

TESTIMONY to the Appropriations Committee

February 5, 2010

Re: Why Connecticut needs Primary Care Case Management

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Executive Director

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. Providers are not at financial risk for the services they provide or authorize. PCCM is a form of the patient-centered medical home model, featured in both 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.

The current HMO-based HUSKY program is deeply troubled, has been for its entire tenure, and is not improving. HMOs have received 24% rate increases; an independent audit commissioned by the Comptroller's Office last year found \$50 million in overpayments. In 2007, barely half of HUSKY children received scheduled check ups, and over one in ten did not get any health care at all from the program. In a 2007 secret shopper survey, trained surveyors posing as HUSKY clients were only able to secure an appointment for care with one in five providers listed by the HMOs; that survey has not been repeated and DSS has no plans to do so. Few CT providers accept HUSKY, while other states' participation rates are far higher, including states with less generous rates for services. Providers report that the hassles of dealing with HMOs are a significant barrier to HUSKY participation.

We were very pleased to see in the Governor's budget document Wednesday 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.

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.

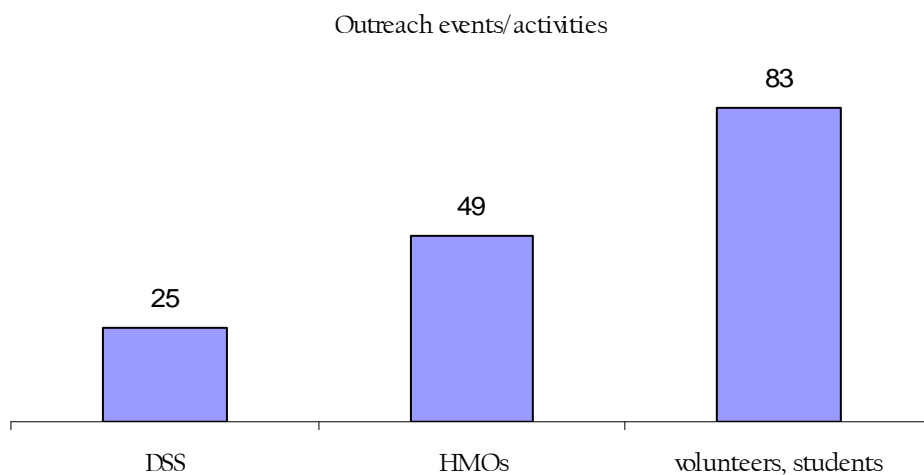
CT needs an alternative to HMO-based administration for HUSKY. Without a viable alternative, both HUSKY families and taxpayers are held hostage to whatever rate increases, including administrative costs, the HMOs demand. Because there is no HMO between the state and families, PCCM affords the state better 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 253 consumers. 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 urge the General Assembly to:

- Implement PCCM statewide by July 1, 2010. Every HUSKY family deserves to have this option.
- Offer PCCM as an option to HUSKY Part B children, allowing them access to this important alternative to HMOs
- Hire an independent ASO 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 ASO 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.
- Delay the PCCM evaluation until at least one year after at least 20,000 people are enrolled.
 - Any evaluation must be conducted by a truly independent evaluator, with no ties to HMOs or DSS or expectation of future funding, with experience in similar program evaluations.

- Require DSS to conduct a secret shopper survey of each HUSKY program annually
- Commission regular, independent audits of HUSKY program finances
 - A modest investment last year yielded evidence of \$50 million in HMO overpayments
- Create a Special Master for PCCM, appointed by and answering to the General Assembly, to oversee the program if by 12/31/2010:
 - 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 our thoughts on this critical program for Connecticut families.