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Statement of Eric Kosofsky, DPM
before the
Human Services Committee
in support of
HB 5411
March 10, 2010

Sen. Doyle, Rep. Walker and members of the committee:

My name is Eric Kosofsky. I am a Podiatric Physician, in practice in Hartford and represent the Connecticut Podiatric Medical Association today in support of House Bill 5411, *An Act Concerning Medicaid*.

Section 1(b) restores podiatric services to Medicaid. We believe this is a long overdue—and very justified—step. As part of this discussion, I would like to make three points:

First, removing podiatry from the Medicaid program has not saved taxpayer dollars

As shown in an OLR memo (Nov. 2006), eliminating podiatry has not saved the state any money. Instead of seeing a podiatrist, Medicaid recipients are shifted to a higher-cost specialist or simply go to the emergency room. OLR looked at payments to podiatrists six months before they were dropped from Medicaid, and six months after. OLR concluded that “*it does not appear the state saved any money by eliminating Medicaid coverage for podiatrists*”.

Second, patient access to healthcare is reduced because of the elimination of podiatry

The problem is that patients, instead of being able to see a podiatrist if they have foot or ankle issues, must see an M.D. or other specialist. An article from the *New Haven Register* (Jan. 2006) documented the limits to which these specialists are willing to participate in Medicaid. Patients, particularly those who are in nursing homes, can wait weeks before being seen for serious issues. Meanwhile, we have podiatrists who would be eager to provide treatment.

Third, podiatrists can play a leading role in helping reduce Diabetes in the Medicaid population

The Department of Public Health five-year plan for diabetes prevention and control specifically calls for a concerted effort to expand podiatric services to Medicaid recipients, who are at higher risk for Diabetes. In 2005, DPH reported that \$39 million was billed from all sources in 2002 for hospitalizations in Connecticut related to diabetes with a lower extremity amputation.

Ladies and gentlemen, there are low-income citizens in the state who have had a toe or foot amputated because they did not receive necessary preventive care for Diabetes. This is shocking . . . and totally unacceptable. I urge you do to the right thing—both on a fiscal basis and policy basis—and mandate that Connecticut's Medicaid program once again cover podiatric services.

I appreciate the different competing interests that you need to balance in making health care policy. This change is long overdue, however, and I would urge you to approve HB 5411. I will be happy to answer any questions you might have. Thank you.



OLR RESEARCH REPORT

November 9, 2006

2006-R-0693

IMPACT OF ELIMINATING MEDICAID COVERAGE FOR INDEPENDENT PRACTITIONER PODIATRISTS

By: Robin K. Cohen, Principal Analyst

You asked whether the Department of Social Services (DSS) had saved any money by eliminating Medicaid coverage for podiatrists in 2002.

SUMMARY

According to DSS, it does not appear that the state saved any money by eliminating Medicaid coverage for podiatrists in 2002, despite having factored savings into the FY 03 budget. Rather, the costs for these services have shifted from podiatrists to other medical providers.

IMPACT OF ELIMINATING MEDICAID COVERAGE FOR PODIATRISTS

PA 02-7, May 9 Special Session (§104), required DSS to submit an amendment to its Medicaid State Plan to implement provisions in the FY 03 budget act concerning "optional" services. (Optional services are those services that federal law allows states to provide under Medicaid versus services that are mandatory, such as emergency care.) Although the act did not explicitly require this, DSS interpreted it as a mandate to eliminate Medicaid payment to the following independently enrolled providers: podiatrists, chiropractors, naturopaths, "independent therapists" (physical therapists, licensed audiologists, and speech pathologists), and psychologists for any services they provided to Medicaid recipients aged 21 and older. (This coverage was also eliminated from the then-General Assistance and State-Administered General Assistance programs.)

The change took effect January 1, 2003.

According to a DSS analysis of payments for podiatry services six months before and after the change occurred, Medicaid podiatry costs did not fall significantly. (DSS used the six-month period because it does not have data for any earlier period than six months before coverage was

eliminated.) Rather, most costs were shifted from podiatrists to a category of providers called "Other MD," while a small percentage shifted to orthopedists.

