

TESTIMONY before the APPROPRIATIONS COMMITTEE

RE:

IMPACT OF PROPOSED STATE BUDGET CUTS

Presented by

Katherine S. Yacavone, CEO

SOUTHWEST COMMUNITY HEALTH CENTER, INC (SWCHC)

February 17, 2012

To the Members of the Appropriations Committee:

Re: DSS Proposed 1115 Waiver Changes to the MLIA (HUSKY D) Population

In 2011, Southwest Community Health Center (SWCHC) saw 20,093 patients generating 115,908 medical, dental, and behavioral health visits from 18 licensed sites. Of total patients, 4,439 were Medicaid Low Income Adults who received 18,193 visits, averaging 4 visits per year. The federal government reimburses Connecticut for 50% of the costs of those visits which are now referred to as HUSKY D. **In 2014, the federal government will pay 100% of HUSKY D costs** and in later years the federal share will gradually decline to 90%.

In 2011, thirteen of the fourteen federally qualified health centers (FQHCs) in Connecticut rendered a total of 328,485 HUSKY D (MLIA) patient visits. As you can tell from these statistics, FQHCs are important providers to the HUSKY D/MLIA population. On behalf of SWCHC and the thirteen FQHCs who are members of the Community Health Center Association of Connecticut I would like to express deep concern with the changes to the HUSKY D eligibility and benefits that DSS has proposed in its 1115 Waiver proposal submitted to CMS and the savings from the Waiver implementation included in the Governor's budget calculation.

Limits on Benefits -- Under the proposed benefit changes, HUSKY D participants would receive different benefits --not yet specified-- than other Medicaid participants. This would introduce a two-tier system that would contribute to even greater health disparities than those that already exist. It is not realistic to imagine any FQHC provider will differentiate the care they provide by payor source. Further, as DSS has established clinical performance benchmarks for providers to reduce health disparities (for chronic diseases including diabetes, hypertension and asthma) under the Medicaid Person Centered Medical Home program, a two-tiered system undermines this goal. Now, as a result of DSS' cost saving measures for HUSKY adults, a two-tiered system for dental care been created at FQHCs. Prescribed dental treatment is curtailed due to limits by age and procedure impacting oral health status.

Count family income in establishing eligibility for adults between 19 and 26.

Counting family income as available to adults for whom families have no financial

responsibility is inconsistent with established Medicaid eligibility rules. In addition, it is questionable whether the assumption for projected savings—that a significant number of HUSKY D patients would have access to commercial insurance coverage through their parents—is sound. At SWCHC in 2011, 99% of ALL patients had incomes at or below 200% of poverty.

Reinstate an asset limit – SAGA eligibility rules included a very low asset limit, which was removed when SAGA was converted to LIA. In 2014, there will be no asset limit for HUSKY D/LIA. Reinstating an asset limit would add a significant administrative burden to a state agency, DSS, that is already falling far behind in processing applications for Medicaid enrollment. Limited state resources should not be devoted to the onerous task of reprocessing the current HUSKY D enrollees under an asset test that will be removed less than two years later. As a provider of services to HUSKY D patients, the disruption of coverage will impact patients' health as well as the financial health of the FQHC providers who will continue to provide services regardless of gaps in coverage while disenrollment/re-enrollment proceeds—however slowly it may proceed.

These cuts will prejudice the ability of FQHCs to successfully implement an important DSS initiative for creating Person Centered Medical Homes by draining their already scarce resources.

Cutting the safety net providers **WILL NOT SAVE** the State \$. I believe these proposed 1115 Waiver changes for the MLIA population is, in part, premised on two false assumptions that must be disputed.

1. Increases in the number of MLIA patients and volume of services provided at FQHCs does not equate to a “windfall” or increased revenue/profit for FQHCs: FQHCs deliver care to all persons without regard to insurance status. While the numbers of MLIA clients have increased, so too, have the numbers of uninsured seen at FQHCs. For example, the volume of uninsured patients at SWCHC in 2011 alone has increased 28% and visits to uninsured patients have increased 19%. SWCHC's resources are being strained to provide services to an increased volume of total patients - Medicaid and uninsured patients. FQHCs must place uninsured patients with incomes at or below 200% of the poverty level on a discounted fee schedule. The difference between the payment collected, say \$30, for a physical exam that costs \$143, is only made up through federal or state grants. Federal and state grant funds for uncompensated care have not kept pace with the increased volume of uninsured. In fact, in the past 3 years, DPH grants to FQHCs for uncompensated care have been cut, with a significant cut of another \$666,822 (or 11%) proposed for the next state fiscal year. Without grant funds, there is NO revenue source to offset a \$113 loss for each uninsured visit. Federal law prohibits cost shifting of Medicaid and Medicare reimbursement to cover uncompensated care. Any increase in the uninsured, as in persons disenrolled from MLIA, will only exacerbate the FQHCs' per visit revenue loss. Any further diminution of funding will severely limit SWCHC's ability to provide primary care services in the community setting and only exacerbate the inappropriate utilization of hospital emergency departments.

2. Cuts to HUSKY D/MLIA will NOT save the State dollars: Patients not seen by FQHCs will be seen in the MORE COSTLY Emergency Department settings INCLUDING behavioral health clients. Data for 2010 from the U.S. Dept. of Health and Human Services indicate that the average cost to provide a non-emergent visit in a hospital E.D. is \$1,452. Compare this to a comprehensive, case managed visit at an FQHC averaging \$143. **Would the state rather pay \$143 or \$1,452 for a primary care visit for an MLIA patient?** Cutting the cost effective FQHC delivery system will force an increase in inappropriate ED visits. Higher ED visits will tax a system that is already overburdened; care will be episodic and disjointed in direct opposition to the coordination of care focus of the DSS Person Centered Medical Home initiative.

I respectfully ask the Appropriations Committee to consider these points in addressing the proposed DSS 115 MLIA Waiver.

The cost effective solution is to include MLIA/ HUSKY D persons as full participants in the Person Centered Medical Home initiative. FQHCs serve as the hub of care delivery to the Medicaid population and will continue to do so in the new program. The impact of proposed waiver changes in benefits and means tests will only serve to erode access to care and/or restrict services for thousands of HUSKY D clients seen annually in FQHCs in Connecticut. The most vulnerable of the State's residents, now cared for in cost effective and efficiency community-based settings, will have no alternative but the Emergency Departments for care.