

Legislative History for Connecticut Act

PA 14-62

HB5378

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
PART 13
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Have all the members voted? Have all the members voted? Please check the board to see that your vote has been properly cast.

If all the members have voted, then the machine will be locked and the Clerk will take a tally. The clerk will announce the tally.

THE CLERK:

Senate Bill 336 in concurrence with the Senate.

Total number voting 139

Necessary for passage 70

Those voting Yea 136

Those voting Nay 3

Those absent and not voting 12

DEPUTY SPEAKER SAYERS:

The bill passes in concurrence with the Senate.

Will the Clerk please call Calendar Number 139.

THE CLERK:

On page 35, Calendar Number 139, favorable report of the joint standing committee on Appropriations, Substitute House Bill Number 5378, AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID FUNDED EMERGENCY DEPARTMENT VISITS.

DEPUTY SPEAKER SAYERS:

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Representative Mushinsky.

REP. MUSHINSKY (85th):

Thank you, Madam Speaker. I move acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER SAYERS:

The question is acceptance of the joint committee's favorable report and passage of the bill.

Representative Mushinsky, you have the floor, madam.

REP. MUSHINSKY (85th):

Thank you, Madam Speaker. The Clerk has an amendment LCO 4884. Could the Clerk please call and may I be allowed to summarize.

DEPUTY SPEAKER SAYERS:

Will the Clerk please call LCO Number 4884.

THE CLERK:

LCO Number 4884 designated House Amendment "A" offered by Representative Mushinsky.

DEPUTY SPEAKER SAYERS:

The Representative seeks leave of the Chamber to summarize the amendment. Is there any objection to summarization? Is there any objection?

Hearing none, Representative Mushinsky, you may proceed with summarization.

REP. MUSHINSKY (85th):

Thank you, Madam Speaker. This amendment was written today to address concerns of the Department of Social Services. It moves the effective date to give the DSS time to institute the policy in new contracts and requires them to report to the PRI Committee and the Public Health Committee on the feasibility of arranging visits by Medicaid providers not later than 14 days after the clients were treated at the emergency room. I move adoption.

DEPUTY SPEAKER SAYERS:

The question before the Chamber is adoption of House Amendment Schedule "A". Will you remark on the amendment?

Representative Carpino of the 32nd.

REP. CARPINO (32nd):

Thank you, Madam Speaker. Although this amendment was written today, I do want the Chamber I was well aware of it and I do have a few questions for my Chair. May I?

DEPUTY SPEAKER SAYERS:

Please proceed, ma'am.

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REP. CARPINO (32nd):

Could the Chair please explain why it was pushed out two years? Through you, Madam Speaker.

REP. MUSHINSKY (85th):

Through you, Madam Speaker, the Department is involved in other work qualifying them for 90 percent reimbursement, which has high priority right now, and in addition, the contracts would have to be amended for this new policy, which we believe in the PRI Committee will save the state money, but the contracts are in play and don't expire until 2016 anyway.

So extending the date out to that year will allow them time to insert this policy in the new contracts.

Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Carpino.

REP. CARPINO (32nd):

I thank her for her comments and I do support this amendment. Thank you.

DEPUTY SPEAKER SAYERS:

Will you remark? Will you remark further on the amendment that is before us?

If not, let me try your minds. All those in favor signify by saying aye.

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REPRESENTATIVES:

Aye.

DEPUTY SPEAKER SAYERS:

Those opposed, nay? The ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?

REP. MUSHINSKY (85th):

Thank you, Madam Speaker. This bill was based on recommendations of our Committee at the request of the Appropriations Committee. They wanted us to investigate the use of the emergency room by Medicaid clients and to see what we could do to reduce the cost of the frequent flyers, which are those patients that use the emergency room too often and ought to be using their primary provider instead.

We found that the emergency department use is higher among Medicaid clients than the general population. However, it is not the big cost driver, but it is about four percent of the Medicaid budget, so it is definitely worth our fixing this policy.

A small number of clients have many visits, 20 or more to the emergency room each year, and we're addressing this by requiring the Medicaid administrative services organizations to work with the

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hospitals and identify these Medicaid clients that are frequently using the emergency room and who might benefit from intensive case management, work with them face to face and reduce their use of the emergency room.

Now the reason we know this works is our team investigated, our researchers investigated the successful program at Middlesex Hospital in Middletown where they are already doing this and they have successfully reduced repeat visits and reduced the expenses at the emergency room.

We are also requiring the contracted administrative services organization to expand the way they measure Medicaid clients' access to primary care and specialists, again, to make the most cost effective use of our medical dollars.

We do believe that we will save money with this new approach. We believe it's already been proven in Middletown and that it should be statewide, and I urge your support for this measure.

Thank you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Carpino.

REP. CARPINO (32nd):

Thank you. A few questions, through you to the proponent.

DEPUTY SPEAKER SAYERS:

Please prepare your questions, ma'am.

REP. CARPINO (32nd):

If the good chairwoman could please define some of these terms for us. This bill, though short, is dense with lingo and jargon from the industry. If she could please explain extensive case management as it is used in this context. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Mushinsky.

REP. MUSHINSKY (85th):

Through you, Madam Speaker, yes, it is dense with acronyms. In fact we had to publish a whole page of acronym definitions and translations for the report.

But the Medicaid administrative service organizations, or ASOs, as the jargon has it, reach out to the Medicaid clients on behalf of the state, whether the DSS, the Department of Mental Health and Addiction Services or the DCF, and they are under contract to the state to assist these Medicaid clients who would benefit from intensive case management and then provide further services to these clients.

Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Carpino.

REP. CARPINO (32nd):

Thank you. And if she could also explain ASOs.

Through you.

DEPUTY SPEAKER SAYERS:

Representative Mushinsky.

REP. MUSHINSKY (85th):

ASO is really just a shorthand for administrative service organizations and these are contractors that the state uses to work directly with the Medicaid clients and try to save the state money by putting them in touch with their provider and using the least cost services. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Carpino.

REP. CARPINO (32nd):

I thank her for the answer. And could you also explain whether or not this will apply to mental and behavioral health services that is such a need in the state as the PRI Committee has heard on a number of occasions. Through you, will this affect behavioral and mental health services? Through you, madam.

DEPUTY SPEAKER SAYERS:

Representative Mushinsky.

REP. MUSHINSKY (85th):

Through you, Madam Speaker, yes, and this is one of the groups that when not properly treated they are repeat visitors to the emergency room.

Another type of repeat visitor would be someone with a chronic illness that's not been treated. Some folks have a substance abuse issue. It could be chronic diabetes, anything that's not being treated by a personal provider.

And so, our intention here is to reduce the number of emergency room visits which are about \$350 per visit and treat these patients more successfully and more cost effectively. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Carpino.

REP. CARPINO (32nd):

Thank you both. PRI found that in 2012 over 4,600 clients had ten or more visits to the emergency room and over 800 clients had 20 or more visits. These are staggering numbers.

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I urge support for this bill not only to be more efficient with our healthcare dollars, but to truly bring better care to our citizens, so I urge adoption.

DEPUTY SPEAKER SAYERS:

Will you remark? Will you remark further on the bill as amended?

If not, will staff and guests please come to the well of the House. Members take their seats and the machine will be opened.

THE CLERK:

The House of Representatives is voting by roll.

Members to the chamber please. The House of Representatives is voting by roll. Members to the chamber please.

DEPUTY SPEAKER SAYERS:

Have all the members voted? Have all the members voted? Please check the board to see if your vote has been properly cast.

If all the members have voted, then the machine will be locked and the Clerk will take a tally. The Clerk will announce the tally.

THE CLERK:

House Bill 5378 as amended by House "A".

Total number voting 141

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Necessary for passage	71
Those voting Yea	141
Those voting Nay	0
Those absent and not voting	10

DEPUTY SPEAKER SAYERS:

The bill as amended passes.

Representative Larson.

REP. LARSON (11th):

Thank you, Madam Speaker, good evening. I rise for the purposes of an introduction.

DEPUTY SPEAKER SAYERS:

Please proceed, sir.

REP. LARSON (11th):

Thank you, ma'am. You know, the 11th Assembly District, many people may not know this, but it's clearly the most spirited district in the State of Connecticut. We have three of our largest beer distributors. We have Ten Penny Ale from Burnside Ice, Allen S. Goodman, and I would just like to recognize Roger Loeb who has been in my town for 55 years. He was kind enough to let you sample his spirits and I wanted to take an opportunity. Roger is over there next to Steve Mikutel. Fifty-five years.

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Also Calendar page 20, Calendar 488, House Bill 5222.

Moving to Calendar page 23, Calendar 504, House Bill 5309.

Also Calendar page 23, Calendar 505, House Bill 5484.

And on Calendar page 23, Calendar 506, House Bill 5487.

Moving to Calendar page 26, Mr. President, Calendar 519, House Bill 5375.

Also Calendar page 26, Calendar 520, House Bill 5471.

On Calendar page 30, Calendar 542, House Bill 5378.

Calendar page 33, Calendar 558, House Bill 5459.

And also we earlier today had placed Calendar page 37, Calendar 120, Senate Bill 237.

And one additional item, Mr. President, Calendar page 45, Calendar 158, Senate Bill 209.

So this would be our proposed Consent items at this time, Mr. President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, and if the Clerk would then read the items on the Consent Calendar for verification so we might proceed to a vote.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On Page 4, Calendar 273, Senate Bill 480.

Page 14, Calendar 435, House Bill 5044.

On Page 16, Calendar 450, House Bill 5371.

Also Calendar 451, House Bill 5373.

On Page 18, Calendar 464, House Bill 5293.

On Page 19, Calendar 471, House Bill 5374.

On Page 20, Calendar 472, House Bill 5380.

Calendar 488, 5222.

On Page 23, Calendar 504, House Bill 5309.

And Calendar 505, House Bill 5484.

Also Calendar 506, House Bill 5487.

And on page 26, Calendar 519, House Bill 5375.

Calendar 520, House Bill 5471.

Page 30, Calendar 542, House Bill 5378.

Page 33, Calendar 558, House Bill 5459.

On Page 37, Calendar 120, Senate Bill 237.

And on page 45, Calendar 158, Senate Bill 209.

THE CHAIR:

Thank you. Mr. Clerk. Please announce the pendency of a roll call vote and the machine will be opened.

THE CLERK:

An immediate roll call has been ordered in the Senate.
roll call on today's Consent Calendar has been ordered
in the Senate.

THE CHAIR:

Have all members voted? If all members have voted, please check the board to make sure your vote is accurately recorded.

If all members have voted, the machine will be closed and the Clerk will announce the tally.

THE CLERK:

On today's Consent Calendar.

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 1 passes.

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, would move for immediate transmittal to the House of Representatives of Senate bills acted upon today.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, would yield the floor to members for any announcements or points of personal privilege before adjourning and announcing tomorrow's Session.

THE CHAIR:

Any announcements or points of personal privilege? Announcements or points of personal privilege? Seeing none, Senator Looney.

SENATOR LOONEY:

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But, yeah, that's like a breath of spring.
Here it is Shrove Tuesday; you know, we got Ash
Wednesday.

REP. ZIOBRON: Yeah.

SENATOR KISSEL: Eventually, this Siberian cold is
going to get out of Dodge, and we're going to
be in better shape.

REP. MUSHINSKY: Yup.

SENATOR KISSEL: So, thank you.

REP. ZIOBRON: Yeah, I had to fix myself up
mentally, as well. The good news is driving
here, on the median I saw a lot of robins, and
I actually saw dirty grass, so I think we're on
our way.

REP. MUSHINSKY: Thank you for coming to testify.

REP. ZIOBRON: Thank you.

REP. MUSHINSKY: Any questions? Okay.

REP. ZIOBRON: I'd like to leave this passport with
you, if I could, Representative.

REP. MUSHINSKY: Thank you. Madam Clerk will take
it.

Next witness is Commissioner Patricia Rehmer,
of Department of Mental Health and Addiction
Services.

HB 5371
HB 5372
HB 5378

COMMISSIONER PATRICIA A. REHMER: Good afternoon,
Senator Kissel, Representative Mushinsky, and
members of the committee that may be listening
to this. I'm here to comment on House Bill

numbers with me right now; they're in another testimony -- but we have seen a large increase in the number of visits to that site and in the number of services that individuals are looking at. So that's a site on our web site that people can go to, and it will link. You can put in substance abuse in Wallingford, and it will tell you what facilities are nearby and available for what levels of care.

House Bill 378 [sic] requires DMHAS to contract for intensive case management services through our ASO for Medicaid clients who frequently use emergency departments. We have this practice in place already, so we have intensive case management through our ASO, based on utilization. So if somebody has come into the emergency room multiple times, has gone through a detox program multiple times, they are flagged in the system. When they arrive again in the emergency room or present for a detox, they are assigned an intensive case manager who works with them to ensure that they get the services that they need and stays with them over a longer period of time, so that it's not just detox, detox, detox, detox, but we're getting them the service that they need.

(HB 5378)

We started this practice, actually, before the ASO, when we were hearing that the emergency rooms were overcrowded with individuals who had substance use, and what we, and -- and what was happening at that time was individuals were being admitted on a psych, for a psychiatric admission, which is more expensive to the system. And often, really, it was a matter of they needed a safe place to go and they needed to know what the service system could offer them.

So we sent our regional staff managers in at

that point and they did a lot of that work. And now there's a partnership -- we have regional managers -- between the regional managers, the intensive case managers at the ASO that work together to try and, again, identify high utilizers of service and try and get them to a level of service that they need and then stay with them so that if there's some disruption in their care, we are aware of it and can facilitate an admission if needed or whatever is needed for them in the community.

And I would be glad to answer any questions that you have those about two bills.

REP. MUSHINSKY: Thank you.

I'm glad to know what's already set up, but I have to tell you, doing the casework that I do, I'm still having the experience of helping a family get into the emergency room for treatment. And they are released before --

COMMISSIONER PATRICIA A. REHMER: -- the case manager can --

REP. MUSHINSKY: Well, they're released back to their family or to the street before they are going into the bed -- sometimes there's a gap of a week -- and their discharge. And I -- I call a hospital and I try to talk them out of discharging the person, because the odds are good that there's going to be a relapse in that period --

COMMISSIONER PATRICIA A. REHMER: Yes.

REP. MUSHINSKY: -- after the detox period and the time at, for admission. The person is on their own for, you know, five days, seven days, and there's a very good chance they might relapse

while they're waiting to get their bed.

So, you know, from my experience, working in cases here, I think we're still not there. We don't have that seamless connection that in our research we found the U.S. Army, for example, does have a seamless system, so they can always find a bed for the person somewhere. It might not be immediately near the base but it's there, always find a bed. And we still aren't there yet in Connecticut is my experience.

COMMISSIONER PATRICIA A. REHMER: And Representative Mushinsky, if I can ask, is that adolescents or adults or both?

REP. MUSHINSKY: Adults.

COMMISSIONER PATRICIA A. REHMER: Okay. What I can tell you is that it appears to me when I look at our, I look at our bed capacity pretty frequently to see what our bed availability is, and so for somebody coming out of a detox, there should be a rehabilitation bed available. And so I can look more into that to see what the issue is.

And the other issue is that we should be able to use some transitional housing or recovery houses for individuals who are waiting to go into a rehab bed. But I also can understand how you're seeing what you're seeing, because I think the system that we have flags frequent fliers, and perhaps we need to expand that so that it's not necessarily that you've had to have had four detoxes before we're saying there's something that you need.

Under the old system, it wasn't a number of detoxes, necessarily, it was somebody in an emergency room that needed something, and the

intensive case manager from our department would help them find something. So I think maybe we need to wed those two approaches again, and that perhaps would address the issue of waiting for a bed. Because obviously our case, our regional managers know where the beds are, and I think sometimes we do have to talk to, people into perhaps going to other parts of the state, which has positive and negative implications sometimes. So I can look at that again.

REP. MUSHINSKY: I appreciate that.

Are there questions? Nope.

Representative Carpino.

REP. CARPINO: Thank you.

I just wanted to follow up. I think that bed availability or lack of availability, depending on the part of the state that you're in, would be important, because that's a concern that I -- I hear all the time. Middlesex Hospital is my local hospital, and it's a concern I hear from providers and families alike, so that would be helpful.

And if there's something that with can do to make this a more seamless, less painful process for people who are already in an emotional state, that would be helpful, and I'd be happy to help in any way I can.

I was also just going to ask you to follow up with us, if you could -- or a member of your staff -- the web site with the links. And I'd -- I'd love to see that count, because if that count is going up dramatically and consistently, I think that's important

information to get out there so if there, we have a resource that already exists, that we can share it maybe with a greater population.

COMMISSIONER PATRICIA A. REHMER: Sure; I can get that to you because I know I have it in another testimony.

Middlesex Hospital, by the way -- and I can't explain this -- is the 'highest in the emergency room, that sees the largest number of individuals with substance abuse issues. And one of the things that we have also worked with them to do is to put an individual in recovery in the emergency room, because we think that's very helpful sometimes in assisting individuals who may not be ready to go into a bed to talk to. But it is a concern in that area, so I am aware of that.

