

**PA10-166**

**HB5297**

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Human Serv.	606-607, 619, 658-665, 673-685, 737-741, 764-765, 803, 805, 919-926, 1040, 1042, 1044, 1049-1057, 1062-1064,	57
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**CONNECTICUT  
GENERAL ASSEMBLY  
HOUSE**

**PROCEEDINGS  
2010**

**VOL.53  
PART 6  
1558 – 1869**

rgd/gbr  
HOUSE OF REPRESENTATIVES

251  
April 27, 2010

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Is there any objection to any of these items being placed on the consent calendar for action later? Hearing none, so ordered.

Mr. Clerk, would you please call Calendar 173.

THE CLERK:

On page 7, Calendar 173, Substitute for House Bill Number 5297, AN ACT CONCERNING STATE-WIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM, favorable report by the Committee on Human Services.

DEPUTY SPEAKER GODFREY:

The gentlewoman from Torrington, Representative Cook.

REP. COOK (65th):

Good evening, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Good evening, ma'am.

REP. COOK (65th):

Mr. Speaker, I move for acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER GODFREY:

Question is on passage. Will you explain the

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bill please, madam.

REP. COOK (65th):

Mr. Speaker.

Mr. Speaker, the Clerk has amendment LCO 3868. I would ask the Clerk, please call the amendment and that I be granted leave of the Chamber to summarize.

DEPUTY SPEAKER GODFREY:

The Clerk is in possession of LCO Number 3868, which will be designated House Amendment Schedule "A." The Clerk please call.

THE CLERK:

LCO Number 3868, House "A," offered by Representative Walker, Senator Doyle, et al.

DEPUTY SPEAKER GODFREY:

The gentlewoman has asked leave of the Chamber to summarize. Is there any objection? Hearing none, please proceed, Representative Cook.

REP. COOK (65th):

Thank you, Mr. Speaker.

Mr. Speaker, the amendment on this bill is a compromise between the departments. And what it does is it expands the PCCM rollout to two hospitals; one in Putnam on July 1 and one in Torrington on October 1.

And I urge adoption.

DEPUTY SPEAKER GODFREY:

The question is on adoption of House Amendment Schedule "A." Will you remark further On House Amendment Schedule "A?"

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

Through you, if I may please, ask a question to the proponent.

DEPUTY SPEAKER GODFREY:

Please frame your question, ma'am.

REP. GIBBONS (150th):

Madam, the amendment says that it expands the PCCM to the towns of Torrington and Putnam. It was my understanding that this was going to be expanded to the hospitals in these towns. Does that need to be clarified, or is that understood in the amendment, please?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook, do you care to respond.

REP. COOK (65th):

Through you, Mr. Speaker, that should be

understood.

DEPUTY SPEAKER GODFREY:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

And my other question is, is these are the two towns that we're going to expand the PCCM into in 2010. Are there other towns or other entities that are contemplated for expanding the PCCM in this year?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, not to my knowledge.

DEPUTY SPEAKER GODFREY:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Will you remark further on House Amendment Schedule "A?" Will you remark further on House Amendment Schedule "A?" If not, let me try your minds. All those in favor, signify by saying, aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER GODFREY:

Opposed, nay.

The ayes have it. The amendment is adopted.

Will you remark on the bill as amended? Will you  
remark on the bill as amended? If not -- oh,  
representative Villano.

REP. VILLANO (91st):

Thank you, Mr. Speaker.

Mr. Speaker, I rise to support the amendment and  
urge it's passage.

Mr. Speaker, I had my own amendment filed with  
the Clerk, but I am not going to call it because it's  
important to get this bill passed.

The amendment not called would have simply asked  
for a statewide implementation for the PCCM, which  
this state sorely needs. But calling the amendment  
would have slowed down the process and prevented this  
bill from being passed. So I do urge my colleagues to  
support the bill as amended.

Thank you.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

The gentlewoman from Somers, representative Bacchiochi.

REP. BACCHIOCHI (52nd):

Thank you, Mr. Speaker.

Through you, a few questions to the proponent of the bill as amended.

DEPUTY SPEAKER GODFREY:

Please frame your questions, ma'am.

REP. BACCHIOCHI (52nd):

Thank you.

I didn't quite understand the answer to the question that was given earlier about if the expansion was to be to the hospitals versus the towns.

Some clarification, through you, please, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook, do you care to reanswer the question?

REP. COOK (65th):

Thank you, Mr. Speaker. And through you, to the hospitals of those towns.

DEPUTY SPEAKER GODFREY:

Representative Bacchiochi.

REP. BACCHIOCHI (52nd):

Thank you.

So if I understand correctly, that the commissioner would expand the primary care pilot program to other towns, how is that process going to move forward? How will the commissioner make a decision as to what other towns the program should be expanded to?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, rolling out this program, as Representative Villano had said, was a conversation for rolling out statewide. And right now, with the agreement of the department we are only rolling it to the two hospitals that have been of interest in this year. So if -- that is something that would happen that would be addressed in the future legislative session.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Bacchiochi.

REP. BACCHIOCHI (52nd):

Okay. So only the two hospitals in these two

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towns will see the expansion under this current bill.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, yes.

DEPUTY SPEAKER GODFREY:

Representative Bacchiochi.

REP. BACCHIOCHI (52nd):

And how were the two towns that are in the  
current bill chosen?

Through you, Mr. Speaker.

-DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, they were not chosen.  
They had come upon request asking to be a part of the  
PCCM program.

DEPUTY SPEAKER GODFREY:

Representative Bacchiochi.

REP. BACCHIOCHI (52nd):

Thank you, Mr. Speaker.

And the primary care case management system, that  
is -- could the proponent of the bill please explain

that to me?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, the primary care case management program is a medical model that assigns Medicaid patients to a primary care provider, who is responsible for managing the quality and the appropriateness and efficiency of the care that they receive.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Bacchiochi.

REP. BACCHIOCHI (52nd):

Thank you, Mr. Speaker.

And I understand a report will be provided to the General Assembly. To which committees will that report be provided? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, Human Services and Appropriations.

DEPUTY SPEAKER GODFREY:

Representative Bacchiochi.

REP. BACCHIOCHI (52nd):

Thank you, Mr. Speaker.

And I thank the proponent for the answers.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

If I could just clarify for the Chamber a little bit how we got to this point with the PCCM program.

This was a program that we debated large and wide about two or three years ago. And it's been very successful in some states as an alternative to running Medicaid managed care.

And in Connecticut we have HMOs that do that, but the question was, could it be done more efficiently and more effectively if we let the doctors, the physicians and hospitals be the, not only the providers, but the managers of this managed care?

And I think the jury is still out around the country as to whether it is an effective program, of whether it's a less costly program, whether it's

better for the patient and the client or whether it is not, or it's just an alternative.

Anyway, we have decided two years ago to embark on a pilot and we started PCCMs in four different towns and communities within Connecticut. I believe they were Windham -- I'm not sure -- New Haven I know was one of them. I think Waterbury was another one and there's a fourth town as well.

This past spring we had a public hearing here at the capital to see whether the PCCM as rolled out was working, whether the doctors who were using it, whether it was being efficiently advertised by DSS and whether it was helpful to everybody who was now under PCCM guidance.

And I think that what we heard in the public hearing was somewhat mixed. According to DSS, 24 percent of the patients or the clients who went under PCCM have now returned to a HMO, which is their prerogative to do it.

But we also found there are many doctors in this state who wanted to take on a PCCM within their own practice and they were not allowed to because they were not within the catchbasin, so to speak, of the towns that we had already designated could have a

PCCM.

We also had two hospitals who very much wanted to be part of that program, and they were Torrington and Putnam. And the reason that a doctor's office or hospital wants to, is while they're also paid a fee for service, they are paid an administrative fee based on each patient that they take care of.

And in return they have to take full responsibility for administering the medical care of this patient, sending him to a specialist, making sure that they have some sort of preventative medical management that they are cared for as long as they're under their office.

And it's a much bigger, I think, deal for a doctor to undertake this procedure than it first seems. And some doctors have found out that it works out very well for their practice and others have not. There was some debate about whether DSS was enrolling it out successfully, whether they were advertising it sufficiently, whether people know about it.

And I think we came away from hearing realizing that DSS has done a good job as they can given the limited resources they have at the time being. And it would not be possible to roll this out statewide

immediately.

So this compromised language that we have worked out, and it's been done. And I want to thank the chairs and cochairs of the Human Services Committee who have worked very effectively with DSS to make this happen.

That these two hospitals are the ones that came forth and said, we really want to do a PCCM. And by staggering them, putting one in July and one in October, we'll see how this works out. We're going to get a report on how the whole PCCM program is working some time early in 2011.

I think at that time we can evaluate it, see if it's been good for the clients, been good for the Medicaid patients in Connecticut, been good for the providers and whether we want to continue on and continue to expand it or to leave it where it is.

But thank you, Mr. Speaker, for allowing me to try and explain exactly what we're doing. And I do support the amendment and I support the bill and I urge the Chamber to do the same.

Thank you.

REP. GODFREY (110th):

Thank you, madam.

The gentleman from Waterbury, Representative  
Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker. Good evening  
Mr. Speaker.

Mr. Speaker, through you, a few questions to the  
proponent of the bill.

To Representative Cook, I am reading the bill  
analysis and the body of the bill itself and it seems  
to me that this is a good bill, it serves the  
community. But I do have some questions in reference  
to how the program has been done in the past.

I read that the city of Waterbury was involved in  
this program through the bill analysis that I see on  
the screen. And through you, Mr. Speaker, I would  
like to know which hospital in Waterbury has elected  
to be enrolled in this program and how long it has  
been in the program.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, there has been no  
hospital in the city of Waterbury that is

participating in the program. It has been providers.

DEPUTY SPEAKER GODFREY:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you. Thank you, Mr. Speaker.

And through you, Mr. Speaker, I would like to understand who the providers are and how do they serve the community, seeing that -- in the bill analysis, it says, Waterbury. So I would like to understand who in Waterbury it serves, and how many people are being served?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, they are pediatricians that are providing the service. And to date I do not know specifically the amount of patients that they are seeing per practice.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker.

And through you, Mr. Speaker, so these are private provider, private pediatricians that are not associated with the hospital, meaning that they do care for patients in their own practices.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, yes.

DEPUTY SPEAKER GODFREY:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you. And thank you to Representative Cook for her answers.

One more question I would like to ask is, this program, how long has it been in effect in those cities? And it says in here, Hartford, New Haven, Waterbury and Windham. How long has this program been in effect?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, it was being rolled out

two years ago.

DEPUTY SPEAKER GODFREY:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker.

And through you, Mr. Speaker, does Representative Cook have an idea on the cost of this program and/or the savings? What is a fiscal impact of this program on those four towns where it has been in existence?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker there is no cost according to this amendment in this bill.

And in contrary, there is the potential for millions of dollars in savings once we get up and rolling and we have seen savings to date.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker.

And through you, Mr. Speaker, I would like to

understand how the savings are achieved versus the traditional services that we always offer, or has been offered in the past.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, because the primary care provider takes on the role instead of an MCA, and it indirectly streamlines the process. And we do not continue to send more and more people in and out of emergency rooms, which in essence, is costing the State millions and millions of dollars.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker.

And through you, Mr. Speaker, one final question. And it seems to me that private providers are supporting this law or providing those services on the previous four towns. Now that, in Torrington it will be -- Torrington and Putnam, it will be the hospitals that are performing this function.

How would that be -- who -- how would this differ

from the private providers, taking you to a hospital?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, could I ask the proponent of the question if he could clarify? I'm not understanding his question specifically.

DEPUTY SPEAKER GODFREY:

Representative Noujaim, would you please reframe your question.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker. And through you, Mr. Speaker, in the bill analysis or from what Representative Cook has answered me earlier, that in the previous four towns there are only private providers rather than hospitals who are involved in this program.

But now it this, with this amendment, the hospital in Torrington, Charlotte Hungerford and the hospital in Putnam will be involved in this process. Would there be any difference between what a hospital would provide, a service, and what the private providers would provide in their own practices?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Cook.

