

TESTIMONY to the Human Services Committee  
March 2, 2010

**In favor of HB-5297, An Act Concerning State-Wide Expansion of the  
Primary Care Case Management Pilot Program**

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Connecticut spends over \$800 million each year on three HMOs to provide health coverage to 380,494 children and their parents or caregivers (as of February 1<sup>st</sup>). Since its inception, this program has encountered a growing list of problems. A recent actuarial analysis commissioned by the Comptroller found \$50 million in overpayments in one year. A secret shopper survey in 2007 found that HMO provider panel lists were deeply flawed; unfortunately that study has not been repeated and the administration has no intention to revisit the startling results. Also in 2007, barely half of HUSKY children received check ups and over one in ten did not get any health care at all from the program. We are paying for every one of them to receive care.

Other state Medicaid programs do not experience the same troubles as HUSKY. Very few CT providers participate in the HUSKY program, but 95% of physicians in Maine participate in their Medicaid program. Maine pays their providers even lower rates than CT does, but they administer their program through Primary Care Case Management (PCCM), not HMOs. When Oklahoma switched from HMOs to PCCM in 2004, the state saved \$85.5 million in medical costs in the first full fiscal year and the number of participating providers increased by 44%. They found that outpatient visits went up and ER visits went down. After PCCM, quality of care improved in 14 of 19 standardized measures including check ups for children, appropriate asthma medications, and dental care. Georgia also uses PCCM administer their Medicaid program; nearly all Georgia providers accept Medicaid patients. Maine's provider rates are significantly lower than CT's, Georgia's are somewhat lower than ours and Oklahoma's are approximately the same.

Primary Care Case Management (PCCM) is a way of running Medicaid managed care used successfully by thirty other states. PCCM does not involve HMOs and serves as an important alternative to HMOs in contracting and providing access to care. In PCCM, consumers are linked to a Primary Care Provider who coordinates their health care. Providers are paid on a fee-for-service basis, and receive additional dollars to compensate for care management responsibilities. PCCM is a form of the patient-centered medical home model, featured in national health reform bills. The medical

home model has been adopted by Medicare, most large private payers, and features prominently in the CT Comptroller's plan for the new state employee plan contracts.

We were very pleased to see in the Governor's budget document a proposal to move the HMOs from capitation to a non-risk Administrative Services Organization (ASO) model of financing. While this shift would, if approved, remove one clear economic incentive for HMOs to deny care, it does not address many other problems in the current program. Some of those problems include administrative hassles, a lack of responsiveness to provider or consumer feedback, little or no experience with care coordination, contentious relationships with providers, resistance to accountability, and little transparency in either data collection or finances. I am gratified to see that the administration now recognizes the financial toll HMO capitation has placed on taxpayers, estimated at \$28.8 million for FY 2011, and plans to capture those savings in the future.

CT needs an alternative to HMO-based administration for HUSKY. Without a viable alternative, both HUSKY families and taxpayers are held hostage to whatever rate increases, including administrative costs, the HMOs demand. Because there is no HMO between the state and families, PCCM affords the state better transparency in tracking both finances and care utilization. States with PCCM programs have found equal or better patient satisfaction levels. The core of PCCM, care coordination, supports the patient-provider relationship that is the basis of good care.

Unfortunately implementation of PCCM in CT has been problematic. Despite passage of PCCM into law three years ago, requiring among other things enrollment of at least 1,000 HUSKY members, a year after implementation the program has only 322 members. DSS has testified that this very low level of enrollment was intended and they have no plans to expand their marketing activities. Advocates have struggled to overcome many challenges created by DSS including limiting provider applications to a very short application timeframe, only allowing enrollment of current patients of those providers, refusing to print brochures for providers or consumers, and reversing agreements with the advocate/DSS working group and limiting the program to only two small communities. The lack of resources for marketing PCCM, especially compared to the resources allowed to HMOs, has been a particular problem. It has taken enormous effort on the part of advocates to overcome each of these artificial barriers imposed by DSS including media coverage, legislative, and administrative advocacy at both the state and federal levels.

Despite this extraordinary level of advocacy, many challenges remain unresolved. DSS has repeatedly refused to remove the inappropriate and unnecessary requirement that PCCM providers agree to Freedom of Information constraints. This requirement is irrelevant and intimidating to providers and has served as a barrier to participation. Notably, providers in the HMO system are not subject to this requirement. When the two new HMOs complained that they needed to build their membership to be

financially sustainable, DSS granted them default status until they reached their target. However, DSS has refused to grant a similar policy for PCCM.

In response to concerns about the unfairness of HMO resources from capitated HUSKY rates devoted to marketing, including free ice cream and haircuts, billboards, radio and TV ads, and raffles for school supplies and uniforms, rather than devote similar resources to PCCM marketing, DSS has decided after more than a decade to limit marketing by the HMOs. Marketing guidelines prohibit providers from telling their clients about PCCM, but they can respond to questions about it if asked. To address this contradiction, the advocates purchased and distributed to providers buttons that say "Ask Me About PCCM." We have also produced and distributed hundreds of posters, brochures and FAQs about PCCM for both providers and consumers.

In the absence of DSS' support for the PCCM program, an army of dedicated advocates, interns, students and volunteers has stepped in to recruit providers and inform HUSKY families about the program. It should be noted that in DSS' outreach activities they mention all options available to families, including the three HMOs along with PCCM.

Perhaps our greatest concern is that, despite very low enrollment, DSS intends to go ahead with plans to evaluate PCCM for cost containment among other parameters by July 1st. Any evaluation at such an early stage of a program is unlikely to be valid. A premature evaluation could bias the result and inaccurately label the program a failure before it has a fair chance to reach its potential. We are especially concerned that DSS intends to employ Mercer to conduct the evaluation. Mercer derives a great deal of their business from HMOs across the country and certified the rate setting process that granted the HUSKY HMOs a 24% increase in 2008.

