

Testimony Regarding the Medicaid 1915(b) Waiver Application

Sharon D. Langer, MEd, JD

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Senator Harp, Senator Doyle, Representative Geragosian, Representative Walker and Members of the Appropriations and Human Services Committees:

I am testifying today on behalf of Connecticut Voices for Children, a research-based public education and advocacy organization that works statewide to promote the well-being of Connecticut's children, youth, and families. This testimony is based on our collective experience with HUSKY Program policy and its impact on health care access for Connecticut families. I coordinate the Covering Kids & Families Coalition, a project of Connecticut Voices, which brings together DSS staff, community based organizations, healthcare advocates, and others to share information about the HUSKY program in order to improve coverage and access for families and children. My colleague, Dr. Mary Alice Lee, first with Connecticut Children's Health Council, and more recently at Connecticut Voices, has conducted independent monitoring of the HUSKY program since its inception. Dr. Lee analyzes enrollment and claims data in order to inform policy makers about the extent to which children and families are receiving timely and appropriate health care, such as well-child, prenatal, and dental care.¹ My colleague, Jamey Bell, Executive Director of Connecticut Voices, advocated in judicial, administrative and legislative venues for Medicaid recipients for two decades while she was a legal services lawyer, including acting as lead counsel in the *Carr v. Wilson-Coker* dental care access litigation.

With this background in mind, I offer the following comments to inform the Committees' deliberations on the Department's application to the federal government for a new Medicaid (HUSKY A) 1915(b) Waiver. I set forth some general comments about the waiver application, followed by more specific comments related to various sections of the proposal.

Connecticut Voices urges the Committees to consider carefully the ramifications of approving or rejecting this waiver. First, lacking evidence to the contrary, we have serious, fundamental questions about the wisdom of continuing capitated, risk-based contracts with managed care organizations when so many of the services have been or will be "carved out" of this system. Currently, behavioral health, pharmacy, and dental care services are no longer the responsibility of the managed care organizations (MCOs). As of September 1, 2009, the payments to federally qualified health centers (FQHCs) will also be removed from the purview of the MCOs. It makes little sense to pay for the duplicative administrative non-medical services of three managed care plans (including two for-profit companies) to manage the remaining aspects of care.

However, we also have serious concerns about rejecting this waiver application outright if it means abruptly dismantling the program July 1, 2009, and returning HUSKY families to fee-for-service Medicaid without the program supports and accountability that we advocate.

¹ For recent reports on how the HUSKY Program and its managed care plans are performing, go to Publications-Health & Mental Health on Connecticut Voices' web site www.ctkidslink.org/pub_issues12.html

We are particularly puzzled by the continuation of risk-based managed care when the application itself assumes that savings from PCCM will be the result of not spending the “non-medical load built into the cap rate.” This means that at \$7.50 per member per month, DSS assumes it will pay PCCM providers *less* than the Department currently pays MCOs for their non-medical costs, e.g., administration and profits. At a time of soaring budget deficits and increased enrollment due to the precipitous downturn in the economy, why is the state willing to pay MCOs the “non-medical load” in addition to the cost of medical services to HUSKY children and families? Wouldn’t the money be better spent on paying providers to deliver critically needed health care services? Absent evidence of cost effectiveness of the risk-based program model, we can only assume, based upon this waiver application itself, that risk-based managed care is too costly an option to continue.

We recommend that the Committees require the Department to demonstrate ongoing cost effectiveness of the managed care program and continuing improvements in access to care and utilization. In fact, the Committees could require that data from twelve completed years of managed care be submitted in support of this waiver application, even if the federal government does not require the data for making its decisions on the merit of the application.

However, we also recommend that the Committees require the Department to develop and submit a plan for an orderly, timely transition to a non-risk program that builds on lessons learned from contracting for administrative services and primary care case management, with emphasis on improving access to care and accountability.

We support the requirement for an independent assessment of the program that is required under the waiver. We understand that the Department was advised by the federal government to apply for an “initial waiver” as opposed to a “renewal” waiver due to the many changes experienced by the HUSKY program in the last 16 months. The change from risk-based to non-risk based managed care in November 2007 - and back again to risk contracts with managed care organizations (MCO) in July 2008 - makes it difficult for the Department to compare policies and costs during that time of “transition” with the projected two-year period under the waiver. Because the Department is requesting approval of an “initial” waiver, it must contract for an “independent assessment” of the first and second waiver periods, and the Department has budgeted accordingly (\$100,000).