REP. COOK (65th):

Through you, Mr. Speaker, yes. The hospital would become the case manager and they would also be able to take care of children as well as adults through this program.

Through you.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker. And I would like to thank Representative Cook for her answers.

I do intend to support this bill and urge my colleagues to support it as well.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Will you remark further on the bill? Will you remark further on the bill as amended? If not, staff and guests please come to the well of the House.

Members take your seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is taking a

roll call vote. Members to the chamber, please.

DEPUTY SPEAKER GODFREY:

Have all the members voted? Is your vote properly recorded? If so, the machine will be locked. And the Clerk will announce the tally.

THE CLERK:

House Bill 5297 --

DEPUTY SPEAKER GODFREY:

Whoa. Whoa. Whoa. Whoa.

Representative Gonzalez, for what purpose do you rise?

Representative Gonzalez.

REP. GONZALEZ (3rd):

Yeah. Mr. Speaker, in the affirmative.

Thank you.

DEPUTY SPEAKER GODFREY:

Representative Gonzalez in the affirmative.

And the Clerk will please announce the tally.

THE CLERK:

House Bill 5297 as amended by House "A."

Total Number voting 139

Necessary for adoption 70

Those voting Yea 139

Those voting Nay 0

Those absent and not voting 12

DEPUTY SPEAKER GODFREY:

The bill as amended is passed.

The House will come back to order. I recognize the distinguished Deputy Majority Leader, Representative Olson.

REP. OLSON (46th):

Good evening, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Good evening.

REP. OLSON (46th):

Good evening.

I rise to move for the immediate transmittal of all items needing further action in the Senate.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

The ones acted upon today.

REP. OLSON (46th):

That would be just fine. Thank you.

DEPUTY SPEAKER GODFREY:

Is there any objection? Hearing none, all items acted upon today needing further action by the Senate will be immediately transmitted to the Senate.

The Clerk please call Calendar 251.

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**CONNECTICUT  
GENERAL ASSEMBLY  
SENATE**

**PROCEEDINGS  
2010**

**VOL. 53  
PART 13  
3842 - 4128**

cd  
SENATE

558  
May 5, 2010

Calendar page 11, Calendar 488, House Bill 5297,  
move to place the item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 11, Calendar 490, House Bill 5425,  
move to place the item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 12, Calendar 496, House Bill 5497,  
move to place the item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 13, Calendar 509, House Bill 5126,  
move to place the item on the consent calendar.

THE CHAIR:

Seeing no objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

cd  
SENATE

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May 5, 2010

Calendar page 10, Calendar 461, House Bill 5207;  
Calendar 483, House Bill 5244.

Calendar 484, on page 11, House Bill 5383; Calendar  
487, House Bill 5220; Calendar 488, House Bill 5297;  
Calendar 490, 5425 -- House; Calendar 496, House Bill  
5497; Calendar 509, House Bill 5126.

Calendar page 14, Calendar 511, House Bill 5527;  
Calendar 514, House Bill 5426; Calendar 516, House Bill  
5393.

Calendar page 15, Calendar 520, House Bill 5336;  
Calendar 521, House Bill 5424; Calendar 523, House Bill  
5223; Calendar 525, House Bill 5255.

Calendar page 16, Calendar 531, House Bill 5004.

Calendar page 17, Calendar 533, House Bill 5436;  
Calendar 540, House Bill 5494; Calendar 543, House Bill  
5399.

Calendar page 18, Calendar 544, House Bill 5434;  
Calendar 547, House Bill 5196; Calendar 548, House Bill  
5533; Calendar 549, House Bill 5387; Calendar 550, House  
Bill 5471; Calendar 551, House Bill 5413; Calendar 552,  
House Bill 5163; Calendar 553, House Bill 5159.

Calendar page 19, Calendar 554, House Bill 5164.

cd  
SENATE

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May 5, 2010

Calendar page 20, Calendar 556, House Bill 5498;  
Calendar 557, House Bill 5270; 559, House Bill 5407; 562,  
House Bill 5253; and House Bill -- Calendar 563, House  
Bill 5340; Calendar 567, House Bill 5371; and Calendar  
573, House Bill 5371.

Mr. President, I believe that completes the items

THE CHAIR:

Mr. Clerk, could you please give me on Calendar 567,  
do you have 5516, sir?

THE CLERK:

What -- what calendar?

THE CHAIR:

567 on page 22.

THE CLERK:

It's 5516.

THE CHAIR:

Yes, sir. Okay.

Machine's open.

THE CLERK:

An immediate roll call vote has been ordered in the  
Senate on the consent calendar. Will all Senators please  
return to the chamber. Immediate roll call has been ordered in the Senate on the  
consent calendar. Will all Senators please return to the chamber.

cd  
SENATE

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THE CHAIR:

Have all Senators voted? Please check your vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on adoption of Consent  
Calendar Number 2.

Total number voting	35
Necessary for Adoption	18
Those voting Yea	35
Those voting Nay	0
Those absent and not voting	1

THE CHAIR:

Consent Calendar Number 2 passes.

Senator Looney.

SENATOR LOONEY:

Yes, Mr. President.

Mr. President -- Mr. President, before moving to adjourn, I would like to ensure the entire chamber will wish Laura Stefon, Senator McDonald's aide, my former intern, a happy birthday.

And with that -- and with that, Mr. President, I would move the Senate stand adjourn

**JOINT  
STANDING  
COMMITTEE  
HEARINGS**

**HUMAN  
SERVICES  
PART 2  
353 – 704**

**2010**

KATHLEEN WYATT: Right.

SENATOR DOYLE: -- which is not a defined term --

KATHLEEN WYATT: Right.

SENATOR DOYLE: And then it just says, these homes should, once they're established, they should just report their existence to the DMHAS. There's no big police here. There's references to police -- policing.

KATHLEEN WYATT: Right.

SENATOR DOYLE: The bill, as presented, doesn't have it.

KATHLEEN WYATT: But next year when it comes out --

SENATOR DOYLE: Oh, well, look, next year -- okay. I'm just -- just for the audience here.

KATHLEEN WYATT: Oh, okay.

SENATOR DOYLE: To make it clear, there's no big police presence in this bill. It simply -- it's -- it's -- at this point, it's saying let's have a manager and let's report your existence to DMHAS. There's nothing else.

Thank you.

KATHLEEN WYATT: Thank you.

SENATOR DOYLE: Next speaker is Vicki Veltri. Is Vicki here? Yes, she is, and then after Vicki will be Diane Potvin.

VICKI VELTRI: Good afternoon, Senator Doyle, Representative Walker, members of the Human Services Committee.

SB220 SB281

HB5056 HB5297

For the record, my name is Vicki Veltri, and I'm the general counsel with the State of Connecticut's Office of Healthcare Advocate. And before I go any further, I just want to assure that, Representative Gibbons, if you

ever call our office it'll be the best experience you've ever had with the state government.

So rather than read through the testimony since you have a lot of people here, I just wanted to make a couple points.

I think that -- that -- the bills that we were testifying in favor of, which are 5056, 5297, and 281 are about accountability. And I think, it doesn't matter who's in charge at DSS, who's running that agency. That's a \$5 billion budget and it's one-quarter of the State's budget, so it needs to be accountable, and it needs to be accountable down to every penny. The rest of the State agencies, as you know, are going through the same kind of thing, whether their budget is 1 million or 5 billion, we need everyone to be accountable.

Just a couple of points, I think it's a great idea. I think 50 -- 5056, talks about doing annual audits. I think that's overdue and a great idea for both the performance side and the financial side. And I think it should be done regardless of whether the delivery system is MCO, the current capitated system, or the ASO system.

It's -- what's a little concerning to me about the ASO -- and I know the Commissioner talked about going to the ASO and saving \$28 million. And I just wanted to ask the Committee maybe one of things to look at is -- the Commissioner's also testified that the MCOs have a five-year contract. That's a long contract to have -- to have entered last year and to now be switching systems entirely. So it raises some -- some questions.

I do want to say that there's absolutely no reason that PCCM cannot be rolled out to the state. Any barrier that there is right now is just artificial. And it seems to me we have a lot of clients, and I can't remember off the top of head which committee hearing it was,

Good afternoon.

GARY WATERHOUSE: Good afternoon, Representative Walker, members of the Committee.

My name is Gary Waterhouse, I'm the executive director of the Connecticut Association of Centers for Independent Living.

Centers for Independent Living work for the full integration and dependence and civil rights of people with disabilities through Centers for Independent Living.

Here today to testify in support of Senate Bill 217, AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.

Bottom line is, generally people applying for Title 19 do not have resources to pay for five years of financial documents from financial institutions, therefore, the burden often falls on the family.

We'd like to support Senate Bill 281, AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF PHARMACEUTICAL AND THERAPEUTIC COMMITTEES. I believe there needs to be public participation in any decision-making progree -- program.

We liked to support House Bill 5297, AN ACT CONCERNING STATEWIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM. PCCM is an important fourth option for HUSKY A.

We liked to support House Bill 5354, AN ACT TO PROVIDE INCENTIVES FOR HOSPITALS WHO DEVELOP ELECTRONIC HEALTH RECORDS.

The US Department of Veterans Administration has been developing a national electronic records database for years. When Hurricane Katrina destroyed the VA Hospital in New Orleans, the medical records were backed up off site and were immediately available to the

SB 315  
HB 5232

Then William Ceravone, Sheldon Toubman and Jody Bishop-Pullan.

JOEL MENGES: Should I go ahead? Okay.

Hi. I'm Joel Menges. I'm with the Lewin Group. It's a national healthcare consulting firm. We've been invited here by the Connecticut Association of Health Plans to take you back into the world of how much the Medicaid health plans should be paid.

HB5297

The -- yeah, I submitted written testimonies. It looks like this, and I'll just try to quickly, if you guys have it, go through sort of page by page and stay with the questions. If you're -- I'm happy to stay with the questions if you have some.

The second slide is just quick background. I've -- I've worked -- I'm a managing director at Lewin and have worked in the Medicaid managed care arena for -- for more than 20 years. One thing, just to disclose -- it's not relevant to the work I've done. It hasn't in any way shaped the work -- but we are owned by United Health Care by way of another firm called Ingenix.

I'm here to -- I'm here to, primarily, just comment on the report that Milliman did for the State. It was kind of an -- an odd process, or a contentious process, I think, where Milliman, soon after the current Medicaid managed care program began, Milliman was hired to -- not by DSS but by another arm of the State -- to look at whether the capitation rates could be reduced. And they recommended, roughly, a 5 to 6 percent rate decrease at that point.

My main comments are, you know, just observing this, I've been involved in setting capitation rates in several states, and so forth. It's very, very unusual to look at a program that's just been implemented and launch an investigation as to whether the capitation

rates are good, bad or ugly at that point. It's just too soon. You know, no firm can really make a credible case when the program has -- has barely begun as to why these initial rates are -- are good, bad or ugly. But that was, nonetheless, the charge that was put forth and Milliman did sort of answer that bell, but it was too soon.

Secondly, they had no operational data to work with at that point. So there was not -- they could not provide a basis that sort of correlated to the "too soon" argument.

And -- and, thirdly, they just -- they were outside the tent. They were not an organization that was working from -- from inside DSS and -- and their actuary Mercer, have worked with this program for more than a decade, they're sophisticated rate setters, they were in -- in play.

And I had, you know, tremendous -- and I have tremendous respect for all these organizations in suiting -- including Milliman. But I just don't feel -- and, especially, at this point, we're talking about too soon. It's now 10 months after that point in time, so to pass legislation saying you should implement the Milliman recommendations -- I've just -- seems to me a very bizarre, you know, piece of legislation. And -- and I don't think it should be passed, frankly. It's just a -- it's just a very unusual thing. Time is passed -- as Commissioner Starkowski said today they are tracking a health plans financials in the program now. They've had a year of data to work with. Judgments need to be made on that not on a report that was done, you know, 10 minutes into the program.

So I know I got -- the buzzer went so if you'd like me to -- you want me to fast forward through these slides?

SENATOR DOYLE: Yes, please, yeah. Well, you want to just -- yeah, you can continue.

JOEL MENGES: Okay. I'll go, you know, no more than, another minute real quick.

