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**TESTIMONY OF SHELDON TOUBMAN IN OPPOSITION TO THE GOVERNOR'S PROPOSED HEALTH CARE CUTS AND IN SUPPORT OF EXPANDING PCCM IN THE HUSKY PROGRAM**

Good evening, Members of the Appropriations Committee:

My name is Sheldon Toubman, and I am an attorney with New Haven Legal Assistance Association. I am here to speak in opposition to the Governor's proposals to cut health care benefits for low-income residents under Medicaid, HUSKY and SAGA programs, which are bad for people and bad for jobs. A better solution is to modestly increase taxes on those best able to afford them. Another good solution is to invest in the short term in the statewide roll-out of primary care case management (PCCM) for both the HUSKY A and HUSKY B populations, to reap big rewards in a matter of months.

I call your attention to just **some** of the draconian proposals reducing or eliminating access to health care for low-income residents contained in the Governor's proposals:

- (1) implementing unaffordable copays for Medicaid enrollees, such that they will simply forego treatment until their conditions require expensive emergency room intervention
- (2) ending vision coverage under Medicaid
- (3) eliminating vision and medical transportation under SAGA
- (4) increasing HUSKY B premiums
- (5) imposing prior authorization for psychiatric medications on which individuals have been stabilized

And this is on top of the cuts already adopted last year, in response to the Governor's demands, such as ending the wraparound for dual eligible (Medicare/Medicaid) recipients unable to get needed drugs under their Medicare Part D plans and ending the state-funded medical assistance program for recent immigrants legally present in the country (which fortunately has been temporarily enjoined as unconstitutionally discriminatory).

All of these cuts are taking us in the wrong direction, as more people find themselves needing to turn to the Medicaid and SAGA programs due to the prolonged recession. However, there is one good proposal by the Governor: to replace the current system for providing health care under the HUSKY program through capitated HMOs with a non-risk system run through administrative services organizations (ASOs). After many years of denying the advocates' assertions that there are better ways of providing health care which also save money, the Governor has finally acknowledged that the capitated model is more expensive. Although the details of her proposal have not yet been fleshed out, assuming that there are adequate consumer protections and that there really is no risk imposed on the ASOs, which DSS unfortunately has proposed for the even more vulnerable elderly/disabled Medicaid population, the move to ASOs to save \$29 million is a good idea.

However, even more money can be saved by moving the HUSKY population to PCCM, under which primary care providers, rather than a contracted insurance company, is responsible for coordinating health care. Under the PCCM model already rolled out by DSS last year, but in a very anemic way, primary care providers are paid \$7.50 per member per month for providing this service, in addition to any health services they provide which are reimbursed on a fee for service basis. By contrast, when we last had ASOs administering the HUSKY program, in 2008, they were paid \$18.18 per member per month just for administrative services, with all medical costs being covered by DSS.

Although the Governor's proposed move from capitated HMOs to ASOs is welcome, moving to PCCM will save more money, put care in the hands of those most able to coordinate it—the treating primary care providers—and provide a stable alternative to the ever-changing set of risk and non-risk corporate contractors which have moved in and out of the HUSKY program over the last 3 years.

There also is a very relevant precedent from Oklahoma, where that state in 2003-2004, under pressure from capitated HMOs demanding more state money, went from 3 Medicaid HMOs to statewide PCCM—and saved millions of dollars for the taxpayers right away. In Oklahoma, the HMOs were removed less than 2 months after the decision was made to remove them; the period of time for the transition to statewide PCCM was just 4 months, at the end of which all their Medicaid managed care enrollees were in PCCM; the expenditures for medical services and cash flow actually dropped about \$85.5 million in the first fiscal year; and, even with the increased administrative costs for the state in rolling out the new program, which are particularly high at start-up time, the net savings were \$4.3 million in the first few months and \$3.9 million in the first full fiscal year. And access to health care has continued to improve since then.

At a legislative forum last Friday before this Committee and the Human Services Committee, DSS attempted to explain why the PCCM program it is charged by statute with implementing with “not less than one thousand individuals who are otherwise eligible to receive HUSKY ...A” has essentially been stuck in neutral, with only 322 enrollees for 228 providers. For example, DSS’s Medical Director, Dr. Robert Zavoski, said it is “hard to explain” to providers and enrollees why they should sign up and that is why few have signed up. Actually, it easy to explain. For example:

For enrollees:

“This program will allow you to get the same health care but **without** an insurance company getting between you and your doctor, and you will have someone at your doctor’s office to call for help, unlike the insurance company which you often can’t get through to, let alone get an answer or help from.”

For providers:

“You can finally get the insurance companies out of your hair and not have them **second-guessing your medical judgments** or fighting you over payment for claims they have already approved—and you get compensated \$7.50 per member per month to do that which you are best at doing anyway -- coordinating the health care needed by your patients.”

But DSS apparently is unwilling to say this to enrollees and providers in order to encourage them to sign up. Later at the legislative forum, Dr. Zavoski, the DSS official responsible for promoting PCCM, said:

***“My marketing of PCCM would be like marketing against the managed care companies and I can’t do that.”***

DSS is loath to promote a program when every person who signs up for it is money taken out of the pockets of HMOs, which the agency is trying to keep happy so they will continue running both the HUSKY program and the governor’s deeply-troubled Charter Oak program—even if running HUSKY through PCCM would be much cheaper for the taxpayers, as well as better for enrollees and providers.

DSS appears to be anxious to do an evaluation of the cost-effectiveness of the tiny PCCM program now **before** expanding it any further. A program which has about 1.5 patients to a provider will likely be found by an audit to be very inefficient, especially when that audit is conducted by DSS’s hand-picked auditor, Mercer, Inc. -- the same auditor that gave DSS the green light two years ago to overpay the HUSKY HMOs \$50 million/year.

The legislative forum clearly revealed that DSS was slow-walking PCCM and that, absent outside intervention, it was going nowhere—in opposition to the clear legislative goal of implementing a very robust program of PCCM to run parallel to the HMOs, at least during a meaningful test period. I therefore urge you to invest in the statewide rollout of PCCM without delay, for both HUSKY A and HUSKY B populations, to get us going on an established model for providing quality care at a lower cost to the taxpayers.

Thank you for the opportunity to speak with you this evening.