We urge you to build on the significant work by advocates, providers and consumers in generating interest and enthusiasm for PCCM in CT. We applaud provisions in HB-5297 that would expand PCCM statewide, every HUSKY family deserves to have this option, and delay the program's evaluation until there is meaningful enrollment. However, without significant changes to the way DSS has implemented this program, we will be here next year with the same problems.

DSS has had a year to implement this program and has failed. More intervention is needed. I urge you to consider:

- Hiring an independent entity to administer PCCM
  - Advocates and volunteers have devoted enormous time and energy to marketing and accountability in this program. It is time for the state to take responsibility for these functions that DSS is not willing or able to perform.

- The entity hired must be completely independent of, and ineligible to become, one of the HUSKY HMOs to ensure that PCCM remains an alternative.
- Remove the irrelevant and intimidating Freedom of Information requirement on PCCM providers.
- Rebid the HMO portion of the program by July 1<sup>st</sup> and on a regular basis going forward
  - With the proposed change to the HMO portion of HUSKY, it is very possible that the state could attract new applicants offering better value and more competition to the current three HMOs
  - Most payers re-bid their contracts on a regular basis to ensure they are getting the best value for scarce dollars and to encourage innovation
  - Given the problems with extreme cost increases, low performance, and a lack of accountability, bidding this program out every two years would be prudent contract management.
  - While DSS has a number of policy changes to administer, this cannot be a reason to neglect such a large and important program.
- Require DSS to conduct a secret shopper survey of each HUSKY program annually
- Commission regular, independent audits of HUSKY program finances
  - A modest investment a year ago yielded evidence of \$50 million in HMO overpayments
- If DSS is again unwilling or unable to implement this law, create a Special Master for PCCM, appointed by and answering to the General Assembly, to oversee the program by 12/31/2010:
  - If PCCM enrollment is less than 20,000, or less than 500 primary care providers are participating, or the program is not state wide
  - The Special Master must have the resources and authority to independently administer the program. The Special Master must have the authority to override departmental policies when necessary.
  - To avoid even the appearance of conflicting interests, the Special Master must be completely independent of DSS, their contractors, including the HUSKY HMOs, with no financial or other ties in the last ten years.

Thank you for this opportunity to share my thoughts on this critical program for Connecticut families.

## Update: HUSKY future costs comparison: PCCM vs. HMOs

The last time we, and the General Assembly's Office of Fiscal Analysis, estimated the savings possible with implementation of Primary Care Case Management (PCCM), HUSKY was in the midst of several large transitions including a shift back to capitated managed care from self-insurance. Cost estimates in the program were shifting and difficult to get. In the interim, partly in response to that uncertainty, the Comptroller's Office commissioned an audit of 2008 HUSKY rate setting which found \$50 million in overpayments to the HMOs.

Given a significant deficit expected this year, policymakers are searching for ways to save money on programs. Primary Care Case Management (PCCM) for HUSKY offers that opportunity, especially as an alternative to more costly managed care organizations. In response to legislative requests, we are updating our PCCM savings estimates<sup>1</sup> for the HUSKY program.

The current HMO capitation rates average \$187 per member per month (pmpm).<sup>2</sup> At 10% administrative load<sup>3</sup>, that amounts to \$87 million per year in administrative costs.<sup>4</sup> In contrast, PCCM costs are \$7.50 pmpm plus \$573,589 in administrative costs at DSS<sup>5</sup>, totaling \$34 million per year if every HUSKY family enrolled in PCCM. The difference is \$49.7 million per year.

For several reasons those savings are likely an under-estimate.

- Enrollment in HUSKY has grown significantly over the years and is likely to continue, even accelerate, in the future. National health reform proposals could add another 100,000 to 150,000 members to the program in three to four years. As enrollment grows, the total savings due to PCCM will also grow.
- This estimate assumes that medical costs will be unaffected by implantation of PCCM, but that has not been the experience of other states. When Oklahoma switched their entire Medicaid managed care population from capitated HMOs to PCCM in 2004, medical costs were reduced by over \$24 million in the first

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<sup>1</sup> CT Health Policy Project Policymaker Issue Brief No. 46, October 2008,  
[http://www.cthealthpolicy.org/briefs/issue\\_brief\\_46.pdf](http://www.cthealthpolicy.org/briefs/issue_brief_46.pdf)

<sup>2</sup> 12/08 thru 11/09, from EDS HUSKY enrollment reports and DSS Comprehensive Financial Status Reports.

<sup>3</sup> Average from HMO audit reports to Medicaid Managed Care Council.

<sup>4</sup> Based on 11/1/09 HUSKY Part A enrollment numbers from EDS, It is likely this is an underestimate as HUSKY enrollment has grown steadily over the last year and is likely to continue that growth into the future.

<sup>5</sup> As per DSS budget estimate -- Annual PCCM program costs: SFY 2009 and 2010.

six months (they also “saved another \$20 million in payment lags), and saved over \$80 million in medical costs in the first full fiscal year of PCCM.

- The state has had significant difficulty in achieving fair rates with the HMOs. Too few bidders lead to an uneven negotiation. PCCM provides the state with leverage in those negotiations and a safety net for both HUSKY families and taxpayers if, as happened in Oklahoma, HMOs are not willing to accept what the state can afford. It is impossible to quantify these savings from a strong PCCM program, but they are significant and could, at the least, allow DSS negotiators to recover the \$50 million in overpayments identified in the Comptroller’s audit.

**Bottom Line: Allowing HUSKY families statewide to enroll in PCCM could save the state \$50 million or more annually over the HMOs.**

December 29, 2009