Table 1 illustrates what occurred.

Table 1: Podiatry Services With Dates of Service in FY 03 [1]

		<i>July-December</i>	<i>Jan-June</i>
Physician/Group	Orthopedics	\$ 56,789. 15	\$ 71,133. 03
Physician/Group	Other MD	498,574. 19	946,420. 82
Podiatrist/Group	Podiatrist	577,360. 11	45,595. 88

Source: DSS (November 2006)

[1] The data does not include podiatry services received in clinics or outpatient hospital settings. DSS pays an inclusive rate to these providers, and there is no way to break out podiatry costs. But one can assume that more people received podiatry services in these settings after the policy changed.

RC: ts

01/15/2006

HUSKY plagued by shortage of specialists

Mary E. O'Leary, Register Topics Editor

For two weeks, Nicole Rispoli barely got around on crutches, numbing the pain of a broken leg with medication, as she waited for the surgery that would put six pins and a metal plate in her left fibula and two pins in her ankle.

"It was excruciating," Rispoli said of her ordeal, which began Nov. 9 when she missed a step while going to her basement to do laundry and fell down five stairs.



Mayce Torres, in her East Haven bridal shop, is struggling to find dental coverage. Mara Lavitt/Register

Rispoli, 29, has health insurance through the state's HUSKY Medicaid program. It took her until Nov. 23 to find a doctor — at the Yale Medical Group's orthopedic clinic — who could operate on her leg.

While the HUSKY program gives hundreds of thousands of low-income state residents access to health care, experts said cases like Rispoli's expose a flaw. It's often hard to find surgeons, dentists and other specialists who will accept HUSKY patients.

"If you look at what Medicaid is supposed to cover, it's a Cadillac program. But this Cadillac has no tires, an engine that needs a ring job and is leaking everywhere. Just because on paper you are entitled to the services, doesn't mean that there is anybody out there who can provide them," said Dr. Robert Zavoski, medical director for Community Health Services in Hartford.

"The program is paid so poorly that very, very few subspecialists are willing to do the care," Zavoski said of his experience in referring patients.

Thomas Conroy, a spokesman at Yale University, said payments under Medicaid for its doctors in the clinics were 10 percent of what orthopedists usually receive.

Concern over what the state is getting for the \$700 million it pays annually to four insurance companies to run its HUSKY (Health Care for Uninsured Kids and Youth) Medicaid health plan is heating up. State Attorney General Richard Blumenthal is looking into Rispoli's situation and others who have complained to his office.

HUSKY serves 300,000 low-income residents, two-thirds of them children.

Rispoli is enrolled in Health Net Connecticut, which has 90 names on the list of orthopedic specialists in the New Haven area. It sent the list to Kevin Lembo, the state's health advocate, who is following the case.

Many of the names, however, are duplicates, and the large, private orthopedic groups, when

contacted by the Register, said they either were no longer taking the insurance for Medicaid patients or were not accepting new patients.

"One key question is how and why Health Net is failing to provide adequate orthopedic surgery services for its enrollees," Blumenthal said. "Does this very difficult and daunting case of access indicate that Health Net is effectively restricting access generally through inadequate reimbursement?"

Blumenthal said the discrepancy between the names listed by Health Net and those who take Medicaid insurance has to be remedied.

"The paper commitments need to be made real, otherwise they are meaningless, and that will happen only if the doctors are adequately paid," he said.

'no influence on care'

Conroy said there was no connection between the timing of Rispoli's surgery and her insurance plan.

"All patients receive the same high quality of care regardless of their insurance. Anyone who says their treatment was affected by their insurance is absolutely wrong. It has no influence whatsoever," he said.

Health Net spokeswoman Alice Ferreira called Rispoli's two-week wait "regrettable," and said the Health Net quality-control people were looking into it, but she said they were assured that medically she was treated within an acceptable time-frame.

"Our concern is that it was on the cusp of the two-week window," she said.