Just -- you know, there were issues with the rate ranges in Milliman's report, and so forth, that I just want to call out. That's on Slide 5. The floor of the range was, I think, got into the ether as being a viable, appropriate place to set the rates. I certainly don't agree with that on the basis of work I've done. As I said, there was not operational data.

On the constructive side, just to close up real quickly, tried to -- we did -- we did our work a year ago but there was no hearing, you know, last June on this as we thought there might be. But the work we did, we suggested that the State consider creating a rate -- a risk-sharing corridor so that no one could make a lot of money or lose a lot of money at this business at this point in time when -- when the State is so strapped.

The last thing, I understand, what they want is for the health plans to glean large profits out of this. That's completely understandable and appropriate. At the same time the plans are in a very vulnerable position because things like this Milliman report could completely put them out of business and not allow them to serve your members anymore. That's not an appropriate outcome, either, in my view. But a rate -- a risk corridor that just says you can only win or lose so much might be -- you know, is one thing we came up as just being a way out of a -- the bind that everyone's in at this point.

And then -- then something we've been involved with your program. We helped set it -- Lewin helped set it up in the early '90s was the Medicaid Managed Care Program. But it was -- it was, you know, striking even then. The whole focus and the here -- this is my third time testifying through the years in front of

you -- not this Committee but in this building, certainly.

There's been so much controversy and -- and -- and grinding around how to do the Moms and Kids Program. In the mean time, your high cost people, we're just paying claims. And I think you've -- you've move past that, now. I just want to commend you guys, as a state, for that. Now there is a program in place that's going to bring a coordinated care model to the high-cost population. That population, I'm sure -- I'm doing work in Missouri right now. There's -- when you look at the fee-for-service data, it's just, you know, I think it's becoming more and more evident that fee-for-service is not a good model for high-cost people.

SENATOR DOYLE: Thank you.

Any questions?

Representative Walker.

REP. WALKER: Thank you for your -- your testimony, and thank you for trying to abbreviate it.

What -- what coordinated care model that we're implementing in Connecticut for the --

JOEL MENGES: This is for -- for your Medicaid-only disabled population, SSI. I think there's an RFP that was out and responses put back in to provide serv -- coordinated care services under a nonrisk ASO model.

REP. WALKER: ASO model. Yes, right, right, right. That -- okay.

When you said that I was like, wait a minute, I don't remember that. And I was concerned but yes, I do remember the RF -- so the RFP has gone out?

JOEL MENGES: My unders --

REP. WALKER: It's been out for a while.

JOEL MENGES: My understanding is that it's being, you know -- the proposals are in and are being reviewed at this point. But that's a far, you know, it's a far step forward from sitting back and just paying claims for this population, you know, decade in and decade out.

REP. WALKER: Your -- your report basically says what I think a lot of us feel, is that it's a little soon to make a determination of what we've done and how -- how far we've gone or which -- if we've gone in the right direction or the wrong direction. I think we've still got a long ways to look at.

Did you -- have -- have you looked at any of the reports that were provided by the -- the Department of Social Services on the model that we had before we went to the three MCOs?

JOEL MENGES: The ASO model?

REP. WALKER: Yes.

JOEL MENGES: I haven't analyzed that. I can, you know, I can speak a little bit about it just from, you know, a national experience point of view but I'd have to look at your --

REP. WALKER: Did -- in the -- in your knowledge or what you have been able to review, do you see what the bottom line cost was for the State?

In that -- in that --

JOEL MENGES: I haven't -- I have not worked with your data in that way, at all.

REP. WALKER: Okay.

JOEL MENGES: So I can't speak to, you know, how -- I know, you know, at one point you were down to sort of just one health plan, administering that. Now you have a competitive model with

multiple plans, and so forth, but I don't -- I don't know the numbers.

REP. WALKER: Okay. All right.

Thank you -- thank you for your testimony.

JOEL MENGES: Sure.

SENATOR DOYLE: Thank you.

Representative Abercrombie.

REP. ABERCROMBIE: Thank you, Mr. Chair.

Good afternoon. Thank you for being here.

You talked a little bit in your testimony about the rate ranges that were the basis of the report. Can you explain a little bit how that came about and what it really means?

JOEL MENGES: Sure.

One of the, you know, one of the findings of Milliman's work is that there was a rate range established that was actuarially sound, and, you know, there's a low point to that and a high point to that and the actual payments to the plans were somewhere, you know, in the middle vicinity of that range. Milliman was, like, well, if you paid it, the bottom of the range, the State would have saved, you know, a whole lot of money. The -- you know, the implication of that was almost like, boy, you overpaid. You could have and should have paid at the bottom of the range.

And I think that the fallacy of that argument is that the bottom of the range is, in fact, viable. What the rate range, to me, sort -- at least, means is everything below that floor number the actuarial firm clearly views to be not viable. Everything above the ceiling of the rate range, they feel clearly the State will be overpaying. Nobody -- nobody on the planet knows what the exact right number is in

advance before healthcare claims, you know, spill out. But the -- you know, the notion that you can just pay at the bottom of the range, you know -- all the people inside the tent came -- you know, very strongly came to the conclusion that that was not going to be viable for the health plans. And I think the experience has borne that out.

REP. ABERCROMBIE: Thank you.

Thank you, Mr. Chairman.

SENATOR DOYLE: Thank you.

Any other questions?

Representative Lyddy.

REP. LYDDY: Thank you, Mr. Chairman.

When you said that you were owned by United Health Group?

JOEL MENGES: Yes.

REP. LYDDY: That's also has an interest with the HUSKY population. Correct?

JOEL MENGES: Correct. AmeriChoice is one of the three plans, and they're owned by United Health Group.

REP. LYDDY: Okay. So you're a parent group is an HMO for the HUSKY population?

JOEL MENGES: Kind -- yeah, I mean, you know, United Health Group is a huge corporation.

REP. LYDDY: Sure.

JOEL MENGES: Ameri -- AmeriChoice, which is one of your three health plans, is kind of a sister company in the family to Lewin.

Lewin's a consulting firm, you know. We do independent work from all the others.

Sometimes we get hired by United or AmeriChoice to do a project, but we serve our clients whoever they are.

REP. LYDDY: Okay.

Thank you.

Thank you, Mr. Chair.

SENATOR DOYLE: Thank you.

Any other questions?

Seeing none, William Ceravone and Sheldon Toubman and Jody Bishop-Pullan.

Is William here? Yes.

WILLIAM CERAVONE: Hi everybody.

My name is William Ceravone. I'm here to discuss the HB 5243.

You know, I had stuff written down, but I'm just going to -- I'm just going to say what's on my mind about this.

You know, I heard a lot of good stuff and a lot of bad stuff. You know, I did a lot of time in prison, and I vowed to myself I wouldn't go back because I didn't want somebody telling me when to go the bathroom, when to eat, how much to eat, where I can go, curfews like that.

And when I got out of jail, I went into a rehab. And when I was in rehab I came out, I did a 90-day program in a different town that I came from and I vowed to myself that I wouldn't go back to that town because I didn't want to use drugs again. And I stayed in this town that I was in. And when I finished the program, there was a lady that ran a group in that -- in that town and realized I was about ready to get out and explained to me something about her Sober Houses.

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oversee because that might be the model that we want to move towards? So after this, if you'd like, we could step outside and give contact information to talk more about it, if you feel comfortable with that. Okay?

WILLIAM CERAVONE: My belief -- my belief to CCAR -- it's open to anybody.

REP. ABERCROMBIE: I agree. But not everybody --

WILLIAM CERAVONE: So -- so I mean --

REP. ABERCROMBIE: -- is getting involved with them. That's -- that's the other part of that.

WILLIAM CERAVONE: Well, that's -- that's on the people that don't want to be involved in that.

REP. ABERCROMBIE: Absolutely. You're hitting right on the point that we're trying to make.

WILLIAM CERAVONE: Uh-huh.

REP. ABERCROMBIE: So I would be more than happy to exchange contact information with you.

WILLIAM CERAVONE: Okay.

REP. ABERCROMBIE: Thank you, sir.

SENATOR DOYLE: Thank you.

Sheldon Toubman and Jody Bishop-Pullan.

SHELDON TOUBMAN: Good afternoon.

Senator Doyle, Representative Walker, members of the Committee.

I'm Sheldon Toubman. I'm a staff attorney with New Haven Legal Assistance Association, and I'll try to talk more slowly this time.

HB 5297 HB 5056

First, I'm here to testify in support of SB 281. The Commissioner, this morning, said

that the P&T Committee which decides critical issues of access to drugs has no problem with public input. I can prove that that's incorrect.

Just two week ago, I was explicitly denied permission to testify or speak before the committee. I have an email that says, The Committee has decided that Sheldon Toubman's written testimony is sufficient and has declined his request to speak at the meeting.

Now, I can understand people not wanting to have me speak before them, but there is this thing called the First Amendment, and, in addition, there's something lost when you just take written statements. You don't get to ask questions. So I -- I strongly urge you to pass SB 281.

I'm also here to testify in support of HB 5297 and 5056. Both of these bills would require statewide PCCM. I know that the Governor has announced that we're going to move to ASO model for the HUSKY population which we support.

Optimistically, we think we're going to save the money and more that the Governor has stated. However, we can save more money by statewide PCCM. We can care coordinate better because it'll be the primary care doctor rather than some impersonal call center doing it. And it's going to be more stable because primary care doctors aren't going anywhere, whereas, we all know that companies look at the bottom line whether a contract's worth it for next year or not.

I heard the Commissioner's testimony this morning. He said that in other states where they've gone to it -- Oh, well, you know, it took a long time; it took years.

I have attached to my testimony the actual PowerPoint presentation excerpt from the Oklahoma Medicaid Director. Because last time

I testified before you I referred to that but I didn't sort of have the documentation. And you'll see there that they made a decision on November 7 of 2003, to get rid of the HMOs that were demanding more and more money. One of them refused to accept the bid. And by 12/31 they were out, and then by April 1st the entire state was turned to statewide PCCM. And, as I note in my testimony, I have a slide attached from them, it saved \$4.3 million.

There were several other things that were said by the Commissioner this morning that really were not correct that I would like to address but I heard the buzzer go so -- okay.

Thank you.

It's important when the question was raised by one of the representatives this morning about whether the Commissioner is really committed to this program, to PCCM. And the Commissioner said, absolutely, he's committed to it and they chose Willimantic and Waterbury with the advocates and then they chose New Haven and Hartford.

I think it's important to correct the record. Some of you are veterans of this and know exactly but some may not. That, basically, we worked with the department very well, initially, and the agreement was going to be an invitation to go out to providers throughout the state, asking them to participate in PCCM, and then it would be rolled out explicitly in writing, the invitation, anywhere in the state where providers expressed an interest. And when that happened, there was only three weeks' opportunity for providers to respond, and, despite that, there were over 300 providers that responded. And the Commissioner acknowledged that there were four areas where there was adequate response, New Haven, Hartford, Waterbury and Willimantic.

Despite that, the Commissioner unilaterally

chose only the two smallest, Willimantic and Waterbury. So when he said this morning the advocates agreed to that, we had no input whatsoever and we disagreed with it.

Moreover, he then said, We subsequently chose New Haven and Hartford.

No, that's not true. You may recall on March 31st, this Committee and the Appropriations Committee held a Joint Hearing on a proposed waiver amendment the Department had submitted for the Medicaid Managed Care Program, and in it they attached a one pager on PCCM that had no teeth and no commitment, whatsoever. It didn't refer to New Haven or Hartford, didn't commit to any further roll out. And this Committee and Appropriations stepped its foot and said, No, that's not acceptable. And mandated -- imposed on DSS a requirement, specifically, that it do Hartford and New Haven.

I point this history out because I think it goes to the issue of, frankly, credibility in terms of the Department moving forward.

This morning, also was asked about the money that was appropriated in the previous biennium. It was actually \$2 and a half million per year. And it's also not true that that was based upon 750. The figure of 750 was actually developed long after the money was appropriated and passed in the budget. Even if it were 750 or \$10, whatever, there's no way that all that money would be consumed in those monthly fees of primary care providers.