REP. CARPINO: And -- and I may ask you to follow up with that, maybe on one-on-one.

COMMISSIONER PATRICIA A. REHMER: Sure.

REP. CARPINO: Because that is a, my community and that is a --

COMMISSIONER PATRICIA A. REHMER: Sure.

REP. CARPINO: -- growing concern.

Thank you.

COMMISSIONER PATRICIA A. REHMER: Okay.

REP. MUSHINSKY: Thank you for coming.

Next, Gail Coppage, from the Board of Regents.

GAIL COPPAGE: Good afternoon.

appreciative of the Governor and the Legislature that had the -- the wisdom and the guidance and the support to provide \$17.8 million in state bond funds for the creation of the three new centers, and we feel that we have a responsibility as stewards of the public dollars to be able to come back and talk about the return on investment. So you'll be seeing that very shortly.

Thank you; thanks.

REP. MUSHINSKY: Thank you.

We have a -- a representative from Department of Social Services here, but I can't read who is it. So if the department is here, could you come forward? And give your name for the record, because it's not on the sign-in sheet.

Thank you.

KATE McEVOY: Good afternoon, Representatives and Senator.

HB5378

My name is Kate McEvoy; I'm the Director of Medicaid for the Department of Social Services.

ROBERT W. ZAVOSKI: I'm Rob Zavoski; I'm the medical director for the department, and that was my crummy handwriting.

KATE McEVOY: We can chalk that up to him being a physician.

We're very pleased to join you today to respond to you, specific legislative Program Review and Investigations Committee findings and recommendations that are included in the report entitled "Hospital Emergency Department Use and Its Impact on the State Medicaid Budget." The

report offers 13 specific recommendations, paraphrased below -- this is in our written comments -- with evidence supporting each recommendation.

After an overview of the department's approach to Medicaid services, our responses will track the order and format of the committee's report. I'm pleased to offer the synopsizing overview, and then Dr. Zavoski will walk through a specific response to the recommendations in the report.

Overall, we believe that the seminal finding in the report -- and I'm quoting -- is that although the committee concluded that emergency department visits by Medicaid clients are not a major cost driver of the overall Medicaid budget, especially on a per-visit basis, the committee believes that strategies need to be developed to educate clients in myriad ways to reduce high rates of utilization. If clients were able to access community health care for preventative care, health outcomes would be improved and clients would not cycle in and out of the emergency department.

We wholeheartedly concur with this conclusion, and we thought it would be useful to outline some of the strategies that, as of the launch of health care reform activities in DSS, are already in place and are actually evolving and progressing. And specifically, those include: Use of administrative services organizations for Medicaid, Medicaid medical, behavioral health, dental, and also nonemergency medical transportation services; activities in support of improving access to primary preventative care; efforts to support integration of medical, behavioral health, and long-term services and supports; and, initiatives

designed to rebalance spending on long-term services and supports.

We'd like to just briefly eliminate some of these strategies to illustrate how these contribute to consumer engagement in health care and diversion from use of ED services. So that we concur with the committee's conclusion that ED costs are not a major cost driver, we will as demonstrated below, show that we are deploying a large variety, a -- a broad range of interventions and programs to address overall ED utilization, both by educating and also reinforcing and supporting access to services and supports.

So just to briefly reinforce, we have entirely shifted all of the Medicaid medical, behavioral health, dental, and transportation services to what we call "ASO arrangements." This is most notably captured by the transition, January 1st of 2012, of our medical services from a blend of managed care arrangements to -- and also nonmanaged fee for service -- to this use of an ASO platform. And the key roles of the ASO include member services, provider referrals and support, management of all the prior authorization and utilization management strategies, but also some new and very important and consequential strategies, including use of data -- now wholly integrated set of data for the entire Medicaid population -- to support analysis and risk stratification of the Medicaid population, a process called "predictive modelling" through which the administrative services organization can identify those in highest need of support for intervention through what we call "intensive care management."

There is also a concerted effort to integrate

medical and behavioral health care, a whole-person approach, a person-centered, whole-person approach that supports the needs of individuals with co-occurring conditions. This is also a key aspect of our work with respect to diversion from ED in that so many individuals who ultimately do utilize hospital services also do have a presenting behavioral health condition.

In support of the intensive care management activity, our medical ASO, CHN, has a fully implemented process, an assessment tool that considers various basic human services needs as well as a whole range of traits of an individual that may help identify barriers to access to appropriate use of health care. They have developed a team of nurse care managers. They are geographically grouped, so they focus on areas of the state, and that is state-wide effort. And care managers also collaborate with our behavioral health ASO, Value Options, in support of individuals who have co-occurring needs; as I said, both medical needs and also behavioral health needs. And there, particularly important examples of this work include regular meetings among the staffs of the two ASOs to assess individuals who frequently use the ED and could benefit from intercepts, better supports, and access to care that would obviate the need for an ED visit.

In addition to the ASO work which, of which we're very proud and we are able to demonstrate has already yielded substantial improvement with respect to coordination of care and also diminution of the use of the ED, we are emphasizing a range of strategies designed to increase and reduce barriers to increase use of and reduce barriers to use of primary preventative medical care.

You'll see notations of these strategies in the written testimony, but key among these are a launch again, January 1st of 2012, of what we call our "Person-Centered Medical Home" effort. This is wide lauded across the country as a very successful support for primary care practices and practice transformation, practice transformation in support of enhanced access to primary care, more immediate, more timely, more comprehensive support by primary care practices who use such features as extended hours, use of embedded care management within the practices, and also after-hours support through other means, other means of contact other than an in-person visit; also, emphasizing the use of electronic health records to improve coordination, especially with other sources of care, specialists.

And the DSS program is not only providing technical assistance through our medical ASO to primary care practices but significant financial support, both in the form of enhanced rates and also performance payments that are associated with outcomes, health and client-satisfaction outcomes that are key features of where we want to see the entire Medicaid population's effort and outcome go to.

We are also supporting electronic health records in practices through a very significant amount of federal funding, over the course of the investment, over \$18 million investment in eligible professionals, which include a range of health practitioners and almost \$23 million to eligible hospitals. Electronic health records, again, intended to improve consistency so that there is a comprehensive source of information on a patient across providers and also to help with patient engagement,

ultimately using the EHR to provide a record of visits to patients, and that's something that is important to us also.

Finally we're involved in a range of health equity efforts through both our partner CHN and our other ASOs, intending to equalize the experience in access to care and receipt of care.

With respect to integration of medical and behavioral health care, we also have diverse strategies. Again, here the intent is to recognize a whole-person approach so as not to silo the intervention for individuals across types of care. And notable features of our integrative efforts include a major demonstration effort, oriented toward individuals who are eligible for both Medicare and Medicaid coverage, to create an enhanced intensive care management feature through our medical ASO as well as support for local networks of providers in better coordinating care for these, what we call "dually eligible individuals."

We are also collaborating with our sister department, the Department of Mental Health and Addiction Services -- I know you just heard from Commissioner Rehmer -- on a project called "Health Homes," which has similar goals, coordination for individuals, particularly with serious and persistent mental illness who may not have received optimal support for their medical needs and again focusing on the opportunities under the Affordable Care Act for enhanced funding in support of this coordinative care model.

Finally, Dr. Zavoski and colleagues have championed an effort to endorse more universal

behavioral health screening for young children, actually children ages 1 through 17, as part of our EPSDT benefit in Medicaid. Again, early identification and then connection of children in need with behavioral health services is a particular strategy that we feel is optimally related to supporting children, especially with trauma-informed intervention, again obviating the need in many cases for adult services for those people, potentially through the ED.

Finally, our third category of health reform activities relate to what we call "rebalancing of the long-term care system." Historically, you may be aware that Medicaid's presumption was that funding for long-term services and supports would occur in an institution, and the presumption was that that funding would be used for that purpose. States had to ask essentially for exceptions, which are called "waivers" to support people in Medicaid, in community based services. And Connecticut has a range of these so-called waivers, supporting populations including older adults, people with behavioral health conditions, people with intellectual disabilities, and people with autism, as well as children with severe, serious medical illness and disability, that we are very much at the forefront in Connecticut with shifting resources from institutional settings and enhancing the choice of consumers in long-term services and supports through a range of interventions that include our Money Follows the Person program. Money Follows the Person enables individuals who may have been inappropriately placed in a nursing facility to transition back to community based living.

We're also, however, supporting institutions, diversification of nursing facility services through bond funding, are grateful for the

Administration's support of this type of initiative and also for support for community education through new, web-based efforts, as well as a comprehensive education campaign that will increase knowledge, public knowledge of the need for planning for long-term services and supports and also identify key, both private and public resources.

We finally wish to point your attention to the fact that are significant new resources under ACA for these efforts, support for long-term care rebalancing, through enhanced match and some of the other efforts that we're undertaking, particularly enhanced rates for primary care physicians that are all amplifying the capacity of the Medicaid provider network to serve people in preventative, community based settings.

And that's where Dr. Zavoski will segue to talk about specific aspects of our responses to your recommendations.

Thank you.

ROBERT W. ZAVOSKI: Thank you.

I had or the department has forwarded a formal reply on Friday to the committee that includes electronic copies of the brochures that the -- the report's first recommendation calls for, so I hope you've had a chance to look at all of those.

I think it's important to recognize that the -- as the -- the report does -- that there's many, many reasons that folks use emergency departments. And in order to be able to impact that -- she agrees with me -- we have to be able to address each of them. And but

fundamentally, there's one, major fundamental reason that folks use the emergency department to a large degree in Medicaid; that's because they're sicker. Our clientele has a much, much larger burden of chronic disease, disability, and other chronic, and other chronic problems, including mental illnesses and behavioral illnesses, comparatively in the commercially insured population and the -- the uninsured population. And so for many reasons, they should be using the emergency department for care.

But recognizing also, as socially, that everybody in Connecticut uses the emergency department for a, far more often than they ought to, is because essentially the emergency department is the hallmark of care right now. And if we're going to impact this care, as we've striving to do by improving access to primary care, medical homes, et cetera, that's what we're competing with. Emergency departments are open 24/7; don't need an appointment. If you have a job that does not allow you to take off, as many of our low-income earners have, you have to find time between jobs to be able to get to the emergency department; you don't need an appointment.

Furthermore, if you go see your primary care provider and they order a lab test, that's another appointment, or if you need imaging, x-ray; that's a third appointment. They -- they can get it all at one time.

And if you need a specialist, they may even send the specialist into the ED to see you. And so for many reasons, folks use the emergency department, especially in Medicaid, for very real needs, and that's what we're, that's what we're competing with. And,

frankly, if you're in the emergency department long enough, they'll even feed you.

The department, the -- the report also recommends that the -- the Medical ASO analyze and -- and that the department require a number of reports. We agree with that and many of those reports are already in place. Some of the others, recommended reports are in development, but we're moving forward on that. And I think Connecticut is very uniquely situated to be able to do that reporting, because we're unique that we have one set of data now. And I think the committee should recognize that the ASO model of care we have is one-stop shopping. It means that providers only have one place to call; recipients only have one place to call. But the state only has one place to call to get the data it needs to understand what's going on.

Kate had mentioned an initiative we're developing around universal behavioral health screening of children. Massachusetts was mandated by the courts a few to go, a few years ago to do that, and so it's the one program in the country that has a track record and is able to look at outcomes, with one little problem. They had multiple sources of care; they have multiple MCOs, and so they can't get their own data. Connecticut didn't have that problem; we're able to get the data, so the reports that you ask for and call for here, we're developing, and we'll be able to use those reports to better manage the program.

One of the recommendations in the report talks about our attribution methodology, and it discusses it in a way that I think misinterprets what we're trying to do; and I think that bears some explanation. Under the

old management care system, the MCOs used to assign patients to providers. And at one time, I actually had the largest panel of Medicaid patients and children in the state, and I used to get these reports fairly regularly, at first. That would give me a list of patients that were mine and what they needed, and I would go through that list and I would recognize maybe a third of the names.

And we would go through, trying to find out, okay, who -- who all these folks are, have we ever seen them, where they're going; we could call them, et cetera. And we very rapidly realized that the assignments had no relationship to reality; folks go where they go and where they can go conveniently to seek care.

It also made it very interesting, because sometimes I would admit patients to the hospital and I would ask them, Who's your primary care provider? And they would say, Dr. Zavoski. And I'd say, That's really interesting; could you describe Dr. Zavoski for me? And sometimes he was a tall, blond-haired woman and sometimes I was an Indian man. They never knew who their primary care provider was.

In our new system, we're attributing patients to a primary care provider. What that means is we wait until our recipients seek care, and then we collect all the information about that care and we get it to their provider so that they can use it, so that they can better coordinate that care and direct that care. So we let them vote with their feet. And so it's not a prospective sort of a thing; that doesn't work. It's a retrospective sort of a thing that we're doing, so that the information gets to where it needs to be.

The problem is that if we were to try to put someone's name on the CONNECT card prospectively, we'd be going back to the old system that doesn't work. And, frankly, very few insurers put PCP name on a card anymore, because it's very expensive and you end up chasing your tail because people go different places. Very often, the PCP retires, et cetera, et cetera.

It's also a barrier to care. If my name is on your card and you go see somebody else, they'll look at the card and say, Oh, wait a minute; maybe we can't see you or if we do see you, maybe we won't get paid. You need to go to this doctor who's on your card. Very often I used to get phone calls from specialists. Your name is on somebody's card; we need a referral. I've never seen the patient before. I have no idea what they're being referred for nor should I. So the -- the name on the card starts to get you back into some very bad areas where you're continually spinning your wheels, and yet there's no value added. And so that's why we've gone to the attribution methodology, so that retrospectively we see where folks are going and we send the information where it needs to be.

The port, the report also notes that there was a decline in the attribution rate recently, and the simple reason was that attribution is a methodology. We use a computer program to try to identify where folks are going, where they're getting their primary care, using certain codes, trying to find out which kind of doctors are seeing which patients, where, et cetera, and trying to use the computer to get them where they need to be. It's not perfect. It will never be done. As we learn more about

the system, more about patients, and as the codes change, we will refine it.

When we looked at this last summer, we realized that the original methodology might have had a flaw in it that might -- now I've underlined "might" -- disclose personal health information to the wrong provider. So we made an adjustment, recognizing that the number of people attributed would go down a little bit but that we wouldn't make a mistake by sending information where it shouldn't be.

The report also notices that only about two-thirds of our patients are attributed to a primary care provider and that that's a very low number. Actually, I think that number is great, because many, many, many of our Medicaid recipients have other insurance. And the claims for their primary care go to that other insurance first, so we never see it. Many of our recipients also are in long-term care facilities, and so there aren't primary care claims there as well. So the fact that we have two-thirds of our clientele attributed, essentially within two years of the methodology going live, I think is tremendous. And we're quite proud of it.

I think I'm going to leave it there, because we've been up here for a long time. We have submitted testimony today but also an electronic copy from the department, last Friday, that goes through quite a bit of this.

But if there's questions that either Kate or I could answer, be happy to do that.

REP. MUSHINSKY: Okay. Thank you for coming and for detailed testimony.

I -- we are pushing you to continue to reduce the overuse by Medicaid recipients of the emergency room, and we found that that use is twice as high as general population. And I know you gave some reasons for that, but Middlesex Hospital did tell us that with a concerted effort, they were able to reduce their return visits by case management of their clientele. And they based on their success, we're anticipating we can reduce our costs by 2.2 million a year, which is not small change; you know, it's significant, so we're using their success and trying to replicate that in the hospitals around the state.

One question I did want to ask you, and in our set of 13 recommendations, one of them was for DSS to immediately seek an amendment to its 1115 Waiver from the Centers for Medicare and Medicaid Services, to implement 12-month, continuous eligibility for the Medicaid recipients. Are you doing that?

KATE McEVOY: You know, Representative Mushinsky, and regrettably, we have no 1115 Waiver in place right now. I think there may be some error of understanding of the current array of waivers and demonstrations projects with the department. The department had sought an 1115 Waiver to adjust coverage for the HUSKY D or LIA population, but that denied by CMS. So there is no standing vehicle through which we would do that.

I know there is currently pending a bill in the Legislature to seek the result that you mentioned; that is the continuous eligibility. And the department has submitted testimony; the commissioner has submitted testimony on that, with respect to the benefits for continuity of care; we certainly acknowledge that, but then

the exposure for the additional costs associated with it, the continuous eligibility. And we'd be happy to forward that under separate cover.

REP. MUSHINSKY: Thank you. And thank you for sending the brochure that we were looking for in Recommendation No. 1.

And I also wanted to ask you, we had recommended using mystery, a mystery shopper survey of the primary care providers and specialists to see if the wait times are different for the folks on Medicaid and to measure the ease of access.

