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November 22, 2010

Richard McGreal, Assistant Regional Administrator
United States Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building
Boston, Massachusetts 02203

**Re: Violation of Medicaid Waiver by Connecticut Department of Social Services;
Immediate Corrective Action Needed**

Dear Mr. McGreal:

We write to advise you of a serious violation by the Connecticut Department of Social Services (DSS) of its Medicaid managed care waiver, a violation that also threatens substantial harm to the approximately 400,000 enrollees in the HUSKY A health insurance program for low-income Connecticut families and children. Specifically, the Department has stated that it has unilaterally altered its contracts with three managed care organizations (MCOs) so as to remove the obligation of the MCOs to pay all providers at rates which are at or higher than the Department's fee schedule under the fee-for-service Medicaid program. This requirement was codified in the approved waiver submitted to your agency in March of 2009. That provision of the waiver has not been modified.

As brief background, we note that Connecticut has chronically had a problem with low provider reimbursements in the HUSKY program. Inadequate rates discourage providers from participating in the program, making access to certain categories of providers, such as specialists, particularly difficult. For example, a secret shopper survey done in 2006 found that, on average, only one in four individuals posing as HUSKY A enrollees could obtain an appointment with a provider for several categories of specialists, and only 1 in 3 could obtain an appointment with a pediatrician. In 2007, the Connecticut General Assembly partially addressed this serious access problem by increasing the provider rates under the fee-for-service fee schedule with the intention that the higher fees would apply to the MCOs contracting under the HUSKY program as well. DSS operationalized this by imposing a floor on the payment levels for providers under the MCO contracts equal to the fee-for-service provider rates. As explained by DSS in a November 14, 2008 press release:

“Medical provider rates have never been higher for the HUSKY program, with \$74.6 million in increased state reimbursements. The state raised the “floor” on Medicaid rates, which provides a starting point for negotiations on both HUSKY and Charter Oak. Public health managed care works much like commercial managed care, with providers negotiating individual rates. The fact that Connecticut has raised the

negotiating start point through increased appropriations for provider rates means higher rates for doctors than were previously available.

The increase in doctor payment rates was appropriated for the two-year budget period ending June 30, 2009. While this unprecedented increase also covers doctors participating in non-HUSKY Medicaid and State-Administered General Assistance, *increased rates are available to the thousands of providers already enrolled, and those considering enrolling, with the HUSKY managed care organizations.*"

Accordingly, DSS's MCOs contracts under the HUSKY program have for some time included a provision specifically providing: "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT's Medicaid fee schedule." Section 3.47.g. And on March 2, 2009, in accordance with state law, DSS submitted for approval by two legislative committees a proposed new federal managed care waiver, which codified this requirement. Specifically, it provided, under the heading "State Plan Programmatic/policy/pricing changes": "An adjustment was made to projected MCO capitation expenditures to account for changes to the Medicaid fee schedules...; **mandated floor level of reimbursement for HUSKY A providers**...." Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs, Appendix D4, pages 6-7 (emphasis added). See also Waiver Proposal, at pages 87, 99. With the exception of a change to the provisions related to the state's PCCM program, this renewed waiver was approved by the two committees as is after a hearing on March 31, 2009, and was immediately submitted to your agency whereupon it was approved.

While this would not excuse a violation of the terms of the waiver, we note that the legislature has not reduced the appropriations for providers under the Medicaid program or in any way signaled a retreat from its intentions regarding HUSKY provider rates, recognized by DSS in its November 2008 press release stating that providers are paid under the managed care program no less than they would be paid under the fee-for-service program. Indeed, some legislators have raised concerns that the new higher fee-for-service rates, which are on average set at only 57% of Medicare rates, are still far too low to attract sufficient providers to the HUSKY A program. This is hardly a novel concern, given that the Affordable Care Act will be requiring Medicaid payments, at least for primary care services, at full Medicare rates throughout the country starting in 2013, specifically to address Medicaid access problems.

Notwithstanding the foregoing, at the November 12, 2010 meeting of the Medicaid Care Management Oversight Council, DSS revealed for the first time that, just after submitting its new waiver in March of 2009, it had undermined the "floor" provision by exempting all durable medical equipment and laboratory services providers from this requirement, effective July 1, 2009. And it also revealed that, in August of this year, retroactively to July 1, 2010, it had **exempted all other providers** from this provision, i.e., the provision was effectively removed from the MCO contracts, with no notice to either the Medicaid Council or your agency. See DSS November 12, 2010 powerpoint presentation (excerpt attached).

We also note that DSS is currently negotiating new contracts with the three MCOs for the coming year. It is not at all clear that the reduction in MCO reimbursements to providers to an amount below the fee-for-service rates, as allowed by DSS in violation of the waiver, will

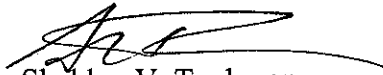
have any benefit whatsoever for either state or federal taxpayers. When specifically asked at the November 12th Medicaid Council meeting whether the new capitation rates will assume that the MCOs are still paying all providers at least at the fee-for-service rates, or some lower amount, the Department's Medicaid Director, Mark Schaefer, refused to answer the question. In response, he stated that the methodology will not be revealed until **after** the new contracts are signed, i.e., after it is too late to address any overpayments to the MCOs. In addition, a DSS report to the Medicaid Council from last month revealed that one of the MCOs, AmeriChoice, has a **medical loss ratio of only 62%** under the HUSKY B (SCHIP) program, while it is extracting 22.9% profits from this program, with the others not much better (October 8, 2010 powerpoint presentation excerpt attached). Given the troubling history of excessive payments to the MCOs, see <http://www.osc.state.ct.us/reports/health/dssaudit.pdf> (Milliman report, with May 27, 2009 cover letter from Comptroller Nancy Wyman), this lack of transparency in state contracting is a major concern, compounding the seriousness of the waiver violation.

We urge your immediate intervention. The waiver provision being disregarded threatens harm to HUSKY A enrollees who will have access problems newly created by the MCOs' ability to demand rates from providers which are even less than the insufficient rates the state pays under the fee-for-service program. Specifically, we urge you to inform DSS:

1. That it must comply with the provisions of its waiver, including those set forth in Appendix D4 related to programmatic changes.
2. That it must immediately amend its contracts with the three MCOs so as to reinstate Section 3.47.g.
3. That it must inform the MCOs that they must: (a) pay all providers at least what DSS itself pays for the same providers under its fee schedule; and (b) reimburse any providers who were paid less than the DSS fee schedule for any services provided since July 1, 2009, in an amount equal to the difference between what they were paid and the amount provided under the fee schedule in effect at that time.

Thank you for your immediate attention to this matter.

Respectfully yours,


Sheldon V. Toubman
Staff Attorney

And on behalf of:

Steve Karp
National Association of Social Workers-CT

Bonita Grubbs
Christian Community Action

Steve Frayne
Connecticut Hospital Association

Paul Wessel
CT Parent Power

Jennifer Jaff
Advocacy for Patients with Chronic Illness

Matthew Katz
Connecticut State Medical Society

Elam Lantz
Greater Hartford Legal Aid

Jillian Wood
American Academy of Pediatrics