Sheldon Toubman, a lawyer for the New Haven Legal Assistance Association, said Rispoli's wait and limited options can be traced to the general lack of specialists in these plans.

Dr. Patrick Alvino, a pediatrician with Branford Pediatrics and Allergy, said they don't know of any private orthopedic group that will take their HUSKY patients and they routinely refer children to the Yale clinic or emergency room.

"For these insurance companies, on paper everything sounds wonderful, but practically that isn't how it works," Alvino said of the two-tier system in which private insurance patients have more options.

availability problems.

Rispoli said customer service staffers at Health Net were unable to find her another doctor after the Yale clinic had to reschedule the operation from Nov. 19 to Nov. 23 because of a conflict.

Rispoli said the customer service person she spoke with admitted problems with the availability of orthopedic specialists.

"She said it was a big problem and they were taking it seriously," Rispoli said and said she was advised to stick with the clinic appointment.

Ferreira expressed surprise that the private groups contacted by the Register, with the exception of a practice in Wallingford, did not take Health Net Medicaid. She said when Health Net employees made calls themselves, all the groups listed as available confirmed that they take new Medicaid patients.

Ferreira made no distinction, however, between doctors agreeing to see people in their private practices and volunteering once a month at the clinics.

Rispoli said she was reassured that the two-week wait would not hurt her. "But it was hard for me. I told them I'd rather be in labor than how much pain I was in," she said.

DENTAL DILEMMA

Across town in another East Haven household, Mayce Torres, who is enrolled in Preferred One for her HUSKY coverage, has been trying unsuccessfully for two years to get basic preventive dental care. When she broke a tooth Nov. 16, she stepped up her search, only to find the same dead end.

Desperate, Torres, 32, took out a small classified ad looking for someone to come to her assistance.

She even found one dentist who would take partial reimbursement from the insurance company, if she came up with the \$750 in cash for a cap in the next two weeks.

A small-business owner — Torres runs a bridal shop in town — she said coming up with the money would be tough, as this is a slow time for weddings.

"I have to pay my overhead; I have to make sure my kids eat," said Torres, who like Rispoli, has three children.

The earliest "emergency" appointment she could get at the Hill Health Clinic, which recently lost a dentist, was this month.

Driving from one office to the next after getting bad information that a dentist would see her, Torres said the discussions with the receptionists were humiliating.

"They make you feel like you are at the bottom of the food chain," she said.

A spokesman for Preferred One could not be reached for comment.

Jaime Bell of Greater Hartford Legal Aid has heard it all before. The lead counsel in a federal lawsuit challenging the lack of dentists and poor compensation offered by the Medicaid plans, Bell said Torres' experience is all too typical.

The suit, which has just been reassigned to a new judge after five years, said the dentist offering to take some of the insurance and charge Torres for other services is actually violating the insurance agreement.

"It's an indication of the brokenness of the system. It makes everyone desperate," Bell said.

Their study of compensation for dentists under the Medicaid managed-care organizations, as well as those financed directly by the state Department of Social Services, found they get "pennies on the dollar" for their work, said Bell.

The attorney said some dentists have complained that after providing the service and sterilizing the room, it actually costs them money to treat a HUSKY patient, with the reimbursement rate for adult care not updated since 1985.

She said federal Medicaid legislation mandates that the states provide comprehensive timely medical care for children, which includes oral health. Despite this, she said the state for the past dozen years has only been able to serve one-quarter of children in need of dental care.

"It's a public health crisis is what it is," Bell said.

The Connecticut Health Foundation is pouring money into the cities to try to increase access to dental care for children, but the local collaboration in New Haven, as elsewhere, is handicapped by the lack of dentists.

It takes months to get children enrolled in HUSKY or qualified for free care at Yale-New Haven Hospital's dental clinic with an appointment six months out, according to advocates.

promptness standards

Matthew Barrett, spokesman for the Department of Social Services, said the agency is finalizing a contract with a firm to look into access to dentists, dermatologists, neurologists, orthopedists and pediatricians to see if the insurance plans meet the promptness standards in their contracts.