ROBERT W. ZAVOSKI: We do several surveys on an annual basis, one of them being a mystery shopper. We also do the CAHS survey -- which is C-A-H-S, and I forget what the acronym stands for -- but essentially assessing people's inability to get into care and whether folks are able to, are -- are taking new clients so that we -- we are in the process. I think I have a meeting on Friday to finalize the plan for this year's mystery shopper.

REP. MUSHINSKY: Okay; that's good.

And then Recommendation No. 7, we were trying to get the department to engage in at least one demonstration project for specialist services delivered by a telemedicine or telehealth model.

ROBERT W. ZAVOSKI: We would love to do that. We, as you know, there is a program down in Middletown with the community health center there that has been doing this for some time. And the department working with the University of Connecticut, we have a -- a new Medicaid

collaborative, which has been put into place, established by both, to look at programs and research, et cetera, that will benefit the Medicaid program. The very first project of that collaborative is to do an evaluation of the Middletown Telemedicine E-Consult program, both from the point of view, was it effective, was it safe -- which I think is a key question -- and then if we were to go forward with it in a broader fashion, what the -- how to price it. And so Dr. Azeltine at UCONN has been working for the past several weeks to pull that together, and we hope to have some results, probably within the month. It is our hope to go forward with something in a broader fashion, somewhat towards the end of the year.

The group that's been working on this also announced, on Friday, that they received a grant from a foundation to do a demonstration expanding this as well, with a comparison in a, with a program up in Maine. So the department is invested in this and very interested in it and pushing for it.

REP. MUSHINSKY: This is all good; thank you.

KATE McEVOY: May I just add, very briefly?

REP. MUSHINSKY: Sure.

KATE McEVOY: It is, it's auspicious that, you know, we have this partnership with the university and are able to explore private sources of funding, because one of the constraints in Medicaid is that it is not permissible for us to do demonstrations, per se. We have to show that services are offered on a statewide basis, uniformly. So often, as you know, historically there's been an investment of either state or private resources that essentially seeded the

experience of a new initiative, such as this, and demonstrated the efficacy of it, and then we've been able to amplify it statewide, using Medicaid dollars.

That said, there are numerous precedents in other states for use of Medicaid for the telemedicine, both for the patient and practitioner consults, but also, excitingly, to PCP, to specialists consults, and also grand rounds approach. So there's a lot of potential here that we agree is very, very fruitful.

ROBERT W. ZAVOSKI: And I would add that the -- the March or February issue of "Health Affairs," for the policy walks in the room is largely about telemedicine, and it was very gratifying to read that a lot of what's spoken of there is what we're putting into place, that yes, this is a promising technology; yes, this is a way to potentially bring work here to more people. But it needs to be done in a way so that the quality of care is maintained, that the patient's safety is maintained, and also that the financial incentives are lined up properly. And we're not there yet. We're working on it but if you read the journal, a lot of great ideas out there, but they're -- they're all maybes and could-bes and we need to check outs.

REP. MUSHINSKY: Okay. Well, thank you.

If you have that handy electronically, you could send it to our PRI Committee, and then we can circulate it among the members.

ROBERT W. ZAVOSKI: Unfortunately, I'm old-fashioned and insist upon the print version.

REP. MUSHINSKY: Okay.

ROBERT W. ZAVOSKI: But I'll see --

REP. MUSHINSKY: Well scan it.

ROBERT W. ZAVOSKI: -- what I can do; yeah.

REP. MUSHINSKY: Have somebody scan it.

A VOICE: (Inaudible.)

REP. MUSHINSKY: Send it to PRI, and then we'll --

ROBERT W. ZAVOSKI: Yes, Representative.

REP. MUSHINSKY: We'll have all the committee read it; we appreciate that. Appreciate that, because we -- we can't possibly cover all the medical literature as well as all the other stuff we have to read; we -- we just can't, so --

A VOICE: (Inaudible.)

REP. MUSHINSKY: -- please send it to us and we will look at it.

Thank you.

Are there questions?

Senator Kissel.

SENATOR KISSEL: Just briefly, Kate, you and I go way back.

KATE McEVOY: Absolutely.

SENATOR KISSEL: I remember we were on a Select Committee on Aging.

KATE McEVOY: It's so --

SENATOR KISSEL: And we were --

KATE McEVOY: -- nice to see you, Senator.

SENATOR KISSEL: Nice to see you as well.

But I'm just wondering -- this is for my own, personal edification -- how long have you been at DSS? I've lost track and it's like, it seems like you're in a new role now.

KATE McEVOY: Yes. I -- I'm at DSS for two years, so, and recently appointed Medicaid Director. Rob is, as he said, the Medical Director, so we're colleagues in leadership in Medicaid.

SENATOR KISSEL: Well, congratulations. Your presentations, both of you, were extraordinarily detailed.

ROBERT W. ZAVOSKI: Yeah.

SENATOR KISSEL: You know, sometimes we get maybe a little ahead of ourselves because we don't know all the nuances and the details, but that's why these public hearings are so important, so that we can fine-tune. But I think we're all sort of rowing in the same direction, and we want what's best for the people of the State of Connecticut, so thank you.

KATE McEVOY: Absolutely.

REP. MUSHINSKY: Thank you for coming.

We're going to move --

KATE McEVOY: May I? I just had one comment. I --

REP. MUSHINSKY: Sure.

KATE McEVOY: -- beg your pardon, because I know there are many other speakers --

REP. MUSHINSKY: Sure.

KATE McEVOY: -- waiting to offer their testimony.

I want to affirm what you said about Middlesex Hospital and just reinforce how strongly we concur with respect to use of care coordination and just to say again, and marquee feature of the ASO arrangement, particular for medical services, is that intensive care management service.

We've recently been able to report to the Medical Assistance Program Oversight Council that the ICM function has had a significant effect for those served -- and that's about 40,000 individuals -- in diverting people from the ED and also reducing inpatient admission. And we'd love to share that report with you as well, because that does illustrate the immediate, the near-term impact of that intervention but also speaks to the overall integration of strategies that DSS is using.

REP. MUSHINSKY: Thanks for coming in.

KATE McEVOY: Thank you.

ROBERT W. ZAVOSKI: Thank you.

REP. MUSHINSKY: You know we've been joined by Senator Eric Coleman, of Bloomfield. Maybe a few more will trickle in; we'll see as we go.

So if there are no other agency folks, we move on to the public list. And the first witness is Hue Galloway, followed by Laura Green.

we found the same thing.

Anyway, we -- we do appreciate your coming in and testifying. I know it's hard and appreciate that you're strong enough to do that. And even if you just send one copy of your testimony, that's fine; we can scan it in. And if you want us to get in touch with you as the bills move --

ANA M. GOPOIAN: Uh-huh.

REP. MUSHINSKY: -- give us your e-mail too; okay?

ANA M. GOPOIAN: Thank you.

REP. MUSHINSKY: Questions?

Okay; thanks.

ANA M. GOPOIAN: Thanks.

REP. MUSHINSKY: Next witness is Peter Strauble, Struble, followed by Efrain Madera.

PETER J. STRUBLE: Good afternoon, Madam Chairman, committee members.

My name is Peter Struble. I'm a resident of Wallingford, recently retired as the fire chief here in Wallingford. And the Wallingford Fire Department is, provides emergency medical services, paramedic services and transport to emergency departments. Now I'm working with the University of New Haven, doing work with prehospital care in paramedicine.

I'm speaking in support of Bill 5378, at least in concept, as it raises an important discussion we must begin to have about health care. My purpose in testifying at this hearing

is to ensure that the committee is aware of an important community resource that should be considered when seeking solutions for reducing both emergency room visits and hospital readmissions.

We already know that programs focused on high-risk populations can reduce hospital readmission, reduce costs, and increase the interval between discharge and the need for readmission to a hospital or a visit to an emergency department. Emergency medical personnel are uniquely positioned within the existing infrastructure to interface with patients at every phase of their care, from the point of injury or illness through their convalescence.

Any discussions in health care that focus on preventative care outside the hospital should, at the very least, consider the prehospital emergency care provider's role. This concept is nationally known as "community paramedicine." Community paramedicine is a paradigm shift for the use of paramedics in the United States. It's an emerging model in which paramedics function outside their usual emergency response and transport roles, delving into the world of primary care. As the health care world increasingly shifts toward prevention and well-care, the system will increasingly demand more folks that can function in the community health, primary care, and prevention role.

Community paramedicine is increasingly becoming recognized as a promising solution to efficiently increasing access to care, especially for underserved populations. The entire prehospital care industry in Connecticut is based on a transport model. Patients are

highly encouraged to go to the hospital by EMTs and paramedics, just in case there's a problem. Connecticut's state Office of Emergency Medical Services regulations do not allow treat and release, alternate transport destinations, or any form of community paramedicine.

If a Medicaid patient calls 9-1-1, no matter what case management has been done with that patient, it is highly likely that that patient will be transported to the hospital in an ambulance, under the current system, because the providers legally have no choice. I am concerned that Connecticut is behind the curve in innovative solutions that utilize prehospital care providers as part of a team approach.

I would encourage this committee to reach out to your colleagues on the Public Health Committee and engage in discussions to encourage the development of community paramedicine models for Connecticut. I would also encourage you to take an innovative step at, at least identifying local, prehospital care providers as potential members of case management teams, as referenced in this piece of legislation.

And, lastly, I'd like to thank you for having this hearing here. The last and first time that I testified was in Hartford, and I spent 10 hours in a, in a hearing room before I got up to be able to testify. So this is a great outreach that you do.

Thank you, very much.

REP. MUSHINSKY: Thank you, former police chief -- fire chief.

First of all, I have to apologize for abusing your name; I didn't realize it was you. And I thought -- and I couldn't read your writing -- and I thought it said Peter Stauble, so I -- I apologize for that.

PETER J. STRUBLE: I've had worse.

REP. MUSHINSKY: Now, then you threw me because you didn't wear your uniform. Now that you're working at UNH and you don't have the fire chief uniform, that threw me too. So I apologize for abusing your name.

But community paramedicine, that's very interesting, and it sounds like it would be not only efficient, work better; well, it sounds like it would save us money too. So we will check that out. Is anybody on our committee also on Public Health? Yeah, I --

PETER J. STRUBLE: If I --

REP. MUSHINSKY: -- don't, I don't --

PETER J. STRUBLE: If I could --

REP. MUSHINSKY: -- think anybody is.

PETER J. STRUBLE: -- if you want to take a look at a model, Maine --

REP. MUSHINSKY: Okay.

PETER J. STRUBLE: -- of all places just started twelve pilot programs. So they didn't delve into it with both feet until they knew -- because it is very new -- but they developed twelve pilot programs and issued twelve licenses to agencies that were ready to perform. And they're -- they're looking at it

as a year-long study with twelve pilot programs.

Other programs around the country, Mesa, Arizona, for example, are being very, very successful with this and -- and having, you know, huge benefits to patients by -- by not having them consistently going through the -- the ER all the time and -- and getting into that system.

REP. MUSHINSKY: This is good. So thank you; we'll check this out.

PETER J. STRUBLE: Thank you.

REP. MUSHINSKY: And I also want to give a credit to Speaker Sharkey, who is the one that told us to do some road hearings. So -- so we're -- we're here because Speaker Sharkey said get out into the field; don't have them all in Hartford.

PETER J. STRUBLE: Thank you.

REP. MUSHINSKY: So thanks for coming.

Efrain Madera, followed by Daniela Giordano.

EFRAIN MADERA: Good afternoon, Madam Chairman and committee.

I thought being on the board members of my community -- community was extensively hard, but this is quite difficult, what I've been hearing. You have a lot of challenges before you.

My name is Efrain Madera. I am currently a student in the social work program at Southern Connecticut State University, writing in support of the H.B. 5374,^o which has already

one of the things we discuss in the testimony -- and that's addressed pretty extensively in the report -- is that it really isn't just DCF who bears a responsibility for these children, because by virtue of the fact that they're aging out of care, many of them will be transitioning to the support of other state systems because of the trauma and other things involved with their foster care experience. And so we really think that it's important that, at minimum, DSS, SDE, DOL, and DOH are able to address the health care access, education, labor, and housing concerns of the report and that the report also be submitted to the relevant committees of the Legislature that have oversight over those agencies.

REP. MUSHINSKY: Okay; that's explicit enough. Thank you.

Are there any questions? Nope.

We'll check out that bill in the Children's Committee.

KENNETH FEDER: Yeah. Thank you, very much.

REP. MUSHINSKY: Dr. Laine Taylor, followed by Sonya Wulff.

SB 202

LAINE E. TAYLOR: Good afternoon. Thank you, so much.

My name is Dr. Laine Taylor; I'm a child psychiatrist. I'm representing the Connecticut Council of Child and Adolescent Psychiatry. As a child psychiatrist, a Connecticut resident and a, an advocate for children, I am speaking in support of House Bill 5371, 5372, 5373, and 5378.

As very well stated by Ms. Giordano, the greatest gap for access to mental health care within the state is from middle-class families with private insurance. The accessibility to provider's programs and the adequate length of treatment hits our working-class families the hardest. Connecticut has a safety net for its poor through the use of HUSKY, and the wealthy of the state are able to access fee-for-service treatment. This gap in care is relevant for all medical care but impacts mental health care to a greater extent. We're enthusiastic about the efforts within the state, both within the Legislature as well as the Governor's Office to improve access to mental health care.

With regards to House Bill 57 -- 5371, we'd like to speak, specifically speak to the in-home services as well as reporting by private insurances. To make this really brief -- it's been a long day for you guys -- we'd like to support the report, reporting the use of state funding for in-home services by those with private insurance, to provide the state with information and determine further necessary steps to make this service accessible even within that access gap I just mentioned.

In-home services are crucial for many families, and it's only accessible to those who have HUSKY insurance. Even private-pay, you're unable to access it. Many of our families wind up having to utilize our state funding in order to access in-home services.

With regards to House Bill 5372, I want to speak specifically to substance abuse. And as a clinician who cares for children and families who struggle with substance abuse, hearing the testimony earlier today from those who -- who

while, most importantly, serving our children and families' quality of service options. So thank you for that.

Finally, with regards to House Bill 5378, there are two areas in which we'd like to comment. Firstly, we'd like to make a comment on the telehealth demonstration project. We're very much in support of this and we actually think the telehealth and telemedicine services will greatly increase access to care, both within our urban and our rural communities here in the state of Connecticut.

Many states are already utilizing telemedicine and telehealth, and as a child psychiatrist, specifically there are pilot programs that have been developed by Value Options through Yale University to improve, as a, as a pilot program for primary care connecting with child psychiatry subspecialists.

So we are very much in support of this and we would like to specifically recommend that the language not include the use of "audio telephone" and "facsimile." There's also a similar bill, Senate Bill 202, which is being discussed at the Insurance company -- Committee on Thursday.

Lastly, we're in support of the extension of Medicaid Insurance for up to one year after a family no longer meets criteria for this program. Many of the children and families that we serve utilize programs only offered if coverage is provided by HUSKY Insurance. We want to encourage the families to not rely on state funding for care, but an abrupt change in payer often means abrupt change in availability of services.

As an example, I mentioned earlier that in-home psychiatric treatment is only available to families with HUSKY. If there's a change in eligibility within that family, there can be an abrupt discontinuation of that service. And that service is -- is specifically targeting high-risk families who have high mental health service needs. So a year bridge of care will allow for adequate planning, based on what is offered within their new, or their new insurance company, so that the family and the treatment team can plan appropriately.

Thank you, so much, for the opportunity to voice our support for these bills.

And please feel free to contact our organization for further communication.

HB 5378
SB 202

REP. MUSHINSKY: Did I hear -- thank you -- did I hear you correctly that you do not want us to include audio telephone or fax?

LAINE E. TAYLOR: Correct.

REP. MUSHINSKY: Why?

LAINE E. TAYLOR: Many of the -- the language from many other states that have implemented telemedicine bills do not include those, and from our perspective that broadens it too much.

And if we're talking about rates, which I think is actually a really important discussion, setting reimbursement rates, that we want to do it alongside with what matches a face-to-face consultation or face-to-face interaction. Telephone and a facsimile is not, is not commonly used with a medical practice and isn't reimbursable otherwise; we don't believe it should be a reimbursable through the

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PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE

March 4, 2014
3:00 P.M.

telemedicine.

REP. MUSHINSKY: Because it's not face-to-face, so
it's not as valuable.

LAIN E. TAYLOR: Right.

REP. MUSHINSKY: Okay.

LAIN E. TAYLOR: Exactly.

REP. MUSHINSKY: I got it. Thank you.

Any questions? Okay.

Thank you, Dr. Taylor.

Sonya Wulff, followed by Scott Gray.

SONYA WULFF: Hi. Hi.

This is my first time at a committee hearing
like this, and I appreciate the opportunity,
and I appreciate you guys. What an education
on the scope and depth of the topics and issues
that you deal with on a regular basis; my
goodness. So thank you for all your work and
your service.

I'm here to voice support for H.B. 5369 and
H.B. 5370, to utilize the parks' revenues back
in the park system versus going into a General
Fund. I definitely agree with a lot of the
people who testified before that gave testimony
before that, you know, the more the better.
Fifty percent is -- is better; a hundred
percent would be ideal.

