- Imposed high cost sharing for the state-funded home care program for seniors, which will drive many off of this program which acts as a brake on more expensive institutionalization

Rather than making these cuts, we should be looking at the **revenue** side of the equation, such as the proposals of CT VOICES for Children, including delaying or cancelling reductions in Connecticut's estate tax which will benefit only the very wealthy, and making the state income tax more progressive.

In addition, while the Governor is anxious to make these additional cuts which really hurt vulnerable individuals, the Rell Administration is inexplicably dawdling in making the \$50 million cut/year to the bottom lines of private Medicaid HMOs which was proposed by the Governor herself, and then adopted by the legislature as an unequivocal requirement in August, retroactive to July 1, 2009-- after an independent audit found that the HMOs were being overpaid this amount by DSS:

“The Legislature reduces the HUSKY appropriation by \$51.8 million annually to reflect a reduction in the capitated rates paid to the HUSKY managed care organizations.” (OFA Budget Book, page 342)

Before making any further cuts to the already badly damaged medical assistance safety net, the Governor should first follow through on the legislatively-mandated cut to the HMOs which she first proposed, implementing that reduction **no later than 1/1/2010**. There are no obstacles to doing this on January 1st because the current contracts expire then and the reductions can and must be made, even if other issues in negotiation with the HMOs are not resolved as of that date.

And please don't listen to the threat that taking this money back from the HMOs might cause them to leave and require us to re-bid for new HUSKY HMO contracts, as DSS recently said in defense of its non-compliance with the legislative mandate to reduce the HMOs' payments:

“Reducing rates with health care contractors to gain budget savings is not something that's done arbitrarily or recklessly – especially when the coverage of more than 350,000 individuals in the HUSKY program could be jeopardized. By jeopardized, we mean avoiding the potential instability advocates usually decry. For example, *if the state cancels the contracts or, alternatively, if contractors walk, we would have to re-bid the while program to procure new insurers and, by extension, enrolled providers.*”

(On-line comment by DSS spokesperson to November 25, 2009 *New Haven Advocate* story (emphasis added))

Even if the HMOs are not simply engaging in their perennial bluff to extract more money from the taxpayers, this position is troubling in that it ignores the fact that the legislature's reduction in payments to the HMOs was not optional, and that Connecticut now **has** a viable alternative to the HMOs under HUSKY! Of course, that option is PCCM (HUSKY Primary Care), and it is a program which DSS's Medical Director, Dr. Robert Zavoski, acknowledges "is used successfully in other states' Medicaid Programs to improve patients' clinical outcomes, and both client and provider satisfaction, while at the same time controlling health care costs."

In addition, under PCCM, any Medicaid-participating provider can participate, either as a primary care provider or as a specialist to which one is referred. So "procuring" a whole new set of providers would **not** be needed for statewide PCCM -- just new PCP contracts in those parts of the state that don't yet have PCCM (after January 1, 2010, PCCM will be in effect in four regions, including towns with about 146,000 of the 358,000 HUSKY A enrollees).

Other states have been here before us: When Oklahoma went from a small PCCM pilot to statewide PCCM over a few short months in 2003-2004, it was precisely because its three HMOs were demanding more money to stay in the program and Oklahoma officials realized that "rebidding HMOs" was **not** the only option—and they apparently were quite glad they chose the statewide PCCM route since they saved \$4.3 million in the first year alone (usually the most expensive one because of start-up costs).

So, as part of its contingency planning, DSS should be embracing this cost-effective new option as an alternative to a burdensome re-bidding of HMO contracts, in the unlikely event the existing HMOs should be unwilling to accept the legislatively-required reduction in taxpayer payments found to be excessive in the Comptroller's independent audit. In fact, given the significant savings that other states have realized by going from capitated HMOs to PCCM, DSS should in any event be aggressively pursuing that option, while implementing the required \$50 million reduction in payments to the HMOs.