Those standards include seeing urgent cases within 48 hours of notification, routine cases within 10 days and well-care visits within six weeks.

They are also required to offer a sufficient number and mix of specialists so the members' needs can be substantially met within their network. If not, they must send a patient out of network.

Barrett said that for complaints on the lack of dental coverage, Medicaid patients should call the HUSKY Infoline at (877) 284-8759 (CT-HUSKY.)

Toubman said in the debate over health care in America, people will often say they don't want a system that rations care.

"We have a system that is all about rationing. It's based on poverty. What we have is chaos," Toubman said.

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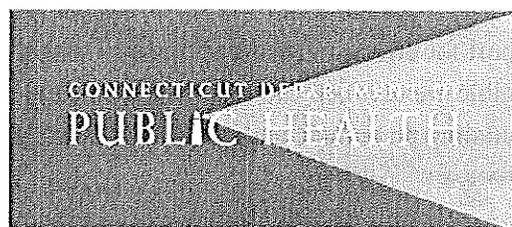
The Connecticut Diabetes Prevention and Control Plan

2007 – 2012



The Connecticut Charter Oak

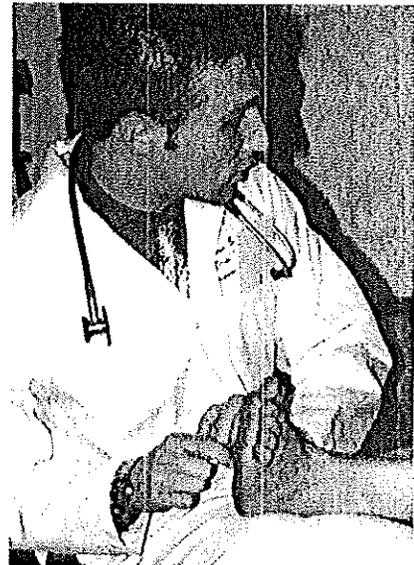
*Enhancing the lives of people affected by diabetes
through community partnerships &
a comprehensive system of prevention and care*



EXECUTIVE SUMMARY

Mission: "The Connecticut Diabetes Prevention and Control Plan is to create an environment for change in which a comprehensive system of care and prevention will reduce or delay the onset of diabetes and its complications, and enhance the quality of life for people affected by diabetes. Successful implementation of the Plan will bring about measurable improvement in the quality of life for people with diabetes and prediabetes, resulting in healthier communities."
Diabetes Advisory Council¹

Diabetes is a chronic metabolic disorder characterized by elevated levels of blood sugar which over time can ravage the body causing eye disease, kidney disease, nerve disease, and cardiovascular disease. An estimated 6.2% of Connecticut adults (163,000 people) have diagnosed diabetes (2003-05 data) with an additional 70,000 people with undiagnosed diabetes. According to the Centers for Disease Control and Prevention, diabetes cost Connecticut an estimated \$1.7 billion in direct and indirect costs in 2003. In 2005, the Connecticut Department of Public Health reported that approximately \$77 million was billed for hospitalizations due to diabetes as a principal diagnosis in 2002. In addition, almost \$39 million was billed for hospitalizations related to diabetes with a lower extremity amputation



Healthy People 2010, the national agenda for disease prevention and health promotion, calls for efforts to reduce the diabetes prevalence rate to 2.5% by the year 2010. Currently, the Connecticut rate is 6.2%. Closing that gap will prove increasingly difficult because Connecticut's population is growing older, specific high-risk groups for diabetes are increasing, and Connecticut's population tends to be increasingly overweight and sedentary. To address this public health issue, the Connecticut Diabetes Prevention and Control Program convened experts in five major topic areas: preventing diabetes, education/awareness, access/policy, disease management, and surveillance. The program is to promote Connecticut meeting the HP2010 goal to lower the prevalence rate by at least 0.5 percent by 2010. Priorities in implementing the plan include:

1. Develop support for efforts to ensure all persons with diabetes particularly those who are Medicaid eligible are enrolled and receiving medically appropriate preventive care and treatment, including podiatric and diabetes self-management education.

organization of the work groups is supported by the Chronic Care Model (See Figure 2. Connecticut's Chronic Care Model p. 50). The *Connecticut Diabetes Control and Prevention Plan* follows the Chronic Care Model, which incorporates both prevention and care elements from a variety of perspectives, including the individual, the health care provider, health care systems, and the community. All are intended to improve outcomes and reduce costs.