I've lived in Connecticut most of my 49 years;
I reside here in Wallingford and enjoy hiking
and camping, kayaking, every, you know, all

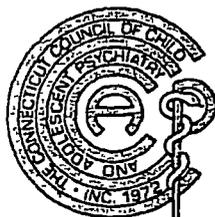
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**Connecticut
Council of
Child and
Adolescent
Psychiatry, Inc.**

March 4, 2014

Testimony in Favor of HB 5371, 5372, 5373, 5378

Good afternoon Senator Kissel, Representative Mushinsky and Program Review and Investigations Committee Members



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Joan Narad, MD
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Executive Director

I am Laine Taylor, DO, and am speaking today in my capacity of Executive Committee Member of the CT Council on Child and Adolescent Psychiatry. The greatest gap for access to mental health services within this state is for the middle class families with private insurance. The accessibility to providers, programs, and adequate length of treatment hits our working class families hardest. Connecticut has a safety net for its poor in the form of HUSKY and the wealthy of this state can access fee for service treatment. This gap in care is relevant for all medical care, but impacts mental health care to a greater extent. The state of Connecticut is realizing the importance and wide reaching impact of mental health and access to mental health care for all individuals over the past year. Much of the effort to improve access has been for children and their families. This is seen in our state legislature's enactment of several laws including PA 13-3 and PA 13-178 which deal in the innovative efforts at delivering mental health screening and interventions to children. This is also seen through the Governor's administrative efforts and collaboration with the Office of the Health Care Advocate. As a Child and Adolescent Psychiatrist, representative of the Connecticut Council of Child and Adolescent Psychiatry, and a Connecticut resident, I am speaking in support of HB 5371, 5372, 5373, and 5374.

Our statements in support of each bill are as follows:

Regarding HB 5371:

As any parent is aware, a child does not exist in a vacuum. The environment of a child includes school, peer interactions, and family. One of our most effective therapeutic interventions is the In-Home therapeutic service. This entails a licensed clinician entering the home to evaluate and address the behaviors of a child within the family structure. It provides the child, family, and clinician with a perspective unavailable through clinic visits. This intervention is not appropriate for all children, but is reserved for children with whom other interventions have been unsuccessful. Currently this is only available to family with HUSKY insurance or DCF voluntary services. The only current access to Intensive In-Home Child and Adolescent Psychiatric Services is through the use of state funding sources. It is the position of the Connecticut Council for Child and Adolescent Psychiatry that this level of care be available to all children within the state, including those with a private insurance payer. Reporting the use of state funding for in home services by those with private insurance will provide the state with information to determine further necessary steps to make this service accessible even within the access gap.

Regarding HB 5372:

The council also supports the development of a council in the administration to review policies and access to substance abuse care for all individuals. There is a deficit of services for individuals who struggle with addiction and their families. It is our hope that policies reviewed and developed by the council will promote access and implementation of evidence based treatments. With that in mind, the council reviewed the individuals named to the council. It is evident that policy makers, the justice department, and social services are well represented. We would like to additionally recommend appointment of a substance abuse medical specialist representative to help the policies to reflect clinically accurate decisions as other areas impacted by substance abuse are represented on this council.

Regarding HB 5373:

The Council is also in support of this bill as it improves transparency of the policies of individual private insurers. With the implementation of the Affordable Care Act, more Connecticut residents will be members of private insurance panels. There are great differences in coverage between plans. Regular reporting of insurance practices to the state will not only allow policy holders to be aware of the practices of their and other insurance companies, but it will provide data for future improvement of care. In recent years, the reporting of this data to various legislative task forces supplied policy makers with factual information as they evaluated the efficacy of programs and previous legislation. We believe that transparency will best serve the public and private sectors while, most importantly, serving our children and families with quality service options.

Regarding HB 5378:

The council is in support of HB 5378 and we would like to comment on two areas which we explicitly support.

1. We agree with the inclusion of a telehealth demonstration project to evaluate efficacy and to set reimbursement rates. The Council has evaluated several active pilot programs in telepsychiatry, including those funded by Value Options of Connecticut. To this point, the pilot programs have shown great utility in increasing access for patients to child psychiatrists. Additionally, the programs have improved coordination of care and facilitated consultation between primary care clinicians and child and adolescent psychiatrists. We believe that setting rates equivalent to face-to-face reimbursement would promote the use of this medium for healthcare delivery. We would like to specifically request that the definition of telemedicine not include audio use of telephone or facsimile.
2. We are in support of the extension of Medicaid insurance for up to one year after a family no longer meets criteria for this program. Many of the children and families that we serve utilize programs only offered if coverage is provided by HUSKY insurance. We want to encourage the families to not rely on state funding for care, but an abrupt change in payer often means an abrupt change in availability of services. As an example. A family who is originally covered by Medicaid is eligible for Intensive In-Home Child Psychiatry Services, if the employment or income status of the family changes such that they are not Medicaid eligible, the In-Home service ends. This disrupts treatment for the child and family. A month bridge of care will allow for adequate planning based on what is offered by the new insurance company.

Thank you for the opportunity to voice our support for these bills. Please contact our organization for further communication.

Testimony in Favor of HB 5371, 5372, 5373, 5378

From: Laine Taylor, DO of Connecticut Council of Child and Adolescent Psychiatry

To: the members of the program review and investigations committee

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STATE OF CONNECTICUT
 DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

Dannel P. Malloy
 Governor

Patricia A. Rehmer, MSN
 Commissioner

Memorandum:

TO: Senator John Kissel
 Representative Mary Mushinsky
 Members of the Program Review and Investigations Committee

FROM: Commissioner Patricia Rehmer, DMHAS

DATE: March 4, 2014

SUBJECT: Written Testimony on HB 5371, HB 5372 and HB 5378

Senator Kissel, Representative Mushinsky, and distinguished members of the Program Review and Investigations Committee: thank you for the opportunity to submit written testimony on HB 5371 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE STUDY ON ACCESS TO SUBSTANCE USE TREATMENT FOR INSURED YOUTH AS THEY RELATE TO THE DEPARTMENT OF CHILDREN AND FAMILIES, HB 5372 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE ALCOHOL AND DRUG POLICY COUNCIL and HB 5378 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS. We commend the Committee for its comprehensive work on these very complex issues but have concerns regarding the cost of the implementation of these proposals as well as the prescriptive language that may prevent us from meeting the individual needs of the people we serve.

HB 5371 requires DMHAS and DCF to develop an urgent care center for individuals with behavioral health disorders and a substance use recovery support plan for youth and adolescents. It is important to state from the onset that DMHAS provides treatment to adults 18 years of age and older. We do not have the facilities, resources or clinical expertise to treat youth and adolescents. That being said however we are more than willing to collaborate with DCF on both development of an urgent care center which we believe can be established through the coordination of each agency's mobile crisis units as well as the development of a substance use

recovery support plan and appreciate that the Committee has given us sufficient time to work that through.

HB 5372 gives new responsibilities to the Alcohol and Drug Policy Council (ADPC), and the ADPC is not a functioning organization. The last two meetings of the Council had very little attendance and the legislative appointments to the council frequently have not attended meetings so the end result will be that the work necessary to carry out the new responsibilities outlined in this legislation will fall to DMHAS. We have not had the money in our budget to fill the administrative and planning positions that would be necessary to carry out the new provisions in this bill.

HB 5378 requires DMHAS to contract for intensive case management services through our ASO for Medicaid clients who frequently use hospital emergency departments due to behavioral health needs. This practice replicates successful local efforts in the state which have regional teams currently in place and supports efforts already underway to start up additional teams based in community with the heaviest usage of Emergency Departments for behavioral health. Value Options currently has intensive case managers in place to implement these activities and can use Advanced Behavioral Health as a model to provide targeted case management for individuals cycling in and out of inpatient detox services. We do not believe it is necessary to spell out how often these teams should meet as teams that have been working together for a long time may decide they will meet less often than teams that are just coming together.

"Oral Health for All"



March 4, 2014

Program Review and Investigations Committee Testimony

Raised Bill No. 5378: AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.

Senator Kissel, Representative Mushinsky and other distinguished members of the Human Services Committee,

I want to thank you for this opportunity to address H.B. 5137. I am Mary Moran Boudreau, testifying today on behalf of the Connecticut Oral Health Initiative, the only oral health advocacy organization in Connecticut with a vision of "Oral Health for All." I am a resident of Windsor.

We are asking you to support Raised Bill No. 5378, An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee concerning Medicaid-Funded Emergency Department Visits. The proposed changes to Medicaid enrollment addresses the issue of lost coverage due to changes in circumstances, such as income and family size.

Connecticut has seen an increase of the utilization of dental care for Medicaid children from 46% to almost 70% since 2007. According to the 2012 CT DPH report, Every Smile Counts, The Oral Health of Connecticut's Children¹, Children in 13% of children in kindergarten have untreated decay, a slight improvement from 2006-2007 at 16%. More significantly, 12% of children in third grade have untreated decay, a significant improvement from 2006-2007 (18%). Some of this can be attributed to the improved Medicaid administration and increased reimbursement rates that occurred in 2008.

Improvements will be greater if "continuous eligibility" is instituted that will provide stabilized enrollment by providing twelve-months of coverage regardless of changes in family circumstances. Continuous coverage demonstrates an increase in participants receiving preventive care which produces better health outcomes as well lower costs.

Presently, there are numerous persons not receiving Medicaid coverage resulting in them not receiving health care they need. This includes dental care, both preventive and restorative, that may have larger ramifications for their overall health and increase costs associated with that.

Just this past week at the Oral Health Day in the Capitol and Legislative Office Building, one of our table participants heard from a woman who was there with the Girl Scouts who saw our flyer on Medicaid and continuous eligibility. She asked if this would affect her in continuing to gain dental treatment, as her family lost coverage at the end of last year, when she found a job that ended up lasting for only 3 months. She had been told she had decay but she could not afford dental services. When her re-application is processed and she does get Medicaid again, there is the chance that she may need more expensive services and may experience pain due to the

delay in services. I use this case to illustrate the need and for continuous eligibility, as a path the wellness for children and adults and to save money in the Medicaid system

Please adopt "continuous eligibility" this year for children and seek federal approval for continuous eligibility of one year for adults who have been determined eligible for the Medicaid program.

If I can be of any assistance, please call me. Thank you for your time and your commitment to the health and oral health of all Connecticut citizens especially those who are the neediest.

I urge your support of H. B. 5378.

Thank you for your attention to this important issue and your commitment to the health and oral health of Connecticut residents.

Sincerely,



Mary Moran Boudreau
Executive Director

1 Connecticut Department of Public Health, Office of Oral Health Every Smile Counts, The Oral Health of Connecticut's Children, Hartford, Connecticut, October 2012
http://www.ct.gov/dph/lib/dph/oral_health/pdf/oral_health_ct_2012_rev.pdf

Robert Zawaski
Kate McAvoy

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The Department of Social Services wishes to respond to specific Legislative Program Review and Investigations Committee findings and recommendations included in the report entitled *Hospital Emergency Department Use and its Impact on the State Medicaid Budget*. The report offers 13 specific recommendations, paraphrased below, with evidence supporting each recommendation. After an overview of the Department's approach to Medicaid services, our responses will follow the order and format of the Committee report.

Overview

We believe that the seminal finding of the report is that:

Although the committee concluded that ED visits by Medicaid clients are not a major cost driver of the overall Medicaid budget, especially on a per-visit basis, the committee believes that strategies need to be developed to educate clients in myriad ways to reduce high rates of utilization. If clients were able to access community health care for preventative care, health outcomes would be improved and clients will not cycle in and out of the ED.

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. These include 1) use of an Administrative Services Organization (ASO) platform for Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services; 2) activities in support of improving access to preventative primary care; 3) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS); and 4) initiatives designed to "re-balance" spending on LTSS.

We concur with the Committee's conclusion that ED costs are not a major cost driver in the Medicaid budget, however as will be demonstrated below, the Department and its business partners are deploying a large variety of interventions and programs both to address overall ED utilization, by educating beneficiaries in the best use of their health services coverage including the ED, and most important, the truly significant cost drivers throughout our programs.

Administrative Services Organization (ASO) Platform

Recognizing opportunities to achieve better health outcomes and streamline administrative costs, Connecticut historically contracted with ASOs to manage its Medicaid behavioral health and dental services. On January 1, 2012, Connecticut expanded this effort by transitioning Medicaid medical services from a managed care infrastructure, that included three capitated health plans and a small Primary Care Case Management (PCCM) pilot, to a medical ASO. This extended state-of-the-art managed care services to the entire Medicaid and CHIP population. The medical and behavioral health (BH) ASOs (respectively, CHN-CT and Value Options) provide a broad range of services, including: member support, Intensive Care Management

(ICM), predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling, utilization management, and member grievances and appeals. CHN-CT and Value Options coordinate in supporting the needs of individuals with co-occurring medical and behavioral health conditions through a behavioral health unit staffed by credentialed individuals that is co-located with the medical ASO. The dental ASO (Benecare) has been an instrumental partner to the Department in providing a broad range of services, including member support, care coordination, dental care management, increasing provider participation, network management and improving access to care. Finally, effective in February 2013, Connecticut transitioned its Medicaid Non-Emergency Transportation (NEMT) services to a single ASO (Logisticare).

In support of its ICM activity, CHN-CT fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs (e.g. food and housing security), culturally attuned conversation scripts as well as chronic disease management scripts. Additionally, CHN-CT now has in place geographically grouped teams of nurse care managers. As noted above, an important feature of ICM is coordination with a co-located unit of Value Options (the behavioral health ASO). Care managers from CHNCT, DSS and Value Options meet twice weekly to review hospitalizations and planned admissions to identify the appropriate care manager to take responsibility for the member's care. In cases where neither the physical or behavioral diagnosis is primary, both the CHN and the Value Options care manager remain involved. At any given time, approximately 500 members are receiving ICM because they are diagnosed with a Serious and Persistent Mental Illness (SPMI) in addition to a physical diagnosis.

Access to Primary Preventative Medical Care

Connecticut adults do not use primary care as indicated, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 receiving recommended care. [Commonwealth Fund, 2009] Further, a report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours. [Connecticut Hospital Association, 2009] The key elements of this approach are:

- **Person-Centered Medical Homes (PCMH).** The Department implemented its Person-Centered Medical Home (PCMH) initiative on January 1, 2012. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care. Through this effort, the Department is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance

(NCQA). Practices on the “glide path” toward recognition receive technical assistance from CHN-CT. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures; practices on the glide path receive prorated enhanced fee for service payments based upon their progress on the glide path but are not eligible for quality payments at this time. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

- **Electronic Health Records (EHR).** Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. EHR support more person-centered care and reduce duplication of effort across providers. DSS is collaborating with UConn Health Center to administer a Medicaid EHR Incentive Program and to improve outreach and education to providers. Incentive payments disbursed from September 2011 to January 2013 include \$18,642,346 to 929 eligible professionals and \$22,268,898 to 25 eligible hospitals. “Eligible professionals” include physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists.
- **Health Equity.** DSS and its partner CHN-CT are currently examining access barriers related to gender, race and ethnicity faced by Medicaid beneficiaries. This project is focused on identifying disparities and equipping primary care practices with a toolkit outlining strategies to reduce these barriers. DSS is also continuing to partner with the Office of Minority Health (OMH) on various efforts to improve the health of racial and ethnic populations through the development of policy and programming designed to eliminate disparities.

Integration of Medical and Behavioral Health Care

Many Medicaid beneficiaries, especially those who are dually eligible for Medicare, have complex health profiles. A high incidence of beneficiaries have co-morbid physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a recipient’s medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions. The key elements of this approach are:

- **Demonstration to Integrate Care for Medicare-Medicaid Enrollees.** Connecticut has submitted an application for implementation funding under

the federal Demonstration to Integrate Care for Dually Eligible Individuals. This is a managed fee-for-service model. The Connecticut proposal seeks to integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote practice transformation, and create pathways for information sharing through key strategies including: 1) data integration and state of the art information technology and analytics; 2) Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease; 3) expanded access for Medicare and Medicaid Eligibles (MMEs) to Person Centered Medical Home (PCMH) primary care; and 4) a payment structure that will align financial incentives (advance payments related to costs of care coordination and supplemental services, as well as performance payments) to promote value. The MME initiative will create new, multi-disciplinary provider arrangements called "Health Neighborhoods" through which providers will be linked through care coordination contracts and electronic means.

- **Health Homes for Individuals with SPMI.** Further, this unit is working with the Department of Mental Health and Addiction Services to implement health homes for individuals who are diagnosed with an identified Serious and Persistent Mental Illness (SPMI), have high expenditures, and are served by a Local Mental Health Authority (LMHA). As conceptualized, this model is anticipated to make PMPM payments to LMHAs that will permit them to incorporate APRNs within their existing models of behavioral health support.
- **Behavioral Health Screening for Children.** Finally, DHS is currently modeling a proposal to providing an annual behavioral health screen for children ages 1 through 17 years, as part of an EPSDT evaluation.