Of course, some of that money had to go to marketing. And, in fact, in the early days when we met with the DSS folks, we talked about a marketing plan. We worked very cooperatively. We worked with David Parrella and Rose Ciarcia -- who are no longer there -- but we developed a whole plan of marketing. None of that happened with the exception of a

brochure. And the Commissioner keeps saying, Well, we produced a brochure. But their brochure doesn't tell you why you should sign up with PCCM.

I have talked to our clients who have gotten this brochure and they said, I didn't know what it was about and why should I do it? Here's this one sentence, The primary care provider offers the same services offered a managed care health plan, such as health education, reminders about immunizations, and well-child visits, and help scheduling appointments.

So you read that and say, well, it's smells -- it smells the same. It doesn't say, With this plan, there'll be no insurance company getting between you and your doctor.

With this plan, if you have a problem, you can call the person at the doctor's office who's the care -- designated care coordinator, who has a name, first and last, and a phone number and you can call them for problems instead of the call center of an insurance company, where you can rarely get through. If you can get through, it's top secret what their name is and all that.

So, basically, they don't say the things which would be necessary to get people to enroll. And that's why, as of last month, there were only 322 people that were enrolled.

The Commissioner said he's going to move forward with an evaluation right now. Attached to my testimony -- both these bills are great.

I did suggest three additional things. One of which is to explicitly bar DSS from doing what it's doing now, which is requiring individual doctors, only in PCCM, to be bound by the Freedom of Information Act when the statute doesn't apply to them because they're so small. But they, by contract, make them

subject to it. They don't do this at all for the PCPs enrolled in the HMOs.

So the point is, let's have a level playing field. Let's bar them from doing that. That's one thing that's attached to my testimony.

Second, it is suggested that it apply to HUSKY B, as well as A. Right now, it's -- that's all we have.

Third, I had suggested that -- attached to my testimony -- is that there be separate entities. The Department really, I think, has demonstrated that it's unwilling or unable to seriously market this program and, therefore, some kind of company or entity needs to be hired to actually take that on.

But after hearing the testimony this morning, I have a fourth suggestion. The Commissioner -- I'm sorry -- the Commissioner says he wants to go forward with an evaluation of 322 people. That is a ridiculous waste of the taxpayers' money because we know that evaluation can't be adequate. And, in addition, who have they chosen to have -- do it? Mercer, Mercer the same auditors. They're captive. All right. I know the gentleman from the subsidiary of United Health Group that joined AmeriChoice said that, Oh, Mercer's a great outfit, but they're a captive auditor. They do what DSS wants.

And if you listened carefully, you heard the Commissioner sort of give it away this morning when a question was asked of what'll be in the evaluation PCM. And he said we're going to make sure it says -- something. So you know that it's going to be directed. And since they've demonstrated that they're concerned about PCCM taking away from the HMOs, unless we put this evaluation off and have it done by a truly independent entity after there's a significant number of people, we're not going to have an adequate -- a test.

So I would urge you to adopt language barring them from doing the evaluation now, as well as keeping the language that's in 5297 that says, and do one by July 2011.

SENATOR DOYLE: Thank you.

Representative Walker.

REP. WALKER: No, nothing else.

SENATOR DOYLE: Representative Gibbons.

REP. GIBBONS: We may have the same questions.

Thank you, Mr. Chairman.

Good afternoon.

SHELDON TOUBMAN: Good afternoon.

REP. GIBBONS: Thank you for speaking more slowly though -- though someday I'm going to make you sit down with me, and I'm going to ask questions over every single sentence. It might take us five hours to get through, but we'll get there.

Now I've been speaking so fast myself, I've forgotten what I was going to say.

I think the big question is with this evaluation. I certainly understood from the Commissioner this morning that he wants to go ahead with the evaluation. Do you feel we should let them go ahead with the evaluation if we have an independent agency, or are both sides going to dig in their heels as to whether it's going to start or not start?

SHELDON TOUBMAN: I -- I think -- I just think it's a waste of money because I don't think -- I think you folks have been following this close enough and you know about the -- the \$50 million. I don't think it's going to be credible, anyway. So it seems that given the

tiny numbers the best thing is just to bar it.

And I did want to point out that the Commissioner did rely upon the fact that it's true, that the waiver amendment that you guys imposed on them in response to their weak one, did say that there would be an evaluation -- evaluation by July 1st, and then based upon the results of that, decision would be made to go statewide. But that could be changed any time.

If you pass legislation that says, Don't do it. They can go back to CMS and get it changed. Their CMS doesn't really care about this if it's put off because it -- there's an inadequate participation right now. There'll be no resistance to doing that.

REP. GIBBONS: Thank you.

And the other point the Commissioner made is that the two states where the PCCMs have been the most successful, i.e. Oklahoma and North Carolina, the managed care organizations really were not very effective and gave much lower reimbursement rates than what the doctors were going to get under the PCCM plan. Do you have a comment on that?

SHELDON TOUBMAN: Yeah. I'm -- I'm afraid that that statement is not correct.

REP. GIBBONS: Okay.

SHELDON TOUBMAN: The --

REP. GIBBONS: Is there a way that we could find that out? Quickly.

SHELDON TOUBMAN: Yes. From -- I attached to my testimony an excerpt of the Oklahoma Medicaid Director's Evaluation of the whole history really of going to PCCM that was done a couple years ago. And I'll check to see if there's anything specifically on that. But my understanding, in fact, from the medical

director of DSS, Dr. Starkowski, is that the increase in the provider rates actually occurred two years later. So we do -- Oklahoma isn't apples to apples. The only thing that changed is we went from one model of delivery, three capitated HMOs to statewide PCCM. That's the only thing that really changed.

REP. GIBBONS: Okay.

Thank you, Mr. Toubman.

Thank you, Madam Chairman -- Mr. Chairman.

SENATOR DOYLE: Thank you.

Representative Cook.

REP. COOK: Thank you, Mr. Chair.

Hi, Sheldon.

SHELDON TOUBMAN: Hi.

REP. COOK: I've gotten so used to listening I think caught you. I -- I get it now.

You answered my question about how much was committed for the PCCM committee and the roll out, the 2.5 million over the last two years so that means that through the Department, we're missing somewhere in the neighborhood of \$5 million that were committed to this program. Yes?

SHELDON TOUBMAN: Yeah. I mean there was, you know, 300 people times \$90 a year is -- is the cost -- the incremental cost for the -- the care coordination by the primary care providers.

There was some staff time, but -- at the -- at the forum on February 5th, Dr. Starkowski was straightforward in saying, basically, we have one staff person, Rivka Weiser.

REP. COOK: Right.

SHELDON TOUBMAN: He's one staff person on PCM plus a little of his time so that would have to be subtracted but I mean, really, we're not talking about a lot.

REP. COOK: So we're talking about \$27,000 plus his his staff and a little bit of time.

SHELDON TOUBMAN: Yeah.

REP. COOK: So, okay. So let's go under the assumption that we're missing now, a little bit less than \$5 million, which kind of went into my first question that I had asked them earlier, where's the money and what happened to it? Which we still don't have that answer.

In your opinion, and, clearly, in your opinion, if we rolled this out statewide, understanding that there's going to be, you know, time and energy and what have you -- but there's clearly efficiencies. We know that Oklahoma saved \$80 million within the second year after this was successfully rolled out and implemented. Do you have a figure, if we rolled out PCCM statewide, what our potential cost saving to this state could be in two years? I mean, minus the first year of roll out and getting things rolling. I'm just looking for a year -- yearly possible savings.

SHELDON TOUBMAN: Well, you know, Ellen Andrews, my colleague, has been working on this -- has suggested it might be in the range of \$50 million a year after -- after the initial startup period.

But, I mean, just using the Oklahoma experience. The most expensive period is the initial first few months. You have to create infrastructure.

REP. COOK: Right.

SHELDON TOUBMAN: We don't -- I mean, the depart --

one person at DSS is not infrastructure. So you do have to create infrastructure but according -- and this is attached to my testimony -- according to them, they had to invest about \$6 million upfront in that, you know, adminis -- new additional administrative cost -- 6.9 million. But they still saved, in those first few months, 4.3 million so you get the money back very quickly.

Down the road, I can't really answer your question very well. But I believe Ellen did suggest it'd be 50 million a year.

REP. COOK: Thank you.

Mr. Chair; one more?

SENATOR DOYLE: One more?

REP. COOK: Two.

Who is -- who is, right now -- because I asked the Commissioner a question about the advertising and about the practices and what have you being responsible for their own advertising. From my understanding -- and that's why I'd asked the question -- that it's the people who we are asking to participate that are being, you know, required to incur this cost. What do you know about that?

SHELDON TOUBMAN: That's absolutely correct. I mean, there's -- there's no money offered -- there's neither any money offered to providers to do marketing nor -- you heard the testimony -- they're not willing to do marketing.

You know who's doing some of the marketing? I -- I have to say is the United Way of Greater New Haven has kindly printed, you know, thousands of the brochures that the advocates have done which say the things, like, there won't be an HMO or insurance company between you and your doctor, any more; you'll have somebody to call.

We are putting out those, and United Way has been kindly -- kind to help us out with that support. But, basically, there has been no support and that should be contrasted with the fact that up until, you know, January 1st, the HMOs were spending millions of dollars, really of our money, the taxpayers' money, specifically for marketing because that's what they did. And the Department approved that. Dr. Starkowski said that the Department approved about 1 percent of what they got specifically for marketing costs. So that's -- at \$800 million, it's about \$8 million of the taxpayers' money that went specifically for marketing solely to build up, you know, enrollment in "my" plan versus "your" plan.

And compared to PCCM for which there's zip.

REP. COOK: One final question. (Inaudible.)

To date, how many hospitals -- hospitals or other practices, statewide, do you know that are not able to be a participant in PCCM that would be interested and would hop on board if we rolled this out statewide?

SHELDON TOUBMAN: I -- I can't -- I don't know for sure, but I've heard that, for example, the Torrington Hospital expressed interest in participating in that.

Certainly, we've heard from individual providers. And for those who were at the forum on February 5th, you heard the -- I thought -- pretty poignant testimony from a pediatrician in Branford who has 2500 or so HUSKY folks. He's next door to East Haven. East Haven's actually one of the pilot areas, but they won't let him participate even though he wants to because his office is next door in Branford. That's the kind of line drawing we're talking about.

REP. COOK: And I know that Day Kimball is also interested so that's two more hospitals -- so -- okay.

Thank you very much for letting me speak.

SENATOR DOYLE: Thank you.

Any more questions?

Representative Walker.

REP. WALKER: Thank you, Sheldon.

First, I just want to attest to the fact that United Way has helped because I ran into Sheldon at an event one weekend at one of our schools and he was out supporting the PCCM.

I don't know if you heard one -- one of the questions that Representative Holder-Winfield asked the Commissioner was, How much would it cost for us to do an audit? And I think his reply was about \$20,000 -- 50? \$50,000 to audit a program of 300 and, you know, some odd. So I think, with that answer that he made, I think, that also sort of let us know that we need to step away from this for a little while.

So thank you for your support and your advocacy.

And don't call me at eight o'clock, again.  
Okay?

SHELDON TOUBMAN: Sorry. Okay.

SENATOR DOYLE: Thank you.

Any other questions?

Seeing none, thank you.

Next speaker is Jody Bishop-Pullan, and then Brian Ellsworth.

WANDA NELSON: If I may, Jody Bishop-Pullan could not stay, she had to leave.

HB5355

**JOINT  
STANDING  
COMMITTEE  
HEARINGS**

**HUMAN  
SERVICES**

**PART 3  
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**2010**

physicians that we currently have on staff, jeopardizing the ability of our ED to continue to serve as a community resource.

Thank you.

SENATOR DOYLE: Thank you.

Any question from the Committee members?

Seeing none, thank you very much.

GAIL D'ONOFRIO: Thank you.

SENATOR DOYLE: The next speaker is Robert Smanik. Is Robert here? Yes. And then Marghie Giuliano, Rhoda -- Rhonda Boisvert and Nancy Trawick-Smith.

ROBERT SMANIK: Good afternoon, Senator Doyle, Representative Walker, and distinguished members of the Human Services Committee. My name is Robert Smanik, and I am president chief executive officer of Day Kimball Hospital in Putnam, Connecticut.