- The *Prevention Work Group* developed strategies to reverse pre-diabetes and to prevent or delay the progression of pre-diabetes to type 2 diabetes.
- The *Disease Management Work Group* developed strategies to: improve how health care providers diagnose and monitor diabetes; improve communication among health care providers and patients; clarify measurement of clinical outcomes; increase self-management practices among people with diabetes; increase screening for pre-diabetes and diabetes; and improve reporting of diabetes diagnoses.
- The *Education and Awareness Work Group* developed strategies for: people with diabetes who must manage and control diabetes; for health care providers to increase their knowledge and to increase participation in education programs; and for the general public to increase awareness about the symptoms, impact, and options related to diabetes.
- The *Access and Policy Work Group* developed strategies to: integrate and increase access to the various elements of successful care, including prevention, treatment, supplies, equipment, medication, diabetes self-management education, and nutrition therapy and to support the medical care system and communities in these efforts.
- The *Surveillance Work Group* developed strategies to capture and share relevant information about trends in diabetes statistics.

While this plan focuses on programs and policies to address diabetes we recognize the importance of stem cell research as an avenue to finding a cure for (type 1) diabetes.ⁱⁱⁱ

The full set of recommendations and strategies is shown in Executive Summary Table 1, beginning on p. vi.

2007 Work Plan. Of the final recommendations, the Diabetes Advisory Council selected two priorities for implementation in 2007:

1. *The access and policy goal is to ensure that comprehensive diabetes care i.e., preventive care, treatment, supplies, equipment, diabetes self-management education, medical nutrition therapy, and medications are offered, available and affordable across the public and private sectors to every citizen in Connecticut in need.* Specific strategies include: 1) support efforts to ensure that all Medicaid-eligible persons with diabetes are enrolled and receiving medically appropriate preventive care and treatment, in their community when possible,

including podiatric care and diabetes education services; and 2) develop a plan to seek legislative support for a program with community clinics, hospitals, and other health care providers to provide free or low cost access to preventive education and care, and treatment for uninsured and underinsured persons with diabetes.

11. *The education and awareness goal is to ensure that all people with diabetes, those at risk for diabetes, and their health care providers all have current knowledge and can apply evidence based guidelines.* Specific strategies include: 1) make available training curricula options for patient education; 2) train non-Certified Diabetes Educators (CDEs) to augment traditional education programs; 3) partner with grocery stores, libraries, and other public places to make diabetes, nutrition, and general better health information available; and 4) to engage HMOs to standardize diabetes education programs benefit availability.

Monitoring. During each year of the plan, the Connecticut Department of Public Health (CT DPH) and the Diabetes Advisory Council will prepare a report on the previous year's activities and results. Data will be collected and tabulated each year by the Diabetes Prevention and Control Program staff, and a report will be prepared by CT DPH and the Diabetes Advisory Council to update funding agencies, partnering health care organizations, and concerned citizens on the plan's progress. Based upon information in the annual report, the CT DPH in conjunction with the Diabetes Advisory Council will create an action plan for the subsequent year. The action plan will clearly state the objectives and the recommended strategies to achieve those objectives in the next calendar year. To fully implement the recommendations of *Connecticut's Diabetes Prevention and Control Plan*, a diverse group of funding sources, from state and federal government to private foundations, must be recruited.

Conclusion: Through this five year prevention and control plan -- with careful attention to results of programs, initiatives and collaborative support of various public and private entities - the Connecticut Diabetes Partnership has made a commitment to lower the Connecticut diabetes prevalence rate from 6.2% to 5.7%, and to improving the quality of life for Connecticut residents with diabetes and pre-diabetes resulting in a healthier community.