Rebalancing of Long-Term Services & Supports

Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports. Connecticut's Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In 2011 54% of long-term care clients received care in the community, but only 40% of spending supported home and community-based care. Further, only 7% of the Medicaid population receives long-term services and supports (LTSS) but 61% (\$2.863 billion) of the SFY'12 Medicaid expenditures (\$4.714 billion) were made on the behalf of these beneficiaries. Key elements of this approach are:

- **Strategic Plan to Rebalance Long-Term Services and Supports.** In January 2013, the Governor, the Office of Policy and Management and the Commissioner of the Department of Social Services released an updated copy of the State's Strategic Plan to Rebalance Long-Term Services and Supports. This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive long-

term services and supports (LTSS). Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Payments Program (BIPP) activities; 3) nursing home diversification; and 4) launch of a new web-based hub called "My Place". The strategic plan identifies 'hot spots' for development of services, including medical services, since it projects demand attributed to the aging population at a town level.

- **Money Follows the Person.** The Money Follows the Person (MFP) initiative has led efforts toward systems change in long-term services and supports. In addition to its work in having transitioned over 1,700 individuals from nursing facilities to the community, MFP is implementing diverse strategies that support reform. Key MFP demonstration services include: care planning specialized in engagement and motivation strategies, alcohol and substance abuse intervention, peer support, informal care giver support, assistive technology, fall prevention, recovery assistance, housing coordination, self-directed transitional budgets including housing set-up, transportation assistance and housing modifications. Systems focus areas for MFP include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions. An additional key aspect of the demonstration is the development of improved LTSS quality management systems. In 2012, the Governor publicly committed to a significant expansion in the target for individuals transitioned, to a total of 5,000 individuals.
- **State Balancing Incentive Payments Program.** Further, MFP also led efforts to submit an application to CMS under the State Balancing Incentive Payments Program (BIPP). Connecticut received confirmation in Fall, 2012 of a \$72.8M award. Key aspects of the award include:
 - The development of a pre-screen and a common comprehensive assessment for all persons entering the LTSS system, regardless of entry point. It is anticipated that medical offices, various State agencies administering waivers, and the ASOs will all utilize the same tool so that the people served by the State's systems won't be continually asked the same question unless there is a status change. The anticipated result is a more efficient system where information is shared and unnecessary duplication is eliminated.
 - The development of conflict free case management across the system.
 - The development of a 'no-wrong door' system for access to LTSS. Phase one of the State's 'no wrong door' launched on June 27, 2013. The web based platform was branded "My Place CT" and aims to coordinate seamlessly with both ConneCT and the health insurance

exchange over the next two years. Additional information about My Place CT is detailed below.

- The development of new LTSS aimed to:
 - address gaps that prevent people from moving to or remaining in the community;
 - streamline the existing LTSS delivery system; and
 - build sufficient supply of services to address the projected demand.

- **Nursing Home Diversification.** Another important feature of rebalancing is use of a Request for Proposal (RFP) process and an associated \$40 million in grant and bond funds through SFY 2015 to seek proposals from nursing facilities that are interested in diversifying their scope to include home and community-based services. Undergirding this effort is town-level projections of need for LTSS and associated workforce, and a requirement that applicant nursing facilities work collaboratively with the town in which they are located to tailor services to local need.

- **My Place.** Finally, the plan emphasizes the need to enable consumers, caregivers and providers to access timely and accurate information with which to make decisions, means of connecting with services (both health-related and social services), and a clearinghouse through which formal and informal caregivers can find opportunities to provide assistance. In support of this, the state launched the "My Place" web site (<http://www.myplacect.org/>) in late June, 2013. Initially the site will start by focusing on workforce development - helping people who are entering or re-entering the workforce to understand what types of caregiving jobs are available, to list positions and to provide contacts. At later stages it will grow and evolve, and will encompass a partnership with Infoline 2-1-1. This effort will be promoted by an extensive campaign of billboards and radio ads. My Place CT envisions kiosks at various community entry points include medical offices, libraries, pharmacies, etc. providing access to people at community locations that they already visit frequently. My Place CT will be supported by community access points where people will not only have access to web based pre-screens and information but also one to one assistance. It is anticipated that RFPs for this service will be announced by the Department within the next 6 months. In the final phase of My Place CT, the web based system will support electronic referrals to both formal LTSS and to local community services and supports. It is anticipated that this support will be especially helpful to hospital discharge planners and others seeking streamlined, automated coordination assistance.

Committee recommendations and specific Department responses:

- 1. The Department should develop brochures, to be made available to clients at federally qualified health centers and primary care offices, about alternatives available to the emergency department if a client does not need immediate attention.**

The Department's medical, behavioral health and dental administrative service organizations (ASOs) have such brochures for HUSKY members that include steps members can take to seek alternative services for non-life threatening medical conditions. For example, the medical ASO developed written brochures and collateral to let members know that they have options for less serious ailments other than an ED. The materials developed include:

- **Urgent Care Brochure (attached in English and Spanish)**

The distribution strategy is as follows:

- Direct mailing monthly to all members with three or more visit to an Emergency Room within a 6 month period of time - March 2014.
- Posting on husky health member website - March 2014.
- Hand delivery to members by ICM team during Face to Face visits - March 2014



NHBTriFold-V6-ENGLI
SH.pdf

- **Nurse Helpline Postcard and Magnet**



Nurse-Postcard-V16.
pdf



Nurse-Postcard-Mag
net-V16.pdf

The distribution strategy is as follows:

- Direct mailing monthly in the Welcome Packet to all new members (postcard and magnet are in English/Spanish)-Began February 2014.
- Direct mailing monthly to all members with three or more visit to an Emergency Room within a 6 month period of time - Beginning March 2014.
- Direct mailing by ICM staff to all postpartum members enrolled in the ICM program - Beginning March 2014.
- Posting on husky health member website - Completed
- Hand delivery to members by ICM team during Face to Face visits - Beginning March 2014

- Nurse Helpline Posters



(Attached in English and Spanish)

The distribution strategy is as follows:

- Hand delivery to PCMH, GP, FQHC and large practices as part of the onsite visit by the Regional Network Managers, Community Practice Transformation Specialist and the Provider Relation staff – Began February 2014

Unfortunately, this intervention, used previously in Connecticut and currently across the nation by many Medicaid managed care organizations, has limited impact on ED usage because there are multiple reasons why Medicaid recipients use EDs. Some, listed in the report, include:

- a lack of accessible urgent care facilities that accept Medicaid;
- a limited number of PCPs in general, especially those who accept Medicaid patients and who offer extended hours/weekend hours,
- the greater prevalence of behavioral health and substance abuse conditions among Medicaid recipients,
- a growing use of EDs by those seeking narcotics, and
- incidents of public inebriation, with the inebriated person brought to the ED via ambulance.

Notably, lack of access to primary care, after-hours access and growing misuse of prescription narcotics are not unique to Medicaid but increasingly challenge those covered by all commercial and public health plans. This helps explain the high rate of ED use among the entire population.

Research demonstrates that the main reason Medicaid recipients access EDs for care more frequently than the commercially insured, is that they suffer with more chronic illnesses and disabilities than the general population, and therefore *should* use emergency services more often. Additionally, Medicaid recipients' social circumstances further limit their ability to viably access services in the community. In particular, Medicaid recipients more often work in low paying jobs where time off for a medical appointment might result in the loss of that job.

The major challenge in diverting Medicaid recipients away from EDs is that it is difficult and cost prohibitive to duplicate the benefits EDs offer over other sources of care. EDs are the Walmart of health care; they provide one stop shopping without an appointment and are open when you need them. There is no need for a second or a third appointment for laboratory tests or imaging; everything is ready when you

need it. The Department and its ASOs assist Medicaid members to find viable alternatives to ED use, including but not limited to the PCMH program (which requires after-hours access), ICM, ongoing collaborative rounds that provide care coordination services for high risk users, and a growing number of out-stationed ASO staff in hospital settings.

One specific and timely intervention to improve access to primary care services should be highlighted, that is the ACA mandated increase in primary care rates to 100% of the Medicare fee. This increase in rates is federally supported for two years, ending December 31, 2014. In recognition of the important impact on access to care evidenced by this rate increase, Governor Malloy's budget address proposed extending the increase for the remainder of the biennium. We heartily endorse this investment.

Finally, the report suggests that because the Committee staff specifically asked the Department and its ASO to report on frequent users, we are unaware of the problem. This is a population for which the Department and the ASOs specifically target for collaborative ICM services.

2. The Department shall require its medical ASO to analyze and report on Medicaid clients' use of the emergency department on an annual basis, the report shall be provided to the Council on Medical Assistance Oversight.

The Department does utilize such reporting and is currently working on such a report, with minor differences, with the behavioral health ASO. In addition, DSS uses the annual medical ASO incentive payments to induce creative programming to further address inappropriate use of the ED, in particular development of a comprehensive pain management program that will include efforts targeting drug seeking visits to EDs.

3. The Department of Social Services shall require the administrative services organizations to conduct the mystery shopper survey of primary care providers and specialists, including whether the providers are accepting new patients, and wait times for appointments for new and existing clients to measure ease of access, as required in the administrative service organization contracts.

DSS currently is using the mystery shopper methodology to verify access to mental health outpatient services as well as for surveys of a variety of indicators of access to health and quality of care. In addition, the medical ASO is currently developing the annual mystery shopper survey with DSS to be conducted in Q3 2014.

4. Once a person is determined eligible for Medicaid and the ASO is notified of the eligibility, the ASO should contact the member to provide information

about primary care providers in their geographic area accepting Medicaid clients. Further, the ASO should inform the client of the advantages of the PCMH – like extended hours, urgent care, and same-day appointments – and offer to work with the client to make that primary care connection.

Contacting newly eligible members and educating them about their new benefits is the medical ASO's routine practice. This includes informing members of the availability and benefits of after-hours and urgent care when needed through their PCMH. The ASO facilitates continuing care for new members with their PCP if they already have a CMAP enrolled PCP, and assisting them in contacting a PCMH if they don't already have one.

The text of the report makes some incorrect assertions about the attribution methodology that should be clarified. First, the report suggests that the rate of attribution is low overall, especially for adults, due to poor access to primary care services. Attribution is a retrospective review of provider claims to identify a member's choice of a primary care provider (PCP). Once the PCP is identified, member's clinical and claims data is then made available to that PCP to better provide the member's care. Many members have other insurance coverage which pays PCP claims, or are institutionalized in nursing homes, group homes, etc. and therefore Medicaid does not receive claims to use to attribute the member. Others receive services only from specialists caring for a severe chronic illness, such as cancer; others choose not to seek primary care. For all of these reasons, member attribution will never reach 100%.

The report also highlights a decline in the attribution rate between the second and third quarters of 2013. This decrease was due to a one time adjustment of the attribution methodology after we discovered a small likelihood that confidential health information might be attributed to the incorrect clinician using the original methodology. Furthermore, compared to other states' medical home programs, that we attribute 67% of our recipients is an accomplishment of which we are very proud.

In addition, the report states that "Under the ACA, PCMHs receive enhanced payments..." Enhanced payments are made to PCMHs under policy adopted by the Department.

5. Once a Medicaid client has been attributed to a primary care provider, that provider's name and contact information should be printed on the Connect (Medicaid) card issued (or reissued at redetermination) to the client.

One of the reasons that the Department adopted attribution under the ASO model is that it recognizes patterns of access to care used by recipients. It is a retrospective assignment of recipient health information to clinicians who the recipient has chosen by seeking their care, which then enables that clinician to best provide that care. In other words, the recipient "votes with their feet" and their clinical data

follows them. Assignment, the old managed care methodology that used member cards, hoped that recipient's feet would take them where the plan assigned them, unfortunately more often than not they didn't.

ID cards are issued by the medical ASO within 15 days of enrollment; however, the member's primary care provider (PCP) information is specifically not included on the card. Were this information on the card, multiple cards would need to be issued to the member as they change PCPs at considerable expense yielding minimal benefit. Furthermore, including a primary care provider's name on the card is often a barrier to care because many other providers refuse to see members not assigned to them for fear of not being paid. Although the Department has never limited payments this way, many commercial plans do so this fear still persists.

6. Statutorily adopt a 12-month continuous eligibility provision for children during the 2014 legislative session. Further, DSS shall immediately seek an amendment to its 1115 waiver from the Centers for Medicare and Medicaid Services to implement 12-month continuous eligibility for all adult Medicaid recipients.

The Department is assessing the fiscal impact of continuous eligibility, however, Connecticut does not have an 1115 waiver and we are unaware of any effort to seek one. Furthermore, the Department sought to amend coverage for the Low Income Adult (LIA) coverage group through an 1115, but the waiver was denied by CMS.

7. By January 1, 2015 DSS engage in a demonstration project as authorized in P.A. 12-109 and that at least one demonstration project reimburse for specialist services delivered by a telemedicine or telehealth model.

The Department and the University of Connecticut Health Center established a partnership in late 2013 to collectively conduct research and program review benefitting the Medicaid Program. The partnership's first project is an evaluation of the impact, cost-effectiveness, and most importantly, patient safety of the pilot program mentioned in the report, as well as a review of other such programs nationwide. The Department hopes to broaden the scope and reach of the telehealth pilot in the first half of 2014.

8. The Department monitors its administrative services organizations' reporting requirements to ensure all contractually obligated reports, including the Emergency Department Provider Analysis Report by ValueOptions, are issued as required.

It remains the Department's intent to continue to closely monitor all reports.

9. The Department of Mental Health and Addiction Services, in conjunction with DSS financial staff and the Office of Policy and Management, ensure that

expenditures for all intensive case management services eligible for Medicaid reimbursement be submitted to the Centers for Medicare and Medicaid Services.

We believe that all eligible expenditures are duly submitted for federal financial participation; however DSS will again confer with DMHAS about this matter.

10. DSS and DMHAS should contractually require that the intensive case management teams of CHN-CT, ValueOptions and ABH: identify hospital EDs for the program based on the number of frequent users; and engage ED staff of the relevant hospitals in helping to identify Medicaid clients who would benefit from this community care intensive case management.

DSS and DMHAS should contractually require that at least one staff member from the regional intensive case management teams be co-located at hospital EDs participating in the program, at hours when frequent users visit the most and when ED use is highest.

11. These ICM staff should:

- **work with ED doctors to develop a care management plan (and accompanying release of information) for clients who agree to participate;**
- **be knowledgeable about the community services and providers in the area;**
- **serve as liaisons between the hospital ED staff and the community providers identified in the client's care plan; and**
- **meet weekly with providers to monitor clients' progress.**

DSS and the medical and behavioral ASOs conduct Hospital Watchlist- case rounds meeting twice weekly. The rounds include clinical staff of all sorts from all three organizations to identify members with multiple physical and behavioral health conditions. One group specifically targeted is those members who show a high pattern of visits to the ED related to alcohol and substance abuse conditions. Members may be seeking narcotics; which makes it challenging to manage their care. They demonstrate an elusive pattern of behavior and create barriers to providing continuity of care; hence all Intensive Care Management teams (CHNCT, CTBHP and ABH) are working collectively to address each identified member's situation and need for support.

Medical ASO ICM Care Managers also participate weekly on-site at specific hospitals willing to accept them (Waterbury and Midstate) to address inappropriate ED use. We hope to establish ongoing participation at Middlesex Hospital as well and have participated onsite at Yale, St. Francis and Bridgeport in roundtable meetings identifying actionable steps to address the frequent ED user. ICM also established a direct referral process for providers and hospital social work staff to reach ICM for

not only discussion and referral of high ED users; but also for members with frequent readmissions.

While ICM does not presently have the resources to assign a regional Care Manager to be positioned onsite at each hospital to address inappropriate member utilization of the ED, we have established a process of flagging and referring members immediately to ICM. ICM when appropriate has made real time onsite visits to requested sites. Please note hospitals would need to be required to accept these resources.

DSS, with DMHAS and the behavioral ASO, is also enhancing existing protocols for frequent ED users. DSS, DMHAS, and ValueOptions will be identifying the top five EDs based on utilization and re-admission and will deploy a ValueOptions ICM staff to those EDs to impact unnecessary use of the ED and re-admission. Similarly, the medical ASO is endeavoring to co-locate workers on a more limited basis in high volume institutions. This effort would be facilitated by more active cooperation from many of the state's acute care hospitals.

Regrettably, there is an intervention not identified by the Committee's report that should be discussed. The report notes high incidence of ED visits by individuals covered by HUSKY C but says nothing more. A major cost driver among this coverage group is inappropriate ED use by nursing home residents. We request that the Committee amend its report to urge both the nursing home associations, and the hospital association, to partner with the ASOs on ICM and care transitions.

12. Emergency department physicians, should, as a first step follow ACEP guidelines, which includes checking the state's prescription drug monitoring program, prior to prescribing controlled prescription drugs to a patient in the ED.