I am providing testimony today in support of House Bill 5297, AN ACT CONCERNING STATEWIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM. In addition, I'd like to -- or I've submitted testimony in support of House Bill 5328, AN ACT IMPLEMENTING SAGA HOSPITAL RATE INCREASES.

As I noticed that I will be followed soon by Stephen Frayne of CHA, I'll defer comments to Stephen who's much more up to date and -- and understands the technical issues around the SAGA hospital rate increases.

In addition to my written testimony, I'd just like to provide a few other remarks about Day Kimball and why I believe and we believe it's such a -- a ideal opportunity for DSS in their Primary Care Case Management Program. Day Kimball is the single acute care provider for the 13 towns in Northeast Connecticut. It's

450-square-mile region. It's 90,000 individuals. We have had a 20-year history of employing the pediatricians in that region because they were unable to maintain their practice and private practice. A hundred percent of pediatricians are part of Day Kimball Hospital.

We have worked, in recent time, to elevate primary care and recognize that it isn't provision of primary care. It's really a strategic vision of our organization. Forty percent of the patient load of our pediatric practices is Medicaid. I feel we are a -- a perfect laboratory for this work that's being done by the state and PCCM and have been talking with DSS about the expansion of the program to include our area. Understood early on it was limited to two regions then it expanded to four, sort of knocking on the door saying, why not us, and realized that there are artificial limitations to that. But this is a strategic vision as Commissioner Starkowski had mentioned. There are three other -- MCOs that are involved. This would be the fourth. Quite frankly, it may be our fourth but it is our strategic focus. We'd like to partner with the State to develop that activity. Again, our goal is to establish a primary care center of excellence to secure access in Northeast Connecticut.

SENATOR DOYLE: Thank you, Doctor.

Any questions from the Committee?

Representative Walker.

REP. WALKER: Have you -- you've talked to several of the doctors in your area. Correct?

ROBERT SMANIK: Yes. We have said the pediatricians have been on our staff for over 20 years. In the last 18 months, over 50 percent of the primary care physicians have literally joined up with the organization, unable to sustain their primary care practice.

So this is part of our combined strategic vision as -- as a medical community.

REP. WALKER: Do you -- one of the things that I have questioned was the -- the rate that we paid for the -- for the case management. I think it's --

ROBERT SMANIK: Correct.

REP. WALKER: -- \$7.50.

ROBERT SMANIK: Right.

REP. WALKER: And the -- the physicians are okay with that?

ROBERT SMANIK: Well, because it is in partnership with the hospital --

REP. WALKER: Okay.

ROBERT SMANIK: -- it would be -- quite frankly, from a policy standpoint, we are moving in this direction. We are looking for funding when it can be provided, but we recognize this is sort of on the cutting edge of what's happening in the health care reform. And we're committed as an organization to support our primary care doctors in this way. So we are experimenting with expanding our reach through our diabetic education program, our other nutritionists, our -- our nurse, our discharge planners. We will be building the model moving forward, and we would like to partner where we can both with the State. CMS is coming out with pilot projects. We're in conversations there and some of the commercial insurers.

REP. WALKER: Thank you and thank you for your support. Thanks.

SENATOR DOYLE: Thank you.

Representative Johnston.

REP. JOHNSTON: Bob, thank you for your testimony.

In listening to Commissioner Starkowski earlier, it certainly seemed that in -- in some area at times when he was trying to and the Department was trying to expand the C -- PCCM Program that there wasn't buy in or for whatever reason that there may not have been the cooperation. And I think your testimony today speaks to that if the Department looked into this region of the state that that cooperation is probably already there and it would be embraced and certainly might send a -- send a message to the Department that they might have much better results if they expanded into a region that's -- that's actually seeking it versus having a region chosen and may not have buy in by the hospital or by that region, so glad you came here today and provided that testimony. I think it helps this committee as this process is going to be continuing to go forward and onward over the last couple -- next couple of years.

ROBERT SMANIK: Representative Johnston, thank you for those comments.

And as you know, and I've been at Day Kimball now three years, and I am embracing -- there's a unique collaborative relationship in Northeast Connecticut, both the communities and their acute care hospital, and more importantly in my world, the physicians in the hospital. There is unique trust.

As I said there's been this 20-year relationship with the pediatric providers. Recently, the private primary care providers in large measure have joined the hospital directly. We have facilities in Thompson, Putnam and in Plainfield for pediatric primary care. It -- I -- I think it is for the state a very unique opportunity to have a -- to leapfrog, standpoint. The State -- DSS does not have to attract -- or approach individual providers to get this started. We can do that

collectively with our relationship. There's clearly need in Northeast Connecticut as you are aware. There's a significant indigent population there, and we're there to serve it. And as its manifest in the numbers in our practice, 40 percent of that being Medicaid or self-pay.

SENATOR DOYLE: Thank you.

Any other comments?

Seeing none, thank you very much.

ROBERT SMANIK: Thank you.

SENATOR DOYLE: Next speaker is Marghie Giuliano, then Rhonda Boisvert and Nancy Trawick-Smith.

MARGHIE GIULIANO: Good afternoon, Representative Walker, Senator Doyle, members of the committee. My name is Marghie Giuliano. I'm executive vice president of the Connecticut Pharmacists Association. And I'm here to testify in strong support of Senate Bill 283, AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES.

Actually, the CPA was the lead organization several years ago on having this audit issue addressed because of the financial hits that our pharmacies were taking by the extrapolation method. And, actually, the legislation that was passed in 2005 helped other providers but failed to help pharmacies because there was a section in there that said if the aggregate amount of claims that you submitted each year was greater than \$150,000, then you were still subject to extrapolation. So, obviously, with the cost of drugs and the number of prescriptions and claims that are submitted on an annual basis, no pharmacy is, you know -- submits less than \$150,000 in claims. So it's still -- it's still a big issue for us.

So, to this point, we're certainly supportive

may not be here. Okay, Ellen's not here.

Is Brandon Levan here? Brandon? No.

Is Dominique Thornton here? Yes, she is.

After Dominique is Mary Farnsworth.

DOMINIQUE THORNTON: Good evening, Senator Doyle and Representative Walker, members of the Committee. Thank you for your patience all day today. I've been watching you. I've been able to leave this room, but I know some of you -- many of you have not.

I'm here to speak in favor of two bills, Senate Bill 281, AN ACT CONCERNING PUBLIC PARTICIPATION AND MEETINGS OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE; and also, House Bill 5297, AN ACT CONCERNING THE STATEWIDE EXPANSION OF PRIMARY CARE MANAGEMENT PILOT PROGRAM.

The president of Mental Health Association and a man with 25 years of experience in the community of mental health and Dr. Steve Madonick who's a member of our board, also submitted testimony to the P and T Committee and were declined to have permission to speak at this committee. And I -- I submit to you that it is urgently important that the public be able to participate because, as I mentioned in -- the last time I spoke before this Committee, restrictions of Medicaid -- medications increase other costs. And I emailed to the entire committee a list of sources that I was aware of. And I've also submitted additional sources -- these are different sources, additional sources, in this testimony as well that shows that there's a significant and drastic increase in the number of outpatient hospital visits and physicians visits when they -- when PDL is implemented. So what we're looking for is a robust panoply, an arrangement, a variety of mental health medications to be made available and not to be constrictive.

The committee was looking at prior authorization as a way to restrict the access and reduce cost. Prior authorization really doesn't take into consideration the impact that it will have, and, indeed, in fact, it has many unintended impacts on Medicaid prior authorization. And there's a PHD Medical Care Journal listed that shows that it does achieve a less -- less optimal outcomes among low-income patients with chronic mental illness.

And on the second page, I've outlined a very eloquent and lengthy -- I'm not going to read it for you because it's in there -- quotation from a researcher who found, you know, that it's not the cheapest alternative.

And just in summation, why would the Mental Health Association be in support of Primary Care Case Management because people with severe mental illness die 25 years earlier than the average population. And the reason for this is not necessarily suicide but the nontreatment, nonregulation, noncare coordination of chronic co-morbid conditions, physical conditions. So with -- we believe that with case management, they will get a better -- better care, better quality of outcome and be able to live longer healthier lives.

Thank you. Any questions?

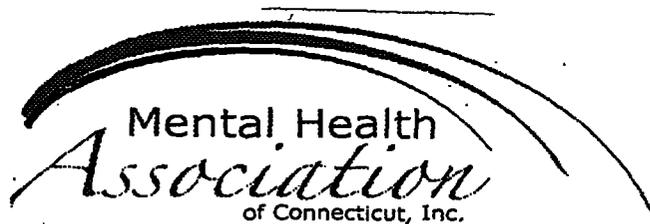
SENATOR DOYLE: Thank you, Dominique.

Any comments or questions?

Thank you. Thank you for your patience.

DOMINIQUE THORNTON: Thank you.

SENATOR DOYLE: Next speaker is Mary Farnsworth, and then we have Wanda Nelson, Laurel Risom. Maybe some can come up together possibly.



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32-8

*Service, Education, Advocacy*

Contact: Domenique Thornton at (860) 529-1970 extension 11

Good Morning Mr. Chairman and members of the Human Services Committee. My name is Domenique Thornton. I am the Director of Public Policy for the Mental Health Association of CT, Inc., (MHAC). MHAC is a 100-year old private non-profit dedicated to service, education and advocacy for people with mental health disabilities. I would like to thank you for the opportunity to speak to you in favor of both Senate Bill 281 An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics (P & T) Committee and House Bill 5297 An Act Concerning the State-Wide Expansion of the Primary Care Case Management Pilot Program. Concerning public input on the P & T Committee, mental health medications have long been exempted in this state from the Preferred Drug List (PDL) in this state for good reason. Adding mental health medications to the PDL will not save the state money. One study showed that "There was a statistically significant increase in the number of outpatient hospital visits and physician visits for the test group compared with the control group in the first 6 months after PDL implementation,"<sup>1</sup> Requiring Prior Authorization (PA) is no guaranteed remedy for this situation. The legislature has difficult decisions to make balance the costs of care with the lives of some of the sickest and poorest residents in the state of Connecticut. But, you should consider that PA ignores the setbacks, bad experiences, symptom remission or other life problems caused by step therapy required to "fail first" for persons who have severe and chronic mental illness. One study<sup>2</sup> reports that the "PA implementation can be a barrier to initiation of non preferred agents without offsetting increases in initiation of preferred agents, which is a major concern. There is a critical need to evaluate the possible unintended effects of PA policies to achieve optimal health outcomes among low-income patients with chronic mental illness." Members of the public, health care providers and others should be

<sup>1</sup> Murawski MM, Abdelgawad T, Exploration of the impact of preferred drug lists on hospital and physician visits and the costs to Medicaid. The American Journal of Managed Care [Am J Manag Care], ISSN: 1088-0224, 2005 Jan; Vol. 11

<sup>2</sup> Lu, Christine Y. PhD; Soumerai, Stephen B. ScD; Ross-Degnan, Dennis ScD; Zhang, Fang PhD; Adams, Alyce S. Unintended Impacts of a Medicaid Prior Authorization Policy on Access to Medications for Bipolar Illness. PhDMedical Care: January 2010 - Volume 48 - Issue 1 pp 4-9

Similarly, House Bill 5297 An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program is a very good idea. Medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities. Medical homes have become an important theme of health reform discussions at the federal and state levels.<sup>4</sup> Medical homes are not buildings but are a coordinated and patient centered approach to attending to medical care delivery. Eight states have recognized the potential of adopting a medical home model and seven are in the process of developing a criteria to recognize medical homes.<sup>5</sup> Medical home pilots and programs are operating in at least 37 states including Connecticut.<sup>6</sup> The patient-centered medical home has the potential prevention as well as for better management of chronic diseases. I currently serve on the Sustinet Advisory Subcommittee for Patient Centered Medical Homes. Thank you.

