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**Testimony of Sheldon Toubman before the Appropriations Committee  
Regarding HB 6518 and HB 6519**

Good afternoon, Members of the Appropriations Committee. My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association. I am here to testify regarding HB 6518 and HB 6519.

First, regarding 6518, I am very pleased to say that the essence of this bill, which requires a study of the feasibility of converting "the current managed care system to a self-insured system administered by an administrative services organization," has basically been rendered moot by the Malloy Administration's most welcome announcement on February 8<sup>th</sup> that the troubled HUSKY capitated managed care system is being replaced with the non-risk ASO model, effective January 1, 2012. This is being done both to save money and improve access to care.

In addition, it was announced at that time that primary care case management (PCCM), an innovative new care coordination HUSKY program which the Rell Administration tried to block because it threatened the HUSKY MCOs, was going to be broadly expanded by the January 1, 2012 ASO rollout—and beyond -- along with other innovative care coordination models to be developed later. PCCM does not impose risk on providers and instead compensates them \$7.50 per member per month, in addition to payment for all health services provided, to actively coordinate their HUSKY patients' care and avoid expensive medical complications. Connecticut's PCCM program was carefully crafted over many months with extensive input from a diverse workgroup of providers, advocates and hard-working Department of Social Services ("DSS") technical staff, drawing on successful PCCM models in several other states.

Despite this announcement, some form of 6518 still is necessary to fully implement the Malloy Administration's goals, in light of ongoing resistance by DSS officials. I will be submitting substitute language for 6518 shortly accomplishing this.

Even before being elected, the Malloy Administration made clear one of its goals in the health area: "Expand Connecticut's Primary Care Case Management (PCCM) system, HUSKY Primary Care, to 400,000 low income children and parents in the HUSKY program" (Campaign Policy Book)

Very early on, the Administration made good on this promise. At the February 8th press conference with Lieutenant Governor Nancy Wyman, OPM Secretary Ben Barnes could not have been clearer:

“[T]his will ... enable us to work to incorporate some of the most promising new care delivery models that are available now. **We intend to have *Primary Care Case Management* medical home options as part of the plan on day one**, on January 1<sup>st</sup>. Obviously, the number of organizations and the number of providers who are able to participate through that system may not be as great as we ultimately want it to be on January 1<sup>st</sup> of 2012, but **we intend to move aggressively to expand the medical home portion**—you know, the services that are provided through the medical home services delivery model—once we convert to the ASO.”

(Transcribed from video of press conference, available at <http://www.ctn.state.ct.us>)

At the same press conference, Lt. Governor Wyman explained that providing this kind of care coordination, which was promised but rarely delivered by the MCOs, will save money because individuals who have appropriate care management are less likely to develop expensive medical complications, requiring ER visits and even hospitalization.

Since then, on March 15, 2011, Secretary Barnes reiterated, at a hearing before the Human Services Committee, the Administration’s commitment to both the transition to the ASO model and the expansion of PCCM.

But, regretfully, DSS has refused to implement the expansion of PCCM. At several public meetings since the announcement, including those of the Medicaid Care Management Oversight Council, DSS representatives pointedly refused to even refer to PCCM as part of the implementation of the Administration’s Medicaid restructuring plan. At one recent meeting, a DSS official even suggested that the name of the “PCCM Subcommittee” of the Medicaid Council should be changed. Most recently, two days ago, DSS officials made a public presentation to HUSKY outreach workers about the Medicaid restructuring and, while referring to “medical homes” under the ASO generally, would not refer to the PCCM model.

Given this unwillingness to implement the Administration’s goals, it is not surprising that not one of the many artificial barriers DSS had erected under the Rell Administration to ensure very low enrollment in the PCCM program has been removed, though most of them are entirely within its control. For example, though having been repeatedly asked to do so, DSS has not taken one step to undo:

1. The prohibition on participating primary care providers (PCPs) affirmatively mentioning the PCCM option to their existing HUSKY enrollee patients, to encourage them to sign up with that option instead of continuing to receive services through one of the MCOs.

2. The contractual obligation imposed on individual PCPs signing up with PCCM (but not with the HUSKY MCOs) to be directly subject to the Freedom of Information Act, even though their state payments are all far below the statutory minimum triggering that obligation (\$2.5 million/year in state business and taking over the role of the government).

3. The refusal to default anyone into PCCM while defaulting about 2,000 new HUSKY enrollees who do not select a plan (about 30% of new enrollees) into the three MCOs **each month**, even in those four parts of the state, covering about 41% of HUSKY enrollee population, where PCCM is fully operational with willing and able PCPs who have hardly any PCCM enrollees.

Regarding this last refusal, almost two months after the Malloy Administration's announcement that it will be terminating all of the MCO contracts as of January 1st, DSS has since done two rounds of defaulting new HUSKY enrollees **only** into the three MCOs which will be leaving in January -- a total of about 4,000 individuals; **none** have been defaulted into PCCM, the "promising new care delivery models" which Secretary Barnes said will be substantially expanded by January 1<sup>st</sup>. **Last month, after the Administration's announcement, over 600 new HUSKY enrollees were defaulted into each of the three MCOs- more than are enrolled in the entire PCCM program statewide (516).**

With this ongoing resistance, legislation clearly requiring DSS to implement the Malloy Administration's goals is necessary. The substitute language I will submit will clarify, consistent with the February 8<sup>th</sup> announcement, that an ASO will be selected and go into operation in August and roll out the new non-risk program for all Medicaid enrollees by January 1, 2012. It also will specify that only one ASO will be hired, since it would be administratively wasteful to have more than one ASO administer the same kind of benefits for the same population—just as there is only one ASO for all Medicaid dental services and one ASO for all Medicaid behavioral health services.

Beyond this, the substitute language will clarify that the multiple barriers erected by DSS to severely restrict enrollment in PCCM must be removed right away and that, if any federal Medicaid permission is needed to do this, it should be sought immediately. Lastly, it will require that the ASO hired shall begin September 1 the implementation of an aggressive program of enrollment in PCCM for both HUSKY enrollees and PCPs.

Once this aggressive enrollment of PCPs and HUSKY enrollees occurs, consistent with the Malloy Administration's goals, we should be able to reap the financial rewards of quality care management through PCCM. Thus, in relation to 6519, I urge that the study of ways to save money in Medicaid specifically focus on enhancing the non-risk PCCM model with disease management and other programs which can be expected to save additional money through better preventative care, rather than changes which will restrict access to care for short-term savings.

Thank you for the opportunity to speak with you today.