The Department agrees, however, the Prescription Drug Monitoring Program is overseen by the Department of Consumer Protection/Drug Control and access to that system must be requested and obtained through DCP.

13. The CMS strategies bulletin should be circulated among the Program Integrity and Pharmacy Management staff of the Department of Social Services. In addition, the Office of Quality Assurance shall identify Medicaid clients who are outliers in the state's Prescription Drug Monitoring Program and refer these clients to the review team to determine whether these clients should be placed on the Medicaid prescription restriction program.

We appreciate the Committee's recommendation for drug treatment. DSS' Office of Quality Assurance is the only unit within DSS that is allowed access to the Prescription Drug Monitoring Program. Currently, the Office of Quality Assurance does alert staff within the Division of Health Services/Pharmacy Program of

potential outliers and individuals who should be considered for the pharmacy lock-in program. The pharmacy lock-in program is a functionality of the Retrospective Drug Utilization Review Program which is a requirement of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires state Medicaid programs to conduct a comprehensive drug utilization review program based on outcomes identified through the review of Medicaid paid claims data. The RetroDUR program collects and analyzes claims data against predetermined criteria to identify and correct aberrant prescribing practices, client misuse, and provider fraud. The RetroDUR program also has functionality to identify potential pharmacy restriction candidates and to specify a pharmacy and/or physician provider to assist in correcting client abuse or misuse.

Concurrent with RetroDUR and using the resulting data, the Department's DUR contractor also conducts a pharmacy restriction program. Through RetroDUR, the contractor identifies certain clients who demonstrate the potential to abuse or misuse of prescription drugs. These clients are offered the opportunity to change their behavior and demonstrate appropriate use of prescription drugs. If the clients continue inappropriate behavior, they are restricted to the use of a single pharmacy for a one-year period.

Statistical Errors

Lastly, per your request, the Department of Social Services wishes to respond to a few factual errors that we have found in the report:-

1. The Executive Summary Page 1, Paragraph 5 stated that "In comparison with overall ED use, the number of Medicaid visits to the ED has increased from 519,312 in 2010 to 589,260 in 2012.

Correction from DSS: - The correct Medicaid ED visits in 2012 were 605,506 instead of 589,260.

2. Page 18 of the Report, Figure I-11. Costs by HUSKY Program per Visit and per Client: CY12 shows that ED per visit for HUSKY B is the highest at \$431 when compared to all other HUSKY Program. Also all the figures showing in the graph for Per-Visit Cost among all HUSKY program are not correct.

Correction from DSS: - ED per visit cost in HUSKY B is not the highest, but rather the lowest among all other HUSKY program. This is due to the fact that the HUSKY B population is comprised of children.

Please see the table below showing the correct figure of ED per-visit cost for each HUSKY program:

HUSKY Program	Per-Visit Cost by ED PRI (Page 18 - Figure I -11)	Per-Visit Cost Correction by DSS
HUSKY A	\$271	\$307
HUSKY B	\$431	\$295
HUSKY C	\$378	\$460
HUSKY D	\$306	\$403

**Ways to Get Health Care
When it's NOT an Emergency**

**Always contact your doctor first if available.*

⊕ Urgent Care Clinics

When your doctor is not available, urgent care clinics can provide care for non-life threatening medical problems or problems that can't wait.

Reasons to visit an Urgent Care Clinic

- Common illnesses such as colds, coughs, flu symptoms, ear infections, sore throats, migraines, fever or skin infections
- Minor injuries such as a twisted or sprained ankle, back pain, minor cuts and burns, minor broken bones, or minor eye injuries

Urgent care clinics usually accept walk-ins. Many are open seven days a week. Some are even open late during the week.

DP



**Call Our 24-Hour
Nurse Helpline**

Our nurses are available 24 hours a day, seven days a week. Make them your first call when you're not sure if you should see your doctor or go to the emergency room.

Do you think you need to see your doctor right away, or do you have a health problem that you are not sure can wait? Do you have follow up questions to a recent visit to a doctor that you forgot to ask?

You can ask questions and talk to the nurse about any health issues that you may have. A nurse will always be ready to help you.

Available 24 hours a day, 7 days a week
Call them at 1.800.599.9999



**When
it is an
Emergency**

*For true emergencies,
go to your nearest
Emergency Room or call 911.*

An emergency can be an illness or injury that needs immediate attention and/or could be life threatening such as being unable to breathe, a major broken bone, an injury to the neck or spine, loss of consciousness, chest pain, head or spine injury, or ingestion of poison.

The Nurse Helpline
is a service of the
HUSKY Health Program.



MS0902046-1114

**Where to
Get Health
Care When
It's Not an
Emergency***

**Always contact your doctor first if available.*



**Unsure of where to
get care when you are sick
or injured, but when it's
not a true emergency?**

*This brochure will help guide
you to alternative care.*



000292



Urgent Care Centers that participate in the HUSKY Health Program.

Ansonia

CVS Minute Clinic
24 Pershing Dr
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Avon

CVS Minute Clinic
358 West Main St
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Bloomfield

The Urgent Care Center of Connecticut
421 Cottage Grove Road
860-242-0034
Mon-Fri: 8am-8pm
Saturday: 9am-5pm

Bridgeport

St. Vincent's Medical Center Urgent Care
4600 Main Street
203-371-4445
Mon-Fri: 8:00am-8:00pm
Sat-Sun: 9:00am-5:00pm

Bristol

CVS Minute Clinic
839 Farmington Avenue, Rt 6
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Cheshire

Mediquick Urgent Care Center - Midstate Hospital
680 South Main Street
203-694-6700
7 days per week 8:00am-7:30pm

Colchester

Backus Health Care - Colchester
163 Broadway
860-537-4601
Mon-Fri: 8:00am-6:00pm
Sat-Sun: 9:00am-5:00pm

Colchester

CVS Minute Clinic
119 South Main Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Coventry

CVS Minute Clinic
3514 Main Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

East Hartford

First Choice Health Centers, Inc.
94 Connecticut Blvd
860-528-1359
Mon-Thur: 7am-7pm
Friday: 7am-5pm
Sat: 8:00am-2pm

East Haven

Yale Urgent Care Center
371 Foxon Road
203-466-5600
Mon-Fri: 8:00am-7:00pm
Sat: 8:30am-3:30pm
Sun: 9:00am-12pm

Enfield

CVS Minute Clinic
875 Enfield Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Fairfield

St. Vincent's Urgent Care Walk In
1055 Post Road
203-259-3440
Mon-Fri: 8am-8pm
Sat-Sun: 9am-5pm

Fairfield

Fairfield Urgent Care Center
309 Stillson Road
203-331-1924
Mon-Fri: 8am-8pm
Sat-Sun: 9am-5pm

Glastonbury

CVS Minute Clinic
2639 Main Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Granby

CVS Minute Clinic
20 Bank Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Hamden

CVS Minute Clinic
2045 Dixwell Avenue
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Hamden

Walk-In Center Hamden
2543 Dixwell Avenue
203-230-4160
Mon-Fri: 8:00am-8:00pm
Sat: 8:00am-2:00pm
Sun: 8:00am-Noon

Hartford

Charter Oak Health Center Inc
21 Grand Street
860-550-7500
Mon-Thurs: 8:00am-6:00pm
Fri-Sat: 8:30am-3:00pm

Hartford

Community Health Services
500 Albany Avenue
860-249-9625
Mon-Thur: 8:30am-5:30pm
Fri: 9:30am-5:30pm
Sat: 9am-1pm

Ledyard

Backus Healthcare - Ledyard
743 Colonial Ledyard Hwy
860-464-3104
Wed: 8:00am-Noon

Menden

Mediquick Urgent Care Center - Midstate Hospital
61 Pomeroy Avenue
203-694-5350
Mon-Fri: 6:00am-11:30pm,
Weekends/Holidays: 8:00am-7:30pm

Milford

My Health 1st Urgent Care, LLC
470 Bridgeport Avenue
203-693-3676
Mon-Fri: 8am-8pm
Sat-Sun: 8am-6pm

Monroe

St. Vincent's Urgent Care Walk In Center
401 Monroe Tpke
203-268-2501
Mon-Fri: 8:00am-8:00pm
Sat-Sun: 9:00am-5:00pm

Montville

Backus Health Care - Montville
80 Norwich New London Tpke
860-848-6304
Mon-Fri: 8:00am-6:00pm
Sat: 9:00am-2:00pm

New Haven

Medical Walk In Care of Westville, LLC
1351 Whalley Avenue
203-889-2676
Mon, Tue, Wed, Fri: 8:30am-5:00pm
Thu: 12pm-7:00pm
Sat: 8am-1pm

Newington

MedCare Express
2335 Berlin Tpke
860-757-3575
7 days per week 8:00am-8:00pm

North Haven

Urgent Care Center
163 Universal Drive
203-298-4600
Mon-Fri: 8am-8pm
Sat-Sun: 8am-6pm

Norwalk

Urgent Care Center
677 Connecticut Avenue
203-298-9752
Mon-Fri: 8am-8pm
Sat-Sun: 8am-6pm

Norwich

Westside Medical
606 West Main Street
860-889-1400
Mon-Fri: 8:00am-8:00pm
Sat: 9:00am-2:00pm

Orange

Urgent Care Center
109 Boston Post Road
203-874-3682
Mon-Fri: 8am-8pm
Sat-Sun: 8am-6pm

Plainfield

Day Kimball Medical Group | Walk-In Day Kimball Healthcare Center
12 Lathrop Road
860-457-9150
Mon-Thur: 8:30am-7:30pm
Fri: 8:00am-6:00pm
Sat: 9am-3pm
Sun: 9am-12:30pm

Ridgefield

CVS Minute Clinic
467 Main Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Riverside

CVS Minute Clinic
1239 East Putnam Avenue
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Rocky Hill

CVS Minute Clinic
323 Cromwell Avenue
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Rocky Hill

Rocky Hill Medical Center
412 Cromwell Avenue
860-563-3844
Mon-Fri: 8am-6pm
Sat: 8am-3pm

South Windsor

CVS Minute Clinic
525 Buckland Road
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Southbury

CVS Minute Clinic
22 Depot Hill Road
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Southington

Southington Urgent Care P.C.
1131 West Street, Bldg 1
860-621-7682
7 days a week 8:30am-6:30pm

Southington

CVS Minute Clinic
326 Main Street
866-389-2727
Mon-Fri: 8:30am-7:30pm
Sat: 9:00am-5:30pm
Sun: 10:00am-5:30pm

Stamford

Firefly After Hours Pediatrics
101 High Ridge Road #207
203-968-1900
Mon-Fri: 4:00pm-11:00pm
Sat and Sun: 12:00pm-11:00pm
(Add'l Winter hrs by appt
Thur-Fri 12pm-11pm)

Stamford

Immediate Care Center at Tully Care
32 Strawberry Hill Road
203-276-2000
7 days per week 6am - 10pm

Trumbull

First Aid Immediate Care
900 White Plains Road
203-261-6111
Mon-Fri: 8am-8pm
Sat-Sun: 9am-5pm

Vernon

Vernon Walk In Medical Care Center Inc
224 Hartford Turnpike
860-871-6939
Mon-Fri: 9am-7pm
Sat: 9am-4pm
Sun: 11am-4pm

Wallingford

HealthMed Urgent Care LLC
1257 South Broad Street
203-626-5393
Mon-Fri: 10am-7pm
Sat-Sun: 10am-4pm

Waterbury

Urgent Care Center
279 Chase Avenue
203-874-3682
Mon-Fri: 8am-8pm
Sat-Sun: 8am-4pm

Westport

Westport Family Health Center
830 Post Road East
203-291-3800
Mon-Fri: 8am-7pm
Sat: 9am-4pm
Sun: 10am-2pm

*Please call ahead as hours may change

**Not Sure if you
should see your
Doctor or go to
the Emergency
Room?**



**We're here
24/7 even at
2 a.m.**

**Call the 24-
hour Nurse Helpline
at 1.800.859.9889**

The Nurse Helpline is
a service of the
HUSKY Health Program.



MSAPE0034-0913

¿No Está Seguro/a
si usted debe
consultar a su
Médico o ir a la Sala
de Emergencia?



Estamos
aquí 24/7,
aún a las
2:00 a.m.

llame las 24
 horas a la **Línea de Ayuda de la**
Enfermera al 1.800.859.9889

La Línea de Ayuda de la
 Enfermera es un servicio del
 Programa de Salud HUSKY.



MSAPS00034-0913

Not Sure if you should see your **Doctor** or go to the **Emergency Room?**

We're here 24/7 even at 2 a.m.

Call the 24-hour **Nurse Helpline** at **1.800.859.9889**

The Nurse Helpline is a service of the HUSKY Health Program.



MSAPE0034-0813

Not Sure if you should see your **Doctor** or go to the **Emergency Room?**

Do you think you need to see your doctor right away, or do you have a health problem that you are not sure can wait? Do you have follow up questions to a recent visit to a doctor that you forgot to ask?

We're here 24/7 even at 2 a.m.

Call the 24-hour **Nurse Helpline** at **1.800.859.9889**

You can ask questions and talk to the nurse about any health issues that you may have. A nurse will always be ready to help you!

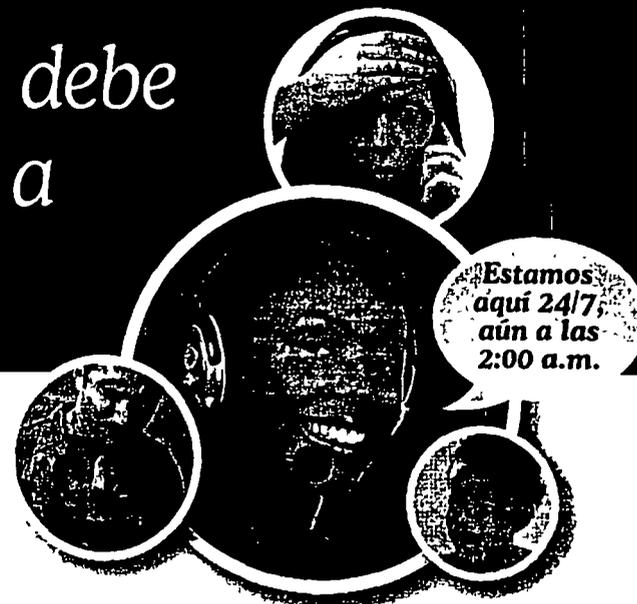
The Nurse Helpline is a service of the HUSKY Health Program.



000296

¿No Está Seguro/a si usted debe consultar a su Médico o ir a la Sala de Emergencia?

¿Cree usted que necesita ver a su médico de inmediato, o tiene usted algún problema de salud que no está seguro de si puede esperar?
¿Tiene preguntas de seguimiento a alguna reciente visita a un médico, que se le olvidó preguntar?



MSAPB0038-1213



Llame las 24 horas a la **Línea de Ayuda de la Enfermera** al **1.800.859.9889**

Usted puede hacer preguntas y hablar con la enfermera sobre cualquier problema de salud que pueda tener. ¡Una enfermera siempre estará dispuesta a ayudarle!

La Línea de Ayuda de la Enfermera es un servicio del Programa de Salud HUSKY.



000297

HUSKY Health Program Members:

Not Sure if you should see your Doctor or go to the Emergency Room?



We're
here 24/7
even at
2 a.m.

Do you think you need to see your doctor right away, or do you have a health problem that you are not sure can wait? Do you have follow up questions to a recent visit to a doctor that you forgot to ask?

You can ask questions and talk to the nurse about any health issues that you may have. A nurse will always be ready to help you!

Call the 24-hour **Nurse Helpline** at

1.800.859.9889



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE
Tuesday, March 4, 2014**

**HB 5378, An Act Implementing The Recommendations Of The Legislative
Program Review And Investigations Committee Concerning Medicaid-Funded
Emergency Department Visits**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 5378, An Act Implementing The Recommendations Of The Legislative Program Review And Investigations Committee Concerning Medicaid-Funded Emergency Department Visits**. CHA supports the recommendations included in the bill, but has concerns about particular provisions as set forth below.

Before outlining our concerns, it's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, equitable, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done. Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

Generations of Connecticut families have trusted Connecticut hospitals to provide care we can count on.

CHA is pleased to have assisted Legislative Program Review and Investigations Committee staff in their efforts to examine emergency department utilization by Medicaid clients. We are grateful for having had the opportunity to facilitate visits by Committee staff to several hospital emergency departments, engage the providers of emergency medical care in conversations about these important issues, understand the various challenges facing hospitals across the state, and learn more about the steps being taken by hospitals and other healthcare and social service providers to address these challenges.

Each year, Connecticut hospitals treat more than 1.6 million patients in their emergency departments. Emergency departments are filled with individuals who cannot find a physician to care for them because they are uninsured or underinsured – or because they are Medicaid beneficiaries and few physicians or urgent care centers will accept the low rates paid by Medicaid. Throughout Connecticut, our emergency rooms are treating those who have delayed seeking treatment because of inadequate or no coverage and those who have no other place to receive care. Connecticut hospitals are the ultimate safety net providers.