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<sup>4</sup> PCCM: A New Option for HUSKY, CT health Policy Project, [www.cthealthpolicy.org/pccm](http://www.cthealthpolicy.org/pccm)

<sup>5</sup> Christopher Atchison, presentation at Building a Medical Home: issues and Decisions for State Policy Makers, NASHP, Oct. 5, 2008, Tampa, FL

<sup>6</sup> Patient Centered Medical Home: Building Evidence and Momentum, PCPCC, 2008, national Academy for State Health Policy, November 2008, National Partnership for Women and Families, Sept. 2008



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TESTIMONY to the Human Services Committee

March 2, 2010

In favor of HB-5297, An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program

Ellen Andrews, PhD  
Executive Director

Connecticut spends over \$800 million each year on three HMOs to provide health coverage to 380,494 children and their parents or caregivers (as of February 1<sup>st</sup>). Since its inception, this program has encountered a growing list of problems. A recent actuarial analysis commissioned by the Comptroller found \$50 million in overpayments in one year. A secret shopper survey in 2007 found that HMO provider panel lists were deeply flawed; unfortunately that study has not been repeated and the administration has no intention to revisit the startling results. Also in 2007, barely half of HUSKY children received check ups and over one in ten did not get any health care at all from the program. We are paying for every one of them to receive care.

Other state Medicaid programs do not experience the same troubles as HUSKY. Very few CT providers participate in the HUSKY program, but 95% of physicians in Maine participate in their Medicaid program. Maine pays their providers even lower rates than CT does, but they administer their program through Primary Care Case Management (PCCM), not HMOs. 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. Georgia also uses PCCM administer their Medicaid program; nearly all Georgia providers accept Medicaid patients. Maine's provider rates are significantly lower than CT's, Georgia's are somewhat lower than ours and Oklahoma's are approximately the same.

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. PCCM is a form of the patient-centered medical home model, featured in national health reform bills. The medical

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 applaud provisions in HB-5297 that would expand PCCM statewide, every HUSKY family deserves to have this option, and delay the program's evaluation until there is meaningful enrollment. However, without significant changes to the way DSS has implemented this program, we will be here next year with the same problems.

DSS has had a year to implement this program and has failed. More intervention is needed. I urge you to consider:

- Hiring an independent entity 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 entity 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.
- Rebid the HMO portion of the program by July 1<sup>st</sup> and on a regular basis going forward
  - With the proposed change to the HMO portion of HUSKY, it is very possible that the state could attract new applicants offering better value and more competition to the current three HMOs
  - Most payers re-bid their contracts on a regular basis to ensure they are getting the best value for scarce dollars and to encourage innovation
  - Given the problems with extreme cost increases, low performance, and a lack of accountability, bidding this program out every two years would be prudent contract management.
  - While DSS has a number of policy changes to administer, this cannot be a reason to neglect such a large and important program.
- Require DSS to conduct a secret shopper survey of each HUSKY program annually
- Commission regular, independent audits of HUSKY program finances
  - A modest investment a year ago yielded evidence of \$50 million in HMO overpayments
- If DSS is again unwilling or unable to implement this law, create a Special Master for PCCM, appointed by and answering to the General Assembly, to oversee the program by 12/31/2010:
  - If 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 my thoughts on this critical program for Connecticut families.



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## Update: HUSKY future costs comparison: PCCM vs. HMOs

The last time we, and the General Assembly's Office of Fiscal Analysis, estimated the savings possible with implementation of Primary Care Case Management (PCCM), HUSKY was in the midst of several large transitions including a shift back to capitated managed care from self-insurance. Cost estimates in the program were shifting and difficult to get. In the interim, partly in response to that uncertainty, the Comptroller's Office commissioned an audit of 2008 HUSKY rate setting which found \$50 million in overpayments to the HMOs.

Given a significant deficit expected this year, policymakers are searching for ways to save money on programs. Primary Care Case Management (PCCM) for HUSKY offers that opportunity, especially as an alternative to more costly managed care organizations. In response to legislative requests, we are updating our PCCM savings estimates<sup>1</sup> for the HUSKY program.

The current HMO capitation rates average \$187 per member per month (pmpm).<sup>2</sup> At 10% administrative load<sup>3</sup>, that amounts to \$87 million per year in administrative costs.<sup>4</sup> In contrast, PCCM costs are \$7.50 pmpm plus \$573,589 in administrative costs at DSS<sup>5</sup>, totaling \$34 million per year if every HUSKY family enrolled in PCCM. The difference is \$49.7 million per year.

For several reasons those savings are likely an under-estimate.

- Enrollment in HUSKY has grown significantly over the years and is likely to continue, even accelerate, in the future. National health reform proposals could add another 100,000 to 150,000 members to the program in three to four years. As enrollment grows, the total savings due to PCCM will also grow.
- This estimate assumes that medical costs will be unaffected by implantation of PCCM, but that has not been the experience of other states. When Oklahoma switched their entire Medicaid managed care population from capitated HMOs to PCCM in 2004, medical costs were reduced by over \$24 million in the first

<sup>1</sup> CT Health Policy Project Policymaker Issue Brief No. 46, October 2008, [http://www.cthealthpolicy.org/briefs/issue\\_brief\\_46.pdf](http://www.cthealthpolicy.org/briefs/issue_brief_46.pdf)

<sup>2</sup> 12/08 thru 11/09, from EDS HUSKY enrollment reports and DSS Comprehensive Financial Status Reports.

<sup>3</sup> Average from HMO audit reports to Medicaid Managed Care Council.

<sup>4</sup> Based on 11/1/09 HUSKY Part A enrollment numbers from EDS, It is likely this is an underestimate as HUSKY enrollment has grown steadily over the last year and is likely to continue that growth into the future.

<sup>5</sup> As per DSS budget estimate -- Annual PCCM program costs: SFY 2009 and 2010.

- six months (they also "saved another \$20 million in payment lags), and saved over \$80 million in medical costs in the first full fiscal year of PCCM.
- The state has had significant difficulty in achieving fair rates with the HMOs. Too few bidders lead to an uneven negotiation. PCCM provides the state with leverage in those negotiations and a safety net for both HUSKY families and taxpayers if, as happened in Oklahoma, HMOs are not willing to accept what the state can afford. It is impossible to quantify these savings from a strong PCCM program, but they are significant and could, at the least, allow DSS negotiators to recover the \$50 million in overpayments identified in the Comptroller's audit.

**Bottom Line: Allowing HUSKY families statewide to enroll in PCCM could save the state \$50 million or more annually over the HMOs.**

December 29, 2009



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**TESTIMONY to the Human Services Committee**

**March 2, 2010**

**In favor of HB-5297, An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program**

**Brandon Levan**

**CTHPP Fellow**

In the absence of any marketing of PCCM by DSS, a team of eight volunteers, working with advocates at the CT Health Policy Project and New Haven Legal Assistance, has been involved in a comprehensive outreach program to encourage HUSKY providers and HUSKY A enrollees to sign up with the new PCCM program. Funding for these activities was provided by the United Way of Greater New Haven, the CT Health Policy Project, New Haven Legal Assistance, and several generous individuals. The activities include:

1. **Contacting HUSKY providers who have not yet signed up with the new program to encourage them to do so, by providing them with DSS and other materials and meeting with groups of providers and individual providers to discuss their potential participation in the program and its advantages for their patients and their practices. Providers and practice managers were contacted both by mail and by phone and we held two evening forums for providers - one in New Haven and one in Hartford.**
2. **Outreach to HUSKY providers who have already signed up for the program, to urge them to promote PCCM with their HUSKY A patients. We have met with them and provided color copies of the official DSS signs to post at all of their offices, posting them ourselves where they have granted us permission to do. We also have provided them with buttons stating: "ASK ME ABOUT PCCM," and suggested that all office staff wear them to encourage dialogue with HUSKY A patients. We have provided a one-page sheet of "Talking Points" for providers to use in answering questions from HUSKY A patients about the program and its advantages.**
3. **Direct outreach to HUSKY A enrollees. This has taken many forms, including providing in-person assistance and information at provider offices, and the placing of posters and flyers about the program at dozens of public places such as libraries, school-based health clinics, churches and social service**

agencies, among other locations. Thousands of flyers were distributed in January and about eighty 13 X 19 color posters have been placed at locations in New Haven and Hartford. The effort also has included tabling at school events to inform HUSKY A parents of this option, and upcoming presentations to groups of HUSKY A parents. Every New Haven public school child has received a PCCM flyer in their backpack.

4. **Meetings with HUSKY outreach workers in the four pilot areas to make sure that they understand the advantages of the program to HUSKY A enrollees, beyond what is stated in DSS materials.**
5. **Media attention.** While DSS has authorized millions of dollars of taxpayer money to be spent on direct marketing by the plans, on everything from radio ads, TV sponsorships, billboards, free hair cuts, airplane banners and bus placards, and it has actively promoted the Charter Oak Health Insurance plan through at least nine press releases, DSS has done no affirmative media outreach regarding PCCM. This has stymied the ability to reach the public with information that the program even exists. Accordingly, we have contacted media outlets to get attention for the program, resulting in several articles in major newspapers and on-line news services.

These community volunteer efforts are responding to the desperate need for this option. Every HUSKY family, not just those in a few select communities, deserves access to this option. I urge you to approve HB-5297.

T45

29-11

TESTIMONY OF  
ROBERT SMANIK, PRESIDENT AND CEO  
DAY KIMBALL HOSPITAL  
BEFORE THE  
HUMAN SERVICES COMMITTEE  
Tuesday, March 2, 2010

**H.B. No. 5297 (RAISED) AN ACT CONCERNING STATE-WIDE EXPANSION OF THE PRIMARY CARE MANAGEMENT PILOT PROGRAM**

Senator Doyle, Representative Walker and distinguished members of the Human Services Committee, my name is Robert Smanik, I am the President and Chief Executive Officer of Day Kimball ("DKH"). I am providing testimony today in support of H.B. 5297, **An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program**. In addition, I would like to speak in support of H.B. 5328, **An Act Implementing SAGA Hospital Rate Increases**.

**H.B. 5297, An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program**

DKH is focused on quality and patient safety, and providing access to the most skilled professionals, the highest quality of care, and the latest technology. Providing care to all who need it, regardless of ability to pay, twenty-four hours a day, seven days a week year-round, DKH is an integral to the quality of life and health in our community. DKH is among the largest employers in Windham County, supporting thousands of families/jobs and generating substantial economic activity. In many respects, the health of our community is linked to the health of our local hospital. Unfortunately, the economic crisis puts tremendous pressure on our Hospital. Thus, DKH puts forth efforts to determine how to best manage, in these challenging times, the Hospital's ability to meet the needs of our community.

With this in mind, I testify before you today to respectfully request, the distinguished members of this committee, to support the expansion of Primary Case Management (PCCM) Pilot Program on a state-wide basis. DKH, in concert with our physicians are proud to have spent many years growing and developing an integrated primary care system. The PCCM pilot is a model of care which fits squarely with the patient base and mission of DKH. I understand that this pilot program is up and running in some other parts of Connecticut. It is my belief that expanding this pilot program will allow other Hospital's, such as DKH, to prove that this model can be very successful. The State's investment in this program can and will produce results if given the right opportunity.

**H.B. 5328, An Act Implementing SAGA Hospital Rate Increases**

As you may know, the SAGA program has been the focus of much legislative attention for several years. The SAGA program was significantly modified in 2004 and subjected hospitals, pharmacies, and community health centers to a cap based on available

CONNECTICUT  
**VOICES**  
 FOR CHILDREN

Testimony Regarding

**S.B. No 220: An Act Concerning the Elimination of Certain Department of Social Services Reporting Requirements**

**S.B. No. 281: An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics Committee**

**H.B. 5056: An Act Implementing the Milliman Report's Recommendations to Achieve Cost Savings in the HUSKY program**

**H.B. No. 5297: An Act Concerning the State-Wide Expansion of the Primary Care Case Management Pilot Program**

Sharon D. Langer

Human Services Committee

March 2, 2010

Senator Doyle, Representative Walker and Members of the Human Services Committee:

I am a senior policy fellow with Connecticut Voices for Children, a research-based public policy think tank that works statewide to promote the well-being of Connecticut's children, youth, and families. I am submitting this written testimony on behalf of CT Voices.

