September 2, 2010

Senator Toni Harp
Chair, Medicaid Care Management Oversight Council
Legislative Office Building
Hartford, CT 06106

Re: Statewide PCCM Solution to Legislative Goal of Conversion of HUSKY to Non-Risk ASO(s)

Dear Senator Harp:

As a diverse group of advocacy, provider and consumer organizations, we write to you and the other members of the Medicaid Care Management Oversight Council, to urge that the Council give very serious consideration to the adoption of a single Administrative Services Organization (ASO) combined with statewide PCCM as a solution to the vexing problems under the current capitated HUSKY managed care program. The Department has recently acknowledged that statewide primary care case management (PCCM) is indeed a solution which would both comply with the recent legislative instruction to move to one or more ASOs in the HUSKY program, and satisfy the federal Medicaid agency (CMS). We urge that this non-risk option, which will control costs by eliminating the excessive administrative costs of capitated managed care organizations (MCOs) and finally bringing long-promised but undelivered care coordination to this program, while minimizing access problems, be the model adopted.

As you know, in Section 20 of PA 10-179, the legislature authorized DSS to convert the current risk-based HUSKY A and B program into a non-risk program, through contracting with one or more "administrative services organizations." Although it used this term, it was clear that the over-arching concern was to move to a non-capitated model, given the cost, access and accountability issues associated with the capitated model long used by DSS (except during the 14 month period in 2007-2009 that the MCOs were changed to "Pre-paid Inpatient Hospital Plans" or "PIHPs" and during which, accordingly to former OPM Secretary Genuario, the overall costs of the program were lower). The legislature assumed $75 million in savings from the move to ASOs effective July 1, 2010.

DSS has been in communication with CMS about the means to accomplish this legislative instruction. In its August 2, 2010 letter, CMS laid out the various means available under federal law:

> As we have discussed, 42 CFR § 438 provides for additional delivery system options under managed care, including prepaid health plans, inclusive of inpatient services (PIHP) or providing only ambulatory services (PAHP), managed care organizations and **primary care case management programs**. (emphasis added).

Nevertheless, at the August 13, 2010 Council meeting, DSS, both in its power point presentation and in its oral presentation, offered only three options: (1) ASOs using the Medicaid provider network; (2) ASOs using the existing MCOs' respective provider networks; and (3) maintaining the use of MCOs through the capitated system, though slightly modifying that system with "risk corridors." The continued use of capitated MCOs, as set forth in option #3, was not contemplated in the legislation. DSS did not mention statewide PCCM, which can be coupled with one or more ASOs, as an option, though this also

was mentioned by CMS in its letter and is fully consistent with the legislature's instruction. However, in response to your questioning, DSS's Medicaid Director, Dr. Mark Schaefer, made clear that a single ASO with statewide PCCM, where care is coordinated by individual primary care providers, would comply with all federal requirements and the legislature's instruction:

> [T]he ASO arrangement is something that's permissible under the PCCM provision of the Medicaid managed care rule. … [I]f you take away capitated managed care and the PIHP arrangement, and you look at the PCCM arrangements, you can have more than one ASO assigning people to PCPs, and the ASOs are essentially your primary care case management provider – they're doing care coordination and linkage and referral and all that stuff. If you condense to one ASO, then you have to have a place where the managing entity for some of the services is still available-- where you have a choice of entity and at that point you'd have to have a network of primary care case management providers. **So a single ASO only works if it's coupled with a statewide PCCM solution.** (emphasis added).

We are at a critical crossroads, not unlike what the state of Oklahoma faced in 2003, when it had a very limited PCCM program in a portion of the state and three capitated MCOs which were demanding additional state payment to continue to participate in its Medicaid program. Officials in Oklahoma, aware that PCCM can save substantially over capitated MCOs while improving access to care, took the responsible path and moved the entire Medicaid population to statewide PCCM in four months, reaping substantial rewards in just the first six months (including a $23.9 million reduction in medical outlays) which continue to this day. North Carolina has similarly seen major cost reductions through its move to statewide PCCM. In both states, provider participation increased with the move to statewide PCCM.

Although it is currently a very small program owing to DSS's lack of enthusiastic implementation, we now have the infrastructure of a workable PCCM program in Connecticut, with the network of providers to which PCCM enrollees can be referred by their primary care provider being the full Medicaid fee for service network. With a reasonable amount of state support, it can be expanded on short order to the whole state, just as it was in Oklahoma.

For all these reasons, we urge you and the other members of the Council to seriously consider the "statewide PCCM solution" explained by Dr. Schaefer and acknowledged by CMS. Particularly since the legislature is considering applying the newly restructured model for HUSKY to all other Medicaid populations, including vulnerable elderly and disabled groups, we no longer have the luxury of ignoring this balanced and tested model now in use in a majority of other states.

Thank you for considering this important request.

Respectfully yours,

Advocacy for Patients with Chronic Illness

American Academy of Pediatrics- CT Chapter

Center for Children's Advocacy

Center for Disability Rights

Center for Medicare Advocacy

CT Academy of Family Physicians

CT Association for Human Services

CT Association of Area Agencies on Aging

CT Association of Centers for Independent Living

CT Association of Nonprofits

CT Association of Resident Service Coordinators in Housing

CT Center for Patient Safety

CT Citizen Action Group

CT Coalition on Aging

CT Family to Family Health Information Network

CT Legal Rights Project

CT Legal Services

CT Lifespan Respite Coalition

CT Oral Health Initiative

CT Parent Power

CT State Medical Society

CT VOICES for Children

Disabilities Network of Eastern CT

FAVOR

Independence Northwest

Legal Assistance Resource Center of CT

Mental Health Association of CT

Middlesex Coalition for Children

National Alliance on Mental Illness-CT

New Haven Legal Assistance Association

Office of the Child Advocate

South Central Behavioral Health Network

cc: Members, Medicaid Care Management Oversight Council
Commissioner Michael Starkowski
Mark Schaefer, Ph.D.
Senator Donald Williams
Senator Martin Looney
Rep. Chris Donovan
Rep. Denise Merrill
Comptroller Nancy Wyman
Healthcare Advocate Kevin Lembo
Richard McGreal, CMS Regional Office