Connecticut hospitals are absolutely committed to initiatives that improve access to high quality care, expand the availability of insurance coverage, and reduce healthcare costs. We are working to improve the quality of care by redesigning the Medicaid program, with a keen focus on patients and improving the care they count on.

Attached to this testimony is an outline of our proposal to redesign Medicaid. This outline was also submitted to the Appropriations Committee in our testimony on HB 5030, *An Act Making Adjustments To State Expenditures For The Fiscal Year Ending June 30, 2015*. In brief, our proposal is modeled on the Medicare Value-Based Purchasing program and incorporates those concepts into the Medicaid hospital payment system. The proposal aligns with the state's health reform agenda; builds upon the existing Medicaid Fee-For-Service payment system; focuses on programs to improve access to appropriate care, thereby reducing disparities and improving population health; uses quality metrics to track and reward change; and invests in hospitals that achieve the shared vision. This proposal includes processes and priorities for hospitals that are well established in the Medicare program. We believe that now is the time to apply the experience and success hospitals have had in improving care and outcomes for Medicare patients to the Medicaid program.

CHA supports the implementation of recommendations included in HB 5378 intended to increase primary care reimbursement, enhance patient-centered care, achieve continuous Medicaid eligibility, expand ways in which Medicaid clients may access specialty care, and require administrative services organizations (ASO) to offer intensive case management services.

Several Connecticut hospitals are already engaged in efforts to improve outcomes for frequent emergency department users. Programs that target ED "super-utilizers" (i.e., patients with complex, unaddressed health issues and a history of frequent encounters with emergency departments) demonstrate early promise of realizing the development of innovative care delivery models with the potential to improve care, improve health, and reduce costs.

CHA supports efforts to identify the ED super-utilizer subpopulations within the state, the factors that drive high utilization among these patients, and the feasibility of eliminating unnecessary utilization through a set of targeted interventions addressing the factors identified in each particular community.

The enactment of this bill will enable the state, through its ASOs, to play a key role by promoting and facilitating the discussion among healthcare and social service providers in each community to address their unique needs. Investing in care coordination resources will bridge the healthcare and social services continuum for their Medicaid clients, thus better managing Medicaid costs.

These measures will also incent and encourage collaboration among state government, hospitals, and other healthcare and social service providers to achieve improved healthcare outcomes for all patients.

Predictability and stability in Medicaid eligibility for children and adults will ensure that patients receive primary and preventative care to keep healthy, and help providers maintain long-term relationships with their patients. CHA supports Section 7, which provides for 12 months of continuous eligibility for children, and Sections 8 and 9, which require the Commissioner of Social Services to seek federal approval for 12 months of continuous eligibility for all adult Medicaid recipients.

While CHA supports most of the measures included in the bill, we are concerned about the following provisions.

Section 1(b) requires that any contract entered into with an administrative services organization include a cost sharing requirement. As drafted, this section is unclear regarding the cost sharing requirements. If the provision is referring to the cost sharing requirement that was enacted last session, it is important to note that CHA opposed that requirement as it may prevent vulnerable, low-income individuals from obtaining appropriate services. In addition, we had concerns that depending on how such a provision was implemented, it could impact a hospital's obligation under the Emergency Medical Treatment and Labor Act (EMTALA), which requires a medical screening for everyone who comes to the ED, regardless of their ability to pay. If the cost sharing requirement is not on Medicaid enrollees, we look forward to working with the Committee to understand the requirement and how it will be implemented.

Included on the list of intensive case management services set forth in Sections 1(b) and 2(c) is the creation of follow-up care plans for Medicaid clients. CHA wishes to highlight the distinction between a "follow-up care plan" administered by an insurer, managed care company, or ASO, which is typically based on utilization data, and a "clinical care plan" developed by a licensed and qualified medical professional based on medical consultation with a patient, and specifically geared toward addressing the patient's healthcare needs.

Finally, CHA is concerned about the language in Section 4(f) expanding the Commissioner's ability to implement policies and procedures in advance of adopting regulations. We recognize the desire to implement policies and procedures in a timely manner; however, we believe that the authority to act outside the Administrative Procedures Act should be used sparingly. Compliance with the Administrative Procedures Act will ensure that input may be provided by the public, consistent with the principles underlying sound administrative procedures.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.



**A Proposal to Implement a Medicaid
Value-Based Hospital Payment System
and Phase Out the Hospital Tax Over
Five Years**

November 26, 2013

Principles for a Medicaid Hospital Value-Based Payment System

- Our efforts should:
 - Align with the state's health reform agenda.
 - Build upon the existing Medicaid FFS payment system.
 - Focus on programs to improve access to appropriate care thereby reducing disparities and improving population health.
 - Use quality metrics to track and reward change.
 - Implement new payment methods to incentivize hospital change.
 - To the extent practical, use the methods and processes developed for Medicare.

Initial Areas of Focus for Hospital-Value Based Payments

- DSS/CHN identified priorities:
 - ✓ Reduce avoidable ED visits
 - ✓ Reduce readmissions
 - ✓ Intensive care management (ICM)
 - Asthma, Diabetes, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)
 - ✓ Inpatient discharge care management programs (ICDM)

Hospital Value-Based Concept to Action

How to Convert Hospital Value-Based Principles and Priorities to Incentives

Medicaid Hospital Value-Base Payment Structure

- **Member Priority Program (MPP)**
 - The MPP has two elements: Intensive Care Management Referral (ICMR) and Quality Reporting and Measurement (QRM); the Medicare analog is Pay-for-Reporting.
- **Hospital-Community Connection Program (HCCP)**
 - The HCCP has two elements: Participation in CHN's Inpatient Discharge Care Management Program (ICDM) and Intensive Care Management Program (ICM), and performance measurement; the Medicare analog is Pay-for-Performance.
- **Hospital Reporting Program (HRP)**
 - DSS/CHN will provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.

Member Priority Program (MPP)

- MPP Essentials
 - Hospital payment rates are annually updated by the Medicare Market Basket update beginning July 1, 2014.
 - To be eligible for the full update, hospitals must provide timely ED and inpatient admission notification as well as HEDIS reporting data; method and frequency to be determined.
 - Hospitals not providing timely ED and inpatient admission notification as well as HEDIS reporting data will have their payments updated by the Medicare Market Basket less 2 percentage points.

Hospital-Community Connections Program (HCCP)

- HCCP Essentials
 - The HCCP is dynamic with incentives and program structure changing over time as the program and experience matures.
 - Beginning July 1, 2014 hospitals are annually eligible for a share of a supplemental Pay-For-Performance payment pool equal to 3% of forecasted total hospital expenditures for the succeeding year.
 - A hospital's share of the funds shall be calculated as its attainment score x share of expenditures x the supplemental pool.
 - An attainment score is the share of the 3% a hospital is eligible to receive – e.g., if a hospital earns 2% of the 3% maximum, its attainment score would be 66%.

Hospital-Community Connections Program (HCCP)

- HCCP (continued)
 - Year 1, July 1, 2014 - June 30, 2015, hospitals will earn 1% each for: participation in the CHN Inpatient Discharge Care Management Program (ICDM), Intensive Care Management Program (ICM), and a stabilization/reduction in statewide Plan All-Cause Readmission rates.
 - Year 2 and 3, July 1, 2015 - June 30, 2017, hospitals will earn .5% each for: participation in ICDM and ICM; and .5% each for stabilization/reduction in statewide rates for: Plan All-Cause Readmission, COPD Admission, CHF Admission, and Adult Asthma Admission.

Hospital Reporting Program (HRP)

- HRP Essentials
 - By December 31, 2013 DSS/CHN/CHA will agree on the content and frequency of performance reporting.
 - By March 1, 2014 DSS/CHN will provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.
 - By July 1, 2014 DSS/CHN/CHA will agree on the form and frequency of meetings to discuss and share Best Practices on implementing the requirements of the MPP and HCCP.

Phasing Out the Hospital Tax: Concept to Action

How to Phase Out the Hospital Tax Over Five Years

Phase Out of the Hospital Tax 2015 to 2019

(in Millions)

	Hospital Payments	Hospital Taxes	Net Benefit to Hospitals	Net Benefit to State
2011	83	0	83	(42)
2012	400	350	50	150
2013	323	350	(27)	189
2014	249	350	(102)	275
2015*	99	350	(251)	320
2015**	79	300	(221)	276
2016**	53	220	(167)	204
2017**	27	140	(113)	132
2018**	14	60	(46)	56
2019**	0			
			(794)	1,561

* Current law **Proposed

**An Act Concerning Implementation
Of a Medicaid Value-Based Hospital Payment System**

Whereas the State has identified a number of priorities in order to improve care to patients and reduce costs to taxpayers; and

Whereas these priorities include (a) reducing the number of avoidable emergency department visits; (b) reducing the number of hospital readmissions; (c) better management of chronic conditions such as asthma, diabetes, congestive heart failure and chronic obstructive pulmonary disease; and (d) better management of patients following discharge from the hospital; and

Whereas the State has determined that the best means of accomplishing these priorities is to establish certain hospital value-based reimbursement principles;

Therefore, we are enacting the following provisions to assist in the achievement of these priorities.

Section 1. Definitions.

- (a) **Member Priority Program (MPP).** The MPP consists of two elements: Intensive Care Management Referral (ICMR) and Quality Reporting and Measurement (QRM).
- (b) **Hospital-Community Connection Program (HCCP).** The HCCP consists of two elements: Participation in the Department of Social Service's Inpatient Discharge Care Management Program IDCM and Intensive Care Management Program (ICM), and performance measurement.
- (c) **Hospital Reporting Program (HRP).** The HRP is data DSS shall provide to hospitals which will include but not be limited to Continuity of Care Document (CCD), summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.
- (d) **Department of Social Services (DSS).** DSS shall mean the department, its commissioner or designated agents.

Section 2. The MPP

- (a) Hospital payment rates shall be annually updated beginning October 1, 2014, by the inpatient Prospective Payment System (IPPS) Hospital Market Basket as published annually by CMS in the Federal Register. To be eligible for the full amount of the update, hospitals must provide timely Emergency Department (ED) and inpatient admission notification as well

as HEDIS reporting data, in a manner and frequency as determined jointly by DSS and The Connecticut Hospital Association.

- (b) Payments to hospitals not providing timely ED and inpatient admission notification as well as HEDIS reporting data shall be updated by the Medicare Market Basket less 2 percentage points.

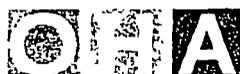
Section 2. HCCP.

- (a) Effective July 1, 2014, hospitals shall be annually eligible for a share of a supplemental HCCP payment pool equal to 3% of forecasted total hospital expenditures for the succeeding year.
- (b) An attainment score is defined as the share of the 3% a hospital is eligible to receive – e.g., if a hospital earns 2% of the 3% maximum, its attainment score would be 67%.
- (c) A hospital's share of the funds shall be calculated by multiplying its attainment score times its share of expenditures times the amount in the supplemental pool.
- (d) Effective July 1, 2014 through June 30, 2015, hospitals shall earn 1% each for: participation in (1) the Inpatient Discharge Care Management Program (IDCM), (2) the Intensive Care Management Program (ICM), and (3) a program to stabilize and reduce statewide Plan All-Cause Readmission rates.
- (e) Effective July 1, 2015 through June 30, 2017, hospitals shall earn (1) a potential one percent of the pool as follows: one half of one (.5%) percent each for: participation in IDCM and ICM; and (2) a potential two percent for the pool as follows: one half of one (.5%) percent each for stabilization/reduction in statewide rates for (i) Plan All-Cause Readmission, (ii) COPD Admission, (iii) CHF Admission, and (iv) Adult Asthma Admission.

Section 3. HRP.

- (a) By June 1, 2014 DSS and CHA will agree on the content and frequency of performance reporting; and
- (b) DSS shall provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.

- (c) By July 1, 2014 DSS and CHA will agree on the form and frequency of meetings to discuss and share Best Practices on implementing the requirements of the MPP and HCCP.



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Program Review and Investigations Committee
In support of HB 5378
March 4, 2014**

Good afternoon, Senator Kissel, Representative Mushinsky, Senator Fonfara, Representative Carpino, and members of the Program Review and Investigation Committee. For the record, I am Vicki Veltri, State Healthcare Advocate 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 plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I would like to thank you for the opportunity to comment on HB 5378, An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Medicaid-Funded Emergency Department Visits. The requirement that intensive care management be integrated into Medicaid recipient's treatment and care supports a critically important element in effective health management. As Connecticut continues to develop and implement health reforms and innovations to improve consumer access to and quality of care, codifying the principles of intensive care management that are already integrated into several Medicaid programs. Care management serves an important function in consumer access to effective treatment while maximizing existing resources. Indeed, the experience of consumers already benefitting from existing efforts of the Medicaid ASO to promote effective coordination of care and intensive care management reinforce this premise.

The telehealth demonstration project proposed by HB 5378 promotes this concept by requiring Medicaid coverage of services delivered via telemedicine and is an important element in the development of a comprehensive, equitable and innovative delivery and reimbursement model. From increased informed decision making capability and enhanced quality of care, telemedicine has the potential to save lives through increased consumer access to their providers for routine, chronic or acute care, resulting in earlier diagnoses and intervention. As individuals integrate the digital environment into their lives, telemedicine represents a logical extension of this trend, and it is reasonable that Connecticut should be at the forefront of this movement.

Finally, HB 5378's requirement that the DSS assess network adequacy for Medicaid recipients will provide invaluable data concerning the current medical environment and patient access to necessary care. By confirming the availability of the Medicaid provider network, we gain crucial insights into the needs of consumers and areas where networks may not be adequate to provide necessary treatment for members.

Thank you for providing me the opportunity to deliver OHA's testimony today. We look forward to continuing to collaborate and advocate for the consumers of Connecticut in this important matter. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

GE, UTC, Travelers this semester. And I've gotten offers from all of them for the summer. So, I feel that this -- the Business School does an excellent job of preparing it's students for the kinds of things we're going to see in the real world.

REP. MUSHINSKY: That's good. That's what we like to hear. Thank you. You're all going to be a success. We can already tell.

SENATOR KISSEL: Yes. We can tell. Akanksha, what kind of business are you -- what kind of business skill set are you -- because this is so broad? But.

AKANKSHA SING: I'm a finance major. And I also have a concentration in management information systems.

SENATOR KISSEL: Okay. Great. Well thank you all for taking time out of your busy schedule. Best of luck in your class work. Make us all very proud.

My contacts don't match well with reading glasses. So, who is it? Doctor Karen. Okay. Doctor Karen Jubanyik. And if I mangled your name, please let me know.

DR. KAREN JUBANYIK: Good afternoon. I am here to testify for the Raised Bill 5378, having to do with over use of emergency departments by Medicaid patients.

SENATOR KISSEL: Okay.

DR. KAREN JUBANYIK: And my name is Karen Jubanyik. I'm the immediate past President of the Connecticut College of Emergency Physicians and I appreciate the opportunity to speak in front

of the co-leaders of this very important committee. I did testify earlier when the committee was in the process of gathering information.

So the American College of Emergency Physicians, while also called ACEP, promotes the highest quality of emergency care and is the leading advocate for more than 28,000 U.S. emergency physicians, their patients and the public. The Connecticut Chapter, CCEP, represents close to 500 physician members living or working in the State of Connecticut.

Our organization was glad to be able to contribute to the research done by the Legislative Program Review and Investigations Committee. And we are very grateful for the hard work that the committee did to consider the challenges involved in reducing ED Medicaid spending while searching for best practices to improve the health of Medicaid patients in our state.

The report is quite amazing. I just had some time to flip through it and I think it will take me weeks to months to review this and really digest all of the information contained. And I think it's going to be an amazing resource for all of us who practice in -- in the State of Connecticut in terms of coming up with better ways to improve our care.

CCEP is certainly in favor with the provision of this bill that frequent ED visitors insured by Medicaid would be referred to an intensive case management system that would emphasize the importance of primary care and specialist availability. Though the bill specifically mentions a one month time frame for primary care follow up, CCEP would actually advocate

for a significantly shorter window of seven to maybe 14 days.

These frequent ED utilizers often have multiple ED visits within the 30 days after an index visit. And therefore, need much quicker follow-up than 30 days. A problem though that Medicaid patients face is that few primary care providers accept Medicaid due to low reimbursement rates. This is not as much a problem with pediatrics, but certainly for adult patients.

And as far as -- as the Committee found, fewer than 50 percent of adults actually -- of Medicaid insured adults actually have a primary care provider identified. And as far as the alternatives to ED care, the vast majority of the over 100 privately owned urgent care centers typically do not accept patients who have Medicaid insurance. They turn them away at the door. And they end up in our emergency department.

For out patient specialty care, there are even fewer options for Medicaid patients. Often times, there's only one of two medical school affiliated clinics available for somebody seeking a urology appointment, a neurology appointment, a neuro surgery appointment, et cetera. The federally funded clinics are often over crowded with limited hours and may not be accessible to patients with transportation issues particularly in the rural areas of our state.