**Senate Bill No. 220** would eliminate the Department of Social Services' statutory obligation to report on various programs under its jurisdiction. While it may make sense in some cases to eliminate or reduce reporting requirements where a program is defunct or a mandate has been fulfilled, we suggest that this Committee first determine whether the underlying obligation contained in a statute has been met before considering whether elimination of the reporting requirement is warranted. We therefore have the following comments about three specific sections of S.B. 220:

**Maintain the reporting requirement regarding presumptive eligibility for pregnant women until it has been successfully implemented. (Sec. 8)**

In 2008, the Department was mandated to implement presumptive eligibility (PE) for pregnant women in accordance with the federal definition of PE under Medicaid. PE allows certain health care providers to make an initial eligibility determination and therefore allows pregnant women to obtain coverage quickly. This is no time to eliminate the reporting requirement set forth in paragraph (e) since the Department has yet to fulfill this statutory mandate. Department personnel recently stated that presumptive eligibility will be implemented this month (March 2010). Presumably, the biannual reporting requirement in paragraph (e) is being eliminated because the Governor has proposed to eliminate the Medicaid Managed Care Council in another bill, and the report required by this section is to be sent to the Council. As we and others testified last week before this Committee, we oppose the elimination of the Council whether or not Medicaid managed care is converted to an administrative services organization. The Council provides an important public forum for discussion of the financing, coverage and access issues related to the HUSKY program which serves about 380,000 children, pregnant women and parents, and an advisory council is required by federal law. See 42 CFR Sec. 431.12 (requiring a medical care advisory committee). In any event, this committee and the Council should be monitoring the implementation of PE for pregnant women. It is good public policy and it is mandated by this statute.

We support S.B. 281 which would allow members of the public to express their views at a meeting of the Pharmaceutical and Therapeutics Committee. An opportunity for public comment seems reasonable and is consistent with an open government. The P&T Committee advises the Department of Social Services regarding drugs that are included on the "preferred drug list" for the state's pharmacy program which serves over 500,000 residents receiving health coverage through HUSKY, Medicaid, SAGA or the Charter Oak Health Plan. Changes continue to be proposed concerning prior authorization of mental health drugs, for example, and concerns that such a mechanism will prevent patients with serious mental illness will not receive timely and appropriate medications. Allowing public comment at the P&T Committee meetings would facilitate better communication between the decision makers and the public.

H.B. 5056 would require the state to "recover fifty million dollars in over payments from [HUSKY] managed care organizations . . . and implement primary care case management state wide. . ." We take this opportunity to reiterate our support for the Governor's proposal to convert HUSKY risk-based managed care to a non-risk administrative services organization model. The Governor's budget assumes a budgetary savings of \$50 million – based on the state Comptroller's audit (i.e., the "Milliman Report" referenced in this bill). In addition, we urge utilization of an ASO in combination with primary care case management (PCCM) and support permitting children in HUSKY B the opportunity to participate in PCCM as an alternative to risk-based managed care plans – assuming the health plans remain in place. Finally, we would also support the transparency and accountability provisions in the bill, e.g., conducting an annual audit of the program.

H.B. 5297 would require the Department of Social Services to expand the primary care case management pilot state-wide by October 1, 2010. We would add to this requirement that PCCM be supported by an administrative services organization for certain functions that primary care providers may find challenging to implement. Under federal and state Medicaid guarantees of "early and periodic screening, diagnostic and treatment" (EPSDT) services, primary care providers – particularly those in smaller practices – may find it difficult to arrange all of the EPSDT mandated services, such as transportation. An ASO can help facilitate such arrangements, as well as provide other back office functions for PCPs.

Thank you for this opportunity to submit testimony concerning the above mentioned bills. If you have any questions or need additional information, please contact me.

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<sup>1</sup> Testimony Supporting H.B. 5020: An Act Implementing the Governor's Recommendations regarding the Tobacco and Health Trust Fund, T. Ali & S. Langer, M.Ed., J.D. (Mar. 12, 2008), available at [www.ctkidslink.org/testimony\\_archive.html](http://www.ctkidslink.org/testimony_archive.html)

<sup>2</sup> If Connecticut had instituted smoking cessation, it would be receiving almost 62 cents on the dollar from the federal government for Medicaid covered services under the stimulus package, from October 1, 2008 through December 31, 2010 – and most likely beyond 2010 – since the expectation is that Congress will authorize continuation of the increase in federal Medicaid matching funds.

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## NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.

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March 2, 2010

**Testimony of Sheldon Toubman in Support of HB 5297 and HB 5056, Expanding PCCM in the HUSKY Program, and SB 281, Requiring the Pharmaceutical and Therapeutics Committee to Allow Public Comment at Its Meetings**

Good afternoon, Members of the Human Services Committee:

My name is Sheldon Toubman, and I am an attorney with New Haven Legal Assistance Association. I am here to speak in support of three bills before you today: SB 281, which would require the Pharmaceutical and Therapeutics (P & T) Committee to receive public comment at its meetings, and HB 5297 and HB 5056, both of which would require an expansion of primary care case management (PCCM) to become a statewide option. All of these bills take us in the right direction by improving public input and accountability in the delivery of health care.

First, SB 281 will correct a serious deficiency in the way in which the P & T Committee goes about deciding whether to remove a drug from the state's preferred drug list and thus subject that drug to restrictive prior authorization under the Medicaid and SAGA programs, specifically its refusal to allow members of the public, including consumers and consumer advocates, to speak at its meetings in order to ensure input into those decisions, unless they are specifically invited to do so. This was recently confirmed directly for me last week, when the Committee, after receiving my written statement, decided not to let me speak at its next meeting on March 4th, while specifically allowing others to make oral presentations at this meeting.

It is unwise policy for a quasi-governmental entity to selectively allow consumers and consumer advocates an opportunity to speak before it prior to making its decisions. Each speaker brings their own perspectives to the issues before the Committee, and its members will benefit from hearing that breadth of concern. In addition, by not allowing oral presentations by some members of the public, including consumers and advocates, the Committee deprives its members of the ability to ask any pertinent follow-up questions of those who have submitted written statements. Finally, I note that, because the P and T Committee is a quasi-governmental agency, it would raise First Amendment concerns if it were to persist in selectively allowing some individuals to speak before it, based on their written statements, while denying this same opportunity to others based on their written statements.

SB 281 will correct this by requiring the Committee to hear public comment at its meetings.

Second, I am here to support HB 5297 and HB 5056, because it is time to require an expansion of primary care case management (PCCM) so it can be an option for the entire state. Although the Governor's proposed move from capitated HMOs to ASOs is welcome, moving to PCCM will save more money, put care in the hands of those most able to coordinate it—the treating primary care providers—and provide a stable alternative to the ever-changing set of risk and non-risk corporate contractors which have moved in and out of the HUSKY program over the last three years. Unlike companies which will not hesitate to terminate a contract if it is not in their bottom line interest, individual doctors coordinating care under PCCM are committed to their patients and are not likely to go anywhere. At the very least, we need a statewide alternative to compete with the ASO-administered model.

There also is a very relevant precedent from Oklahoma, where that state in 2003-2004, under pressure from capitated HMOs demanding more state money, went from 3 Medicaid HMOs to statewide PCCM—and saved millions of dollars for the taxpayers right away. In Oklahoma,

the HMOs were removed less than 2 months after the decision was made to remove them; the period of time for the transition to statewide PCCM was just 4 and 1/2 months; the expenditures for medical services and cash flow actually dropped about \$85.5 million in the first fiscal year; and, even with the increased administrative costs for the state in rolling out the new program, which are particularly high at start-up time, the net savings were \$4.3 million in the first few months and \$3.9 million in the first full fiscal year. The slides from a powerpoint presentation by the Oklahoma Medicaid director confirming all of the above savings are attached to my testimony (see particularly slides 14 and 15).

But, notwithstanding the directly analogous Oklahoma experience, DSS has not promoted the program in a way which would encourage HUSKY enrollees to choose this option. Absent outside intervention, the PCCM program is going nowhere—in opposition to the clear legislative goal of implementing a very robust program of PCCM to run parallel to the HMOs, at least during a meaningful test period.

Accordingly, the two bills which would expand PCCM to be statewide are most welcome.

There are a few suggested improvements to the two PCCM bills as to which I have prepared an amendment, attached to my testimony. They would (1) remove the onerous FOIA obligation imposed by DSS as a matter of contract on individual primary care providers under PCCM (while not imposing it on individual providers under the HUSKY HMOs); (2) make clear that the statewide expansion also includes HUSKY B (HB 5056 already does this); and (3) require DSS to contract with an outside entity to administer PCCM so that it really can move forward.

Thank you for the opportunity to speak with you today.

Proposed Amendment Language for HB-5297

- To hire an independent entity to administer PCCM:

Sec. (NEW) (Effective October 1, 2010) The Commissioner of Social Services shall secure administrative support services for the primary care case management program, except the commissioner shall not enter into a contract for the provision of such services with a provider of comprehensive health care services as described in subsection (b) of section 17b-266.

- To remove the onerous FOI requirement on individual PCCM providers:

Sec. (NEW) (Effective from passage) Records maintained by primary care case management providers shall not be made subject to public disclosure through any contracts with the Commissioner of Social Services or with any organization contracted with by the Commissioner to administer the primary care case management program.

- To expand PCCM as an option to HUSKY Part B children and Charter Oak Health Plan members:

Section 1. Section 17b-307 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Notwithstanding any provision of the general statutes, not later than November 1, 2007, the Department of Social Services shall develop a plan to implement a pilot program for the delivery of health care services through a system of primary care case management to not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Parts A or B, or Charter Oak Health Plan benefits. Such plan shall be submitted to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. Not later than thirty days after the date of receipt of such plan, said joint standing committees of the General Assembly shall hold a joint public hearing to review such plan. Said joint standing committees of the General Assembly may advise the commissioner of their approval or denial or modifications, if any, of the plan. Primary care providers participating in the primary care case management system shall provide program beneficiaries with primary care medical services and arrange for specialty care as needed. For purposes of this section, "primary care case management" means a system of care in which the health care services for program beneficiaries are coordinated by a primary care provider chosen by or assigned to the beneficiary. The Commissioner of Social Services shall begin enrollment for the primary care case management system not later than April 1, 2008.

# **SoonerCare Choice: Oklahoma's PCCM Program**



January 2008

001052

# What Happened?

- Based on estimates from actuaries, the Legislature appropriated base rate increase of 13.6% for the MCOs for CY04
- Final actuarial certified rate was 19.1% increase
- Agency bid MCO rate at 13.6% increase as funded for CY04
- 2 of 3 MCOs accepted bid
- State left with only one plan in each of three service areas

# Managed Care Transition

- Board voted 11-7-03 to eliminate MCO program effective 12-31-03
- Transition of nearly 200,000 enrollees to Fee-for-Service, then to PCCM program in 4 months
- Formed interagency transition team
- Aggressive enrollee outreach campaign
- Provider contracting to extend network statewide
- Expanded care management & program supports

# **Results Jan-June 2004**

- Budget reduced by \$23.9 million for medical payouts
- Budget reduced by \$24.8 million for cash flow gain
- Budget increased by \$6.9 million for estimated administrative costs
- Revenues decreased by \$37.5 million, including federal funds
- Agency saved the projected \$4.3 million in state dollars for SFY04

# **Results SFY2005**

- Expenditure reduction of \$85.5 million
- Revenue reduction of \$81.6 million
- Achieved overall savings of \$3.9 million



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 www.cacil.net

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...Working for the full integration, independence, and civil rights of people with disabilities  
 through Centers for Independent Living

**Testimony of Gary Waterhouse, Executive Director**

**CT Association of Centers for Independent Living**

**March 2, 2010**

**Human Service Committee Public Hearing**

Center for Disability Rights  
 764A Campbell Ave.  
 West Haven, CT 06516  
 V 203-934-7077  
 TDD 203-934-7079

Disabilities Network of  
 Eastern CT  
 238 West Town Street  
 Norwich, CT 06360  
 V/TDD 860-823-1898

Disability Resource Center  
 of Fairfield County  
 80 Ferry Boulevard  
 Suite 210  
 Stratford, CT 06497  
 V 203-378-6977  
 TDD 203-378-3248

Independence Northwest  
 1183 New Haven Rd.  
 Naugatuck, CT 06770  
 V 203-729-3299  
 TDD 203-729-1281

Independence Unlimited  
 Suite D  
 151 New Park Avenue  
 Hartford, CT 06106  
 V/TDD 860-523-5021

**S.B. No. 217 (RAISED) AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.**

**SUPPORT-** CACIL supports limiting to \$20.00 the fees charged by financial institutions to people during the Title XIX eligibility process. All funding available to an individual should be reserved for Medical Care and Treatment. Generally people applying for Title XIX do not have the resources to pay for five (5) years of documents from financial institutions, so the burden falls to the family.