The assessment is an important component of the waiver process. Under the previous waivers, the federal government gave Connecticut permission to require that “children with special health care needs” be enrolled in the Medicaid managed care system. The Department was therefore required to identify these children in order to determine whether they were receiving appropriate services. An independent assessment of the waiver, conducted in 2002, showed that the Department needed to take steps to improve care for children with special health care needs.² Recommendations to the Department included: development of a uniform and systematic approach to identifying children with special health care needs, including DCF-involved children and children who are eligible for Title V services; increasing access to dental care for children with special health care needs; developing and monitoring contract standards for specialty care provider network adequacy; clarification of managed care contract standards and reporting on assessment, care coordination, and

² “Independent assessment of Connecticut’s HUSKY a Program: Access and quality of care for children with special health care needs.” Prepared by the Children’s Health Council for the Connecticut Department of Social Services, December 2002.

case management for children with special health care needs; investigation of specialized payment methods and development of actuarially-sound risk adjusted rates; and development of a plan for monitoring access to care and quality for children with special health care needs. In the intervening years, few of the steps have been taken.

Lastly, as a general comment we found that the waiver application did not describe comprehensively either the managed care plan or the PCCM program. Moreover, it was difficult to know when provisions applied to managed care plans only and when they applied to PCCM practices and when they would apply to both types of managed care. (More comment on the PCCM program follows.)

1. Primary Care Case Management (pages 18, 31)

The application describes the PCCM pilot as being limited and to be rolled out statewide at a later date.

Comment: This section describes the PCCM pilot project as limited to Waterbury and Willimantic. It suggests that the pilot project will be rolled out in other areas of the state but without setting out any timetable or location. It therefore appears that PCCM will be limited to a pilot project in these two geographic areas during the duration of the initial waiver application. It is our understanding, however, from reading the PCCM Plan and talking to members of the PCCM Working Group that the intention was for PCCM to be up and running in any area of the state where there was a sufficient number of primary care providers signed up to participate in PCCM.

In addition, there are no performance measures or goals set forth for PCCM, such as for access, utilization, satisfaction or quality of care. (page 31)

2. Children with Special Health Care Needs (CSHCN) (pages 25-27)

DSS reports on the application that it has a mechanism for identification of “children with special health care needs,” relying on Medicaid coverage groups for children in the care of the Department of Children and Families (DCF). DSS also states that it identifies children in Title V with data transfers from the Department of Public Health (DPH).

Comment: Generally, it is difficult to determine from this waiver application just how the Department identifies and monitors the care of children with special health care needs. For example, many CSHCN who are in foster care or adoptive homes receive Medicaid under different coverage group categories, e.g., HUSKY A for Families (F07). How does the Department identify these children? Does the Department send information about DCF-involved children to its contractors (enrollment broker, managed care plans, primary care case management practices, administrative services organizations, independent performance monitor)? To the best of our knowledge DPH does not provide the Department with information that would identify a child as receiving Title V services. How then would the Department send information about Title V children to its contractors (enrollment broker, managed care plans, primary care case management practices, administrative services organizations, independent performance monitor)? Also, do the approved treatment plans (page 27) apply to PCCM providers? Do the contract provisions cited for managed care organizations also apply to PCCM? Also, how will the Department monitor access to care and quality for children with special health care needs, especially if its contractors are unable to identify these children?

3. Linguistic Access/Medical Interpretation (pages 39-40)

On the one hand, the MCOs are contractually obligated to provide language interpretation services. On the other hand, the application says that PCCM providers are required to “comply with all applicable laws. . . regarding language access for Members, including written information available in the prevalent non-English languages [in] the Providers’ particular service area and by making oral interpretation services available in all non-English languages free of charge to each Member.”

Comment: We take this opportunity to reiterate the importance of Connecticut providing medical interpretation as a separate Medicaid billable service per state statute enacted in 2007. How will the Department monitor the MCOs requirement to provide medical interpretation? Is the expectation that the PCCM providers will provide this service without financial reimbursement?