So it is not uncommon to see a Medicaid patient in the ED multiple times for a problem that could have been managed in the out patient setting. And perhaps even better managed in the out patient setting. These issues are not

seen in the Medicare population.

Therefore it seems reasonable that if Medicaid reimbursements could approach parity with Medicaid, patients would have much more in the way of provider choices. And of course, as a first step, increasing the eligibility to 12 months is a step in the right direction and may improve provider choices for patients.

CCEP wholeheartedly endorses legislation in Raised Bill 5378 that would provide additional support for Medicaid clients with substance abuse problems. And particularly those with unstable housing through joint programs with other state organizations. A major group of ED super users, we call them, are those Medicaid patients with alcohol and substance abuse problems.

Because of a deficiency in addiction treatment options, particularly longer term rehab programs, and dual diagnosis programs that come after a detox. These patients are frequent ED users. Some of them coming to the ED more than once a day. I've had patients even in the past two weeks a young man had been in the emergency department. It was his third visit in 24 hours for alcohol intoxication.

The lack of sober houses and the practice of bringing all patients who appear intoxicated to the ED leads to many unnecessary Medicaid ED visits. It is proposed that sober houses staffed with mid level providers, that therefore APRNs or physician assistants, could safely staff sobering houses to markedly decrease the number of expensive ED visits for this group of Medicaid patients.

Many others states in the country do not have a

system where intoxicated patients found in public are brought to the emergency department. But that's the system that exists in Connecticut. Exists on the college campus, they find an intoxicated patient on the Quinnipiac campus, on the University of New Haven, the Southern Connecticut or the Yale campus, they are brought to Yale New Haven Hospital.

If they find an intoxicated patient on the green, they bring that patient to the hospital. They find an intoxicated patient walking in a suburban neighborhood, they bring the patient to the emergency department. Another group of ED super users -- certainly identified correctly in the report are those with mental health issues.

These patients often stay in the emergency department for days. They have multiple ED visits, while they wait inpatient psychiatric beds. This is particularly a problem for adult and adolescents as the state is woefully low on resources for this vulnerable patient population. So, CCEP endorses legislation that provides additional support to Medicaid clients with mental health diagnosis.

And finally, as part of an effort to reduce national health care spending, multiple specialties have come up with choosing wisely campaigns, where they identify a few points to put forward in the public domain. ACEOP, the American College of Emergency Physicians has adopted a five facet choosing wisely campaign this year.

One point of which is to engage available (inaudible) and hospice care services in the emergency department for patients likely to

benefit. Many patients spend the majority of their lifetime healthcare dollars in the last three months of their life. Numerous outcome studies have shown that patients enrolled in palliative care and hospice programs, not only live longer, but also have higher quality of life rating and significantly reduced cost compared to aggressive care.

However, Medicaid patients are much more likely to choose aggressive care that -- rather than palliative care or hospice care at the end of their life. Providing education to patient -- to clients simply about the benefits of palliative care, or hospice care, would reduce unnecessary health care utilization.

I think the most efficient way, at this point, for lawmakers to increase the appropriate use of palliative and hospice care throughout the state, including the Medicaid population, is by approving a MOLST program. MOLST stands for Medical Orders for Life Sustaining Treatment. Most programs allow medical providers to document patients wishes about end of life care to be respected across settings, whether it be in the nursing home, in the ambulance, in the primary care doctors office or from hospital to hospital.

And these programs have been shown to increase the percentage of physicians who actually have these conversations with their patients about end of life and document these conversations. Most programs exist or are in development in almost every state of the country and most states with mature MOLST programs report significant increases in patients with documented wishes to actually limit expensive and aggressive end of life care.

So, I -- in the -- some -- I think that CCEP agrees with everything that we've sort of had a chance to look for in the report. And really want to work together to accomplish as many of these initiatives as possible. And I just mention these -- this additional idea of choosing wisely to increase the availability of hospice and palliative care for a very vulnerable population that at this point in time suffers from a lack of education and persistent -- persistence of myths about palliative and hospice care.

SENATOR KISSEL: Well, Doctor, I want to thank you for taking the time to come to Asnuntuck for off site public hearing. And I -- I'm sure that my co-chair has some follow up questions.

REP. MUSHINSKY: Yes very interesting testimony. And different from the last hearing. Very different. You have a whole different way of looking at this. At the last hearing we were encouraged to use the Middlesex Hospital model of lining up the frequent visitors to emergency rooms with case worker in the emergency room to start to direct them to use the services that the federally funded health centers, and so on -- and -- and the mental health services.

Rather than just discharging them without a case worker. And they were having immediate success reducing their costs. So, that was one approach. Your approach is very different. You're in the way of broken down the users into different categories. And I don't think anyone had brought up previously the palliative care choice. That's -- that's a new one. And I'm not sure how much of our extra costs on these frequent visitors to emergency rooms is attributed to these people.

If it's a major or minor. I don't know. But mental health we knew about. The alcohol and substance abuse we knew about. And we know we need alternatives for -- to bring down those costs. But we -- but choosing wisely, I think that's the first time this came up. So that's very interesting additional information for us. And we -- we'll screen these bills after the public hearing and figure out where we go from here.

But I'm glad you noticed the excellence of the report. Our staff really is top notch. And this particular report written by Katherine Conlin and Mary Ellen Duffy. But they're -- all of these reports are really deep. And that's why it's such a joy for Senator Kissel and I to work on this committee. Because --

SENATOR KISSEL: You learn too.

REP. MUSHINSKY: -- yes, we -- we just learn in detail better ways to do things. And it's -- it's really rewarding for us to take this and try to re -- fix it. So, anyway, very interesting information. And do you work at Yale New Haven yourself?

DR. KAREN JUBANYIK: Yes. I'm actually an employee of Yale University. But my clinical practice is at the Yale New Haven Hospital.

REP. MUSHINSKY: Okay. Okay. Very good on the ground advice. We appreciate it very much.

SENATOR KISSEL: Now you submitted written testimony?

DR. KAREN JUBANYIK: I did submit written testimony.

SENATOR KISSEL: Okay. And there's specific

recommendations to -- for changing some of the bill proposals or adding to them?

DR. KAREN JUBANYIK: Yes. I think specifically the biggest one would be shortening the time frame from 30 days to a goal of maybe 14 days for patients seen in the emergency department.

SENATOR KISSEL: Okay.

DR. KAREN JUBANYIK: And I think, again -- you know -- the sort of -- seeing if there's ways to partner with a choosing wisely campaign. Because it is the right thing to do. And when you look at whose choosing hospice and palliative care, it's the wealthy educated population in the -- and privately insured population in the state. But in that it's better care -- you know -- and better -- in terms of both length of life and quality of life. Why should -- you know -- the Medicaid patient population not -- you know -- have access to this kind of care.

SENATOR KISSEL: And do you think that's a substantial as far as let's say looking at dollars? Do you think that that's substantial? Or is it --

DR. KAREN JUBANYIK: I think --

SENATOR KISSEL: -- or is it important in terms of like the headaches that you encounter with people coming in. That there's just really -- you know -- because if there's a way to build something in to address that, that might be worth looking into.

DR. KAREN JUBANYIK: -- yes. I think as far as total costs -- you know -- a lot of the Medicaid patients transition to Medicare once

they have a life threatening illness. So, I think in terms of total dollars saved, it's not going to be the biggest chunk of change. But I think it's a really important one. I think -- you know -- improving access for this great kind of care is really the right thing to do.

An important -- and not that expensive. Because I'm just talking about educating people about what palliative care is and what hospice care is. Palliative care is treating symptoms at any stage in a serious illness. And can begin in somebody who just has stage one breast cancer that we expect a full cure.

But palliative care is involved in treating the symptoms, both physical symptoms, emotional symptoms, psychological, financial stresses, everything. And -- it's a -- it's about educating people about what palliative care is. It's not just something that's provided in the last two days when someone has pancreatic cancer and everybody knows they're going to die.

But that's what a lot of the public thinks when you mention palliative care. They say that means I'm going to die. That doesn't mean that. Palliative care is all about providing symptom management. So, it's simple inexpensive things like education. And -- and again partnering with those people who are in a position to make sure that MOLST goes through.

Because what MOLST is is a form that physicians fill out with their patients for whom their told if your patient was to die in the next year, would you be surprised? That's who you're supposed to if you're a physician, or a PA or a nurse practitioner taking care of a patient.

That's who you should -- you know -- have these discussions with. And document with these -- you know -- often little bit cumbersome but one to two page forms about what their end of life wishes would be. And just having a form in the -- you know -- having the form in the state improves the number of physician that are actually having these conversations.

What we did find is even looking at the biggest hospitals in the country that take care of some of the sickest patients, they looked at people who had less than six months to live by any objective standard. And they asked them, how many of you had a conversation with your doctor about your end of life wishes? And only 30 percent, and that's looking at people with end stage cancer at MGH, Dana Farber, Yale -- you know -- big, big name institutions.

And only 30 percent of them reported having conversations with their doctor about what they wish -- what they're wishes would be about aggressive treatment. And what ends up happening is the default is to go to expensive aggressive treatment if the wishes aren't expressed.

SENATOR KISSEL: So, it's really some cost savings but also quality of life?

DR. KAREN JUBANYIK: Yes. Absolutely.

SENATOR KISSEL: Okay. The other thing that I -- I feel good about is -- you know -- as this -- as we move these -- try to move these issues, these bill proposals through the system to have your association on board. I mean, we may -- you know -- say call out the troops. Give us a little help -- you know -- because it doesn't

always work so easy in a short session.

But if there's 500 members here in Connecticut, and that -- what we're trying to do is a little bit of God's work in trying to make the system more rational, and also save some money -- you know -- I think we should all be moving in that direction. But sometimes -- I mean unless you have some lobbyist camped out in the building each and every day, which I'm sure you guys probably don't -- you know -- we're the ones that have to educate our -- our colleagues as to what -- why we're pushing these initiatives.

So, the fact that you took time out of the day to come here and follow up really means a lot.

DR. KAREN JUBANYIK: Yes. I know. I think you'll find our organization is very energetic. And being emergency physicians we work -- you know -- we have a lot of energy. But we also tend to work different shifts. So the reason I can come today is because I'm going to work -- you know -- a night shift. So, our -- our community is not only available but a pretty energetic community.

And we were available after Newtown to provide some testimony about mental health legislation as well as gun control laws. Because we see -- you know -- some of the devastation that happens every day in our communities. So, we -- we've already been very active in Hartford and -- and hope to continue to be so.

REP. MUSHINSKY: I want to -- I want to compliment your organization. Some of the medical groups come in just to talk about money issues. Your group is unique in that whenever you appear at the Capital, you're talking about better ways to do things. Not about money, but just

smarter ways to operate a hospital. And that's refreshing and unusual at -- at the Capital.

SENATOR KISSEL: Yes.

REP. MUSHINSKY: So, I have great respect for your organization.

DR. KAREN JUBANYIK: Thank you. Most of us go into emergency medicine because we love it. And -- you know -- we don't -- it doesn't matter to us if the patients pay individually -- you know -- we just like to take care of the patients. That's why I chose emergency medicine. Every patient I see as an opportunity to -- you know -- provide care, learn from that patient. And -- you know -- provide a service. And without regard to the patients ability to pay.

And so I think you'll find our organization very interested in all these issues. So, thank you very much.

SENATOR KISSEL: Thank you.

REP. MUSHINSKY: Thank you.

SENATOR KISSEL: Is that Stephen Sorrow? Stephen Sorrows. Sorrows? Stephen?

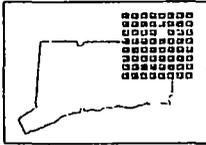
REP. MUSHINSKY: On the state parks.

SENATOR KISSEL: On state parks. On state parks. We don't have enough to lose people. Okay. And this other one. Let's see.

REP. MUSHINSKY: Julie Hulten.

SENATOR KISSEL: Julie Hulten. Okay. Welcome.

REP. MUSHINSKY: Maybe you know where Stephen went.



CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

A Chapter of the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
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Testimony for the RAISED BILL #5378/LCO 1740
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The American College of Emergency Physicians (ACEP) promotes the highest quality of emergency care and is the leading advocate for more than 28,000 US emergency physicians, their patients, and the public. The Connecticut Chapter (CCEP) represents close to 500 physician members living or working in the state of Connecticut.

The Emergency Departments (EDs) in the state of Connecticut continue to have increasing total patient volume, including an increase in visits from Medicaid patients. While the vast majority of ED visits are appropriate, at least prospectively from a patient's point of view, it is important to examine the areas for potential user reduction.

- CCEP is in favor with the provision of Raised Bill #5378 that frequent ED users insured by Medicaid would be referred to an intensive case management system that would emphasize the importance of primary care and specialist availability. Though the bill specifically mentions a one month time frame for primary care follow-up, CCEP would advocate for a significantly shorter window of 7-14 days. These frequent utilizers often have multiple ED visits within the 30 days after an index visit, and therefore need much quicker follow-up than 30 days. A major problem that Medicaid patients face is that few primary care physicians accept Medicaid patients due to low reimbursement rates. For outpatient specialty care, there are even fewer options for Medicaid patients, with months-long wait times for appointments. The Federally funded clinics (FQHCs) are often overcrowded, with limited hours, and may not be accessible to patients with transportation issues. So it is not uncommon to see a Medicaid patient in the ED multiple times for a problem that could have been managed in the outpatient setting. These issues are not seen in the Medicare population, therefore it seems reasonable that if Medicaid reimbursements reached parity with Medicare's, patients would have much more in the way of provider choices.
- CCEP wholeheartedly endorses legislation in Raised Bill #5378 that would provide additional support for Medicaid clients with substance abuse problems. A major group of ED superusers are those Medicaid patients with alcohol and other substance abuse.

problems. Because of a deficiency of addiction treatment options, particularly rehabilitation programs and dual diagnosis programs, these patients are frequent ED users, some of them coming to the ED more than once a day. The lack of sober houses and the practice of bringing all patients who appear intoxicated to the ED causes unnecessary Medicaid ED visits. It is proposed that sober houses, staffed with midlevel providers (Advanced Practice Registered Nurses and Physicians' Assistants), could safely staff sobering houses to markedly decrease the number of expensive ED visits for this group of Medicaid patients.

- Another major group of ED superusers are those Medicaid patients with mental health problems. These patients often stay in the ED for days, awaiting inpatient psychiatric hospital beds. This problem is particularly acute for children and adolescents, as the state is woefully low on resources for this vulnerable patient population. CCEP endorses legislation that provides additional support to Medicaid clients with mental health diagnoses.
- As part of an effort to reduce national health care spending, ACEP has adopted a 5-facet "Choosing Wisely" campaign, one point of which is to engage available palliative and hospice care services in the emergency department for patients likely to benefit. Many patients spend the majority of their lifetime healthcare dollars in the last three months of their life. Numerous outcome studies have shown that patients enrolled in palliative care and hospice programs not only live longer, but also have higher quality of life ratings and at significantly reduced costs compared to aggressive care. However, Medicaid patients are much more likely to choose aggressive care rather than palliative or hospice care at end of life. Providing education to clients about the benefits of palliative care programs would reduce unnecessary health care utilization. An efficient way for lawmakers to increase the appropriate use of palliative and hospice care is by approving a MOLST (Medical Orders for Life-Sustaining Treatment) program. MOLST programs allow medical providers to document patients' wishes about end of life care, to be respected across settings, and have been shown to increase the percentage of physicians who have conversations with their patients about end of life care. MOLST programs exist or are in development in most states and those states with mature programs report significant increases in patients with documented wishes to limit expensive and aggressive care at end of life.
- CCEP continues to urge lawmakers to consider how Medicaid payments are made to Emergency Physicians. The manner in which the Department of Social Services administers the Medicaid insurance program creates significant barriers for Connecticut's Emergency Departments to fulfill their mission to provide timely and compassionate emergency care to a growing population of patients. Some of these decisions are based on an antiquated system when all emergency physicians were hospital employees. Other decisions are based on retrospective reviews and administrative maneuvers which result in under-funding emergency care, thus jeopardizing access to quality emergency care and patient safety. Unlike other insurers, Medicaid payments inappropriately bundle payments for professional and facility fees for emergency services. Emergency physicians should be treated like all

other hospital based physicians, which include the specialties of anesthesiology, radiology, surgery, and pathology. First, emergency physicians should be allowed to participate with Medicaid like all other specialties. Secondly, the invoice for emergency services provided at a hospital, should contain both a facility fee and a professional physician component. Currently, the emergency physician's professional component for admitted Medicaid patients is bundled in to the hospital's per diem rate. The professional component for a discharged patient goes to the hospital and the physician must negotiate with the hospital for that reimbursement. Regardless of the employment structure, DSS should pay for the specialized and essential service the Emergency Physicians provide. Emergency physicians should not be singled out and required to negotiate with hospitals for fair payment of services provided. Medicaid fees are already below cost. To then deny these fees would force less coverage and result in longer waiting times and decreased access to quality emergency care.

I appreciate this opportunity to testify

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