**S.B. No. 281 (RAISED) AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE.**

**SUPPORT-** CACIL supports the inclusion of a requirement that the Pharmaceutical and Therapeutics committee shall ensure that each meeting includes an opportunity for public comment. Giving the public the opportunity to provide anecdotal testimony and records of personal experience will undoubtedly give the committee important and valuable evidence leading to better decision making.

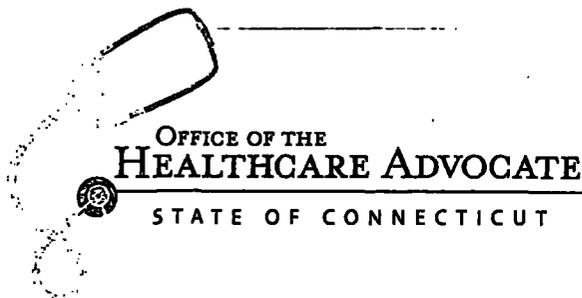
**H.B. No. 5297 (RAISED) AN ACT CONCERNING STATE-WIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM.**

**SUPPORT-** CACIL supports the expansion of the delivery of health care services through the primary care case management system and the application by the Connecticut Department of Social Services of a waiver from the Centers for Medicare and Medicaid Services for the purpose of expanding the primary care case management system.

HB 5354

SB 315

HB 5232

T12  
12-11

OFFICE OF THE  
**HEALTHCARE ADVOCATE**  
STATE OF CONNECTICUT

**Testimony of Victoria Veltri  
General Counsel**

**Before the Human Services Committee  
In support of HB 5056, HB 5297 and SB 281  
And  
In Opposition to SB 220  
March 2, 2010**

Good morning, Senator Doyle, Representative Walker, Senator, Representative Gibbons and members of the Human Services Committee. For the record, I am Vicki Veltri, General Counsel with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to testify on behalf of OHA, in favor of several bills. The first is HB 5056, An Act Implementing the Milliman Report's Recommendations to Achieve Cost Savings in the Husky Program. This bill does many things, all of which we support.

First, the projected savings from the Milliman study were incorporated last year by the Governor into her proposed biennial budget. The final budget reflected a savings of \$50 million in the Medicaid line from the expected recovery of this money from the participating managed care organizations ("MCOs") by the Department of Social Services ("DSS"). The administration has yet to recover these sums, though the Governor actually suggested the recovery. Since the administration has yet to recover the money, or to fairly explain to the legislature and the public why the recovery has not taken place, it is appropriate to place a specific statutory duty on DSS to recover the \$50 million. It does not bode well that neither DSS nor OPM has closed the deal on this budget item. Maybe clear and unambiguous direction will force compliance.

Second, replacing sealed bids with negotiated bids makes sense as a sealed bid may either qualify or disqualify a potential contractor too early in a bid process.

Third, OHA supports an annual audit of the program. It is unclear from the language of the bill whether the proposed audit would be financial or performance-based or

both. We recommend both. HUSKY is one of the biggest items in the state's budget. Although we've gained some transparency through the Freedom of Information cases and some of the reporting that the MCOs and DSS provide, we do not have an ongoing understanding of the finances of the HUSKY program. Since it is clear that there are some financial questions hanging over HUSKY, it is an appropriate time to initiate annual audits of the program, regardless of its structure. Mercer currently conducts the external quality review ("EQR") monitoring of HUSKY. Mercer has a conflict of interest in conducting the EQR since it is also the DSS actuarial services contractor. An annual performance audit can go farther than the EQR review and focus on particular areas or the entire program. (Should HUSKY be converted to an ASO model, there will still be a need for regular financial and performance audits.) Requiring yearly auditing of an \$800 million program will keep the program focused on the efficient delivery healthcare to its 400,000.

Fourth, OHA supports a statewide roll out of primary care case management ("PCCM") to allow all HUSKY and Charter Oak recipients the choice of enrolling in PCCM. Statewide enrollment should erase some of the problems that have come to light, including PCCM recipients in one town not being able to access care in a contiguous town where providers are signed up with PCCM. Opening the program statewide will undoubtedly bring more providers into the PCCM model. To the extent that there providers who treat patients in the state's public programs, it makes sense to encourage the providers to participate in both HUSKY and Charter Oak. For families who have a child in HUSKY B or A, and a parent in Charter Oak, this is common sense. Providers and consumers often have trouble telling whether they or their children are on HUSKY A, B or Charter Oak.

OHA also supports HB 5297, *An Act Concerning Statewide Expansion of the Primary Care Case Management Pilot Program*. We recommend that this bill be revised to include expansion of PCCM to the HUSKY B and Charter Oak populations.

OHA supports SB 281, *An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics Committee*. This body makes decisions about which medications should and should not be included on the state's Preferred Drug List. We believe that because the committee's decisions impact approximately half of a million Connecticut residents and are of critical importance, that public comment should be allowed.

OHA opposes SB 220, *An Act Concerning the Elimination of Certain Department of Social Services Reporting Requirements*. OHA believes that while DSS has multiple reporting requirements, its multi-billion dollar budget requires this reporting and, in fact, OHA encourages the committee to require more transparency from DSS, particularly on its budget. Section 2 of the bill changes DSS' reporting time on federal sanctions or fines, from five to thirty days. When a state agency is sanctioned or fined by a federal agency, notification to the legislature should be instantaneous. Five days, however, is a reasonable window, thirty days is not. In an era in which strict accountability standards are applied to all state agencies, elimination of these reporting requirements also eliminates some of the legislature's oversight.

Thank you for your attention to my testimony. Please contact me directly with any questions at [victoria.veltri@ct.gov](mailto:victoria.veltri@ct.gov) or (860) 297-3982.



T6  
5-11



*Testimony before the Human Services Committee*

*Michael P. Starkowski*

*Commissioner*

*March 2, 2010*

Good morning, Senator Doyle, Representative Walker and Members of the Human Services Committee. I am Michael Starkowski, Commissioner of the Department of Social Services. I am pleased to be here this morning to present testimony on legislation introduced at the request of the department and would like to thank the committee for raising these bills. I am also providing testimony on several other bills with significant impact on the department.

*Legislation Introduced at the Request of the Department*

**S. B. No. 220 (RAISED) AN ACT CONCERNING THE ELIMINATION OF CERTAIN DEPARTMENT OF SOCIAL SERVICES REPORTING REQUIREMENTS.**

This bill was raised at the request of the department and again I would like to thank the committee for doing so. This bill would eliminate or amend a number of the statutory reporting requirements that have been placed upon the department. We bring this bill before you not in an effort to circumvent transparency but rather to lighten the large reporting burden on the department so we may focus our efforts on administering our programs.

To give you a few examples, in 17b-14 the department is not asking that the report be eliminated but rather is asking for an extension of time to submit the required report.

Also in 17b-114o the department is required to report to the legislature on the TANF block grant. We are not suggesting that our reporting be eliminated altogether, rather we are asking that we simply be allowed to continue to share the report that we are federally mandated to produce as opposed to having to create an entirely new state report.

Some examples of requirements we wish to eliminate are one time reports as in 17b-342a which was a report on the PCA pilot program and in 17b-366 which was a report on the assisted living pilot.

SB281

SB283

HB5056

HB5297

HB5328

HB5354

HB5355

HB5329

*Other Legislation Impacting the Department*

**S. B. No. 217 (RAISED) AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.**

While the biennial budget included rate reductions to the MCOs, the Governor recommends converting HUSKY to a non-risk model with the HUSKY program continuing under an administrative services structure. It is clear that if the legislature moves forward with the ASO proposal, a bill concerning managed care rates would be irrelevant. However, we strongly feel that based on the process and procedures employed at the present time the bill is duplicative and unnecessary.

The department currently solicits sealed bids in order to ensure competition on price. Open bids would undermine that process. Once bids have been unsealed and contractors awarded the right to negotiate, the department then proceeds with the negotiation of the financial terms that are the most advantageous to the state. For this reason the department opposes this provision.

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We feel that it is duplicative and unnecessary to conduct an annual audit of the HUSKY program. HUSKY rates are currently reviewed by an independent actuary and certified by the Center for Medicare and Medicaid Services (CMS).

Lastly, we believe that expansion of PCCM state-wide to HUSKY B and Charter Oak would be premature before completion of the evaluation of the pilot program. For these reasons the department is opposed to this bill.

**H. B. No. 5297 (RAISED) AN ACT CONCERNING STATE-WIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM.**

This legislation would require the Department of Social Services to make the primary care case management pilot program available to all HUSKY A clients on a state-wide basis no later than October 1, 2010. The Commissioner of Social Services would be required to report to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the expansion of the pilot program no later than July 1, 2011 and to seek a waiver if necessary from federal law for the purpose of expanding the primary care case management system pursuant to this subsection.

with  
H. B. 5297  
Pilot

The Department remains committed to developing HUSKY Primary Care, as the primary care case management pilot program is known. HUSKY Primary Care is being introduced gradually in target communities across the state according to the terms contained within the General Assembly's approval of the Department's 1915(b) waiver renewal of March, 2009. The requirement for an independent evaluation to be completed and reported to the committees of cognizance by July, 2010 was also included in the approval of the waiver renewal. The department has begun to have preliminary discussions planning for the evaluation and expects will be completed within the timeframe.

The Department of Social Services believes that it is premature to mandate statewide implementation of HUSKY Primary Care until the program is evaluated, the cost-

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effectiveness of the model in Connecticut is determined, and the additional resources necessary for the pilot's success are both measured and identified.

**H. B. No. 5328 (RAISED) AN ACT IMPLEMENTING SAGA HOSPITAL RATE INCREASES.**

While the SFY 2011 budget did include \$66.3 million to cover the cost of increasing SAGA hospital reimbursement rates to the Medicaid rate as part of the SAGA waiver, the budget also assumed \$129.5 million in additional federal revenue as a result of the approval of that waiver. Because the SAGA waiver is not expected to be in place before the beginning of SFY 2012, the revenue will not be available in SFY 2011 to offset these costs. Thus, the department opposes the proposed bill because it would increase our expenditures by tens of millions of dollars without the benefit of the additional revenue that would be generated under the SAGA waiver

**Section 1 of H. B. No. 5354 (RAISED) AN ACT TO PROVIDE INCENTIVES FOR HOSPITALS TO ADOPT ELECTRONIC HEALTH RECORDS.**

As the single state agency for Medicaid the Department of Social Services is responsible for the administration of the Medicaid EHR incentive program. Accordingly it would not be appropriate for DPH to deem DSS' actions necessary. Furthermore, it is our understanding that the Department of Public Health has raised the issue that this bill could jeopardize the pending application for federal funds under the American Recovery and Reinvestment Act of 2009 and for that reason we oppose this bill.

**H. B. No. 5355 (RAISED) AN ACT CONCERNING AN ADVANCED DENTAL**

This bill is a scope of practice bill that expands the role of dental hygienists. The activities and licensure practices in the State of Connecticut are under the Department of Public Health and do not fall within the jurisdiction of the Department of Social Services. We feel that the pilot program contemplated in this bill has inappropriately been placed under the Department of Social Services.

Moreover, ~~this type of pilot program~~ is not fundable as a Medicaid service and would not qualify for federal match. This pilot should be funded as a grant under the direction of DPH.

If the pilot were successful, and the scope of practice of dental hygienists were expanded, this could be included as a Medicaid covered service and might be cost-effective. However, this would have to be examined more carefully.

**Additional Written Remarks:**

*managed care waiver  
needed to run a pilot*

*250% increase in # of dentists  
now part of participating since  
pediatric rates increased*

*medicaid*