We would like to also point out that in order to comply with this requirement, the application mentions that the Department depends on entities that create and/or distribute materials that either are not funded by the Department (e.g., Covering Kids & Families) or at risk of being eliminated under the Governor’s budget proposal (all of the contracted community based organizations listed on page 40).

4. Outreach (page 42)

The application explains that the “State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. . . .”

Comment: It is not clear whether the Department is describing outreach conducted by its managed care organization contractors or the Department itself or both. We think of outreach as an effort to inform potentially eligible populations about the availability of the program. Enrollment assistance can be part of such outreach efforts. Research shows that the best outreach activities target certain underserved populations and provide application assistance and follow-up. While it is true that the Department contracts with community based organizations and others to do outreach and enrollment assistance, many of those contracts are threatened by the Governor’s proposal to eliminate \$500,000 in outreach efforts. It is therefore not clear to what extent the Department’s statements in this section provides an accurate picture of the state’s “outreach” program.

5. Assurance that Enrollment Broker Meets Independence and Freedom From Conflict (page 43)

This section requires the Department to “assure CMS that the enrollment broker contract meets the independence and freedom from conflict of interest requirements.” In response, the Department names the longstanding enrollment broker, ACS State Healthcare, LLC and explains that “[I]n a letter to CMS dated September 22, 2009, the Department provided information requested by CMS regarding business affiliations of ACS State Healthcare, LLC which might impact their independence and freedom of conflict on interest status. The Department is awaiting further direction from CMS.”

Comment: Have the Committees or the Medicaid Managed Care Council seen the correspondence between CMS and the Department from last fall regarding the potential conflict of interest issue? When does the Department expect to receive “further direction from CMS” in light of the fact that it has been six months since the Department responded to CMS’s inquiry?

6. Monitoring Activities (pages 57, 68)

According to the application, the managed care organizations are required to “measure any disparities by racial or ethnic” factors for quality of care. The Department also mentions utilization reviews by the MCOs.

Comment: We are not aware that the MCOs have been conducting measurement or assessment of racial and ethnic disparities. It would be helpful to know how this will be done and how the information will be publicly disseminated.

There is no mention that ongoing independent performance monitoring has been conducted and reported by Connecticut Voices for Children with funding provided by the General Assembly – except for a reference to the “Children’s Health Council” [sic] on page 3 of 14 of Appendix D2.A Administration in Waiver Cost under “Other Financial Participation”. Technically, (and for historical reasons), the contract for independent performance monitoring is between the Department of Social Services and the Hartford Foundation for Public Giving as a fiscal intermediary. The Hartford Foundation makes a grant to Connecticut Voices for the conduct of independent performance monitoring, with regular reports to the Department and the Medicaid Managed Care Council on findings regarding well-child visits, prenatal care and birth outcomes, emergency care, asthma care, and dental care. Reference to ongoing independent performance monitoring should be included in the application. Note: The Governor has proposed elimination of funding for independent performance monitoring in the HUSKY Program, at a time when it is more important than ever for measuring the impact of program changes, such as the carve-outs of dental care and pharmacy, PCCM, and the carve-out of FQHCs later this year. Connecticut claims 50% federal matching funds for the cost of the program (\$218,317 in FY08).

7. Monitoring Results (page 71)

The document explains that since this is an initial waiver, the application does not provide “evidence that the waiver requirements were met for the most recent waiver period” which would have been 2005-2007.

Comment: Although we understand the reasons why CMS suggested that the Department submit this waiver as an “initial application” rather than a renewal given the difficulties experienced during the last 16 month period of “transition” from risk-based managed care to non-risk and back again effective July 1, 2008, we have concerns that *nothing* is being reported in this application to CMS regarding the previous waiver period when in fact the program was in existence. The Department’s own reports and those of its contractors (managed care plans, external quality review organization, auditors, enrollment broker, independent performance monitor, outreach contractors) would provide the Committees and CMS with a wealth of information for understanding what worked and didn’t work in this managed care program. It seems inadvisable to ignore the experience and lessons learned when going forward with this waiver application.

In summary, we urge the Committees to approve the waiver application *if and only if* the Department revises the application to include specific measures for demonstrating improved access to high quality care and the cost effectiveness of managed care vs. other delivery models. Thank you for this opportunity to provide comments concerning the Department of Social Services’ Application for a Medicaid 1915(b) Waiver. If you have questions or need further information, please do not hesitate to contact us.