

**Testimony of
Charter Oak Health Center
Before
The Appropriations and Human Services Committees
Regarding the 1915(b) Medicaid Waiver
Submitted by the Department of Social Services
Presented by
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To the Honorable Senator Toni Harp and Representative John C. Geragosian, Chairs of the Joint Committee on Appropriations; Senator Paul Doyle and Representative Toni E. Walker, Chairs of the Human Services Committees and all Committee Members:

Good afternoon. My name is Kerrie Jones Clark and I am the Sr VP of Administrative Business Development for Charter Oak Health Center in Hartford CT. I am happy to return to Connecticut after eight years as CEO of the Rhode Island Health Center Association and very pleased to be asked to speak about something as critical to the financial well-being of Connecticut as Primary Care Case Management. I am speaking today on behalf of our CEO Alfreda Turner.

Connecticut's thirteen (13) federally qualified health centers (FQHCs) provide critical access and high quality primary care and preventive services to patients in underserved areas of our state regardless of ability to pay. In 2007 health centers combined to care for almost 241,000 unduplicated patients at over 100 sites across the state. Patient visit volume has increased 9% each year since 2003 to over one million visits last year for medical, dental and mental health services. Charter Oak Health Center alone is poised to have over 100,000 visits in 2009.

Connecticut's FQHCs, through 13 separate corporations, combine to create the largest network of providers who care for low income, uninsured and special populations in the state; I mention this to underscore our credentials for commenting something as significant cost effective methods for delivering care. FQHCs have been strong proponents of Primary Care Case Management (PCCM) as a successful and cost-effective medical model for managing the complex health care needs of patients and families at health centers.

When the Connecticut General Assembly enacted legislation to authorize a PCCM pilot program they did so with the understanding the Primary Care Case Management had been authorized by the Omnibus Budget Reconciliation Act of 1981. States began enrolling beneficiaries in their PCCM programs by mid-1980. Seven states implemented PCCM by 1986, 19 states by 1990 and 29 states by 1998. The Connecticut General Assembly recognized that many pilot states were experiencing significant savings as patient care became more coordinated and specialty care, emergency room care and pharmacy costs were all reduced without affecting access of care for patients. While recognizing the most significant savings to states come from managing the care of dual-eligible beneficiaries the Connecticut General Assembly passed legislation believed to be more workable by DSS for a pilot project for the HUSKY A program only. However, in so doing the legislature was signaling the Department of Social Services the state was ready to implement Medicaid managed care programs that would both increased access and create savings as so many other states had already done.

DSS issued an RFA in October, 2008 to which Charter Oak Health Center and health centers across the state responded. At Charter Oak Health Center 38 providers sent DSS applications. We were very disappointed to learn that rather than implement a statewide pilot program DSS elected to conduct the pilot in two areas of the state. We were however pleased that the pilot included two FQHCs, Generations Family Health Center in Willimantic and Stay Well Health Center in Waterbury. It is too soon to say if the pilot is working well, but we are sure the low number of enrollees makes it problematic to demonstrate the true strength of the program on a statewide basis.

Going forward with the pilot, Charter Oak Health Center has concerns regarding its future and the proposed 1915(b) Medicaid waiver that, if approved, will further undermine the PCCM pilot. The specific concerns are:

- **Limiting the PCCM pilot program to two geographic areas (Waterbury and Willimantic) and not statewide as the Committees originally specified** – The success of any pilot is to recruit a strong base of participants to evaluate the true impact of the program in terms of health outcomes, savings achieved and the ability to reproduce the model in other populations, locations or venues. Limiting the pilot to two geographic areas severely compromises the applicability of the model.
- **Limiting participants to those current patients of enrolled PCCM providers, rather than opening the program to all HUSKY A enrollees where there are PCCM-enrolled providers** – With the implementation of any new program, the provider must set up an internal system to facilitate the program. Restricting participants to the panels of enrolled providers has severely curtailed recruitment. As a result, the set up for this pilot becomes more costly, less effective, and ultimately not feasible, especially for small scale providers.
- **Failure to provide adequate promotional materials for the pilot and recruit patients** – As mentioned in the Medicaid Managed Care Council meeting minutes of February 6, 2009, the PCCM model is still unclear to HUSKY members and even some providers.

More information must be disseminated to potential participants in order to increase recruitment and providers should be clear on the expectations of the pilot.

- **Failure to implement the intentions of the Committee's well-crafted pilot plan** – By failing to implement the pilot program to the specifications and intent of the Committees who crafted it, DSS is closing the door on an alternative to its current Medicaid managed care system. Charter Oak Health Center firmly believes that PCCM infuses more choice into our public health care system, both for provider and patient. PCCM eliminates the middleman in Medicaid managed care, thereby creating a stronger network of providers that are more responsive to patients' needs. The added aspect of tracking patient referrals, compliance and outcomes in a more systematic method will provide feedback critical to evaluating the quality of health services being offered and make the system more accountable.

PCCM has been successfully implemented in many states. North Carolina's PCCM program, which serves 838,000 Medicaid enrollees, saved the state \$161 million in SFY2006. Connecticut's health care dollars have been stretched to accommodate more services with fewer resources. PCCM, if implemented properly, has the potential to save the state millions of dollars *and* provide comprehensive and coordinated health care services to the most complex medical patients. A study by the state of Florida in 2004 concluded that PCCM was at least as effective as other programs delivering care, was viewed as positive by enrollees and provided significant savings to the state. Rhode Island has implemented a pilot program for the dual-eligible population and the program was so successful in its first year that the Governor wants to expand the program to all of its 186,000 Medicaid recipients and has projected cost savings of \$66.7 million dollars in FY'10 including \$26.5 million savings for managing the care.

Charter Oak Health Center urges the Appropriations and Human Services Committees to reconsider the waiver proposal and to request DSS to implement the PCCM pilot as originally planned. Short changing the scope of this pilot will only short change the health of our residents who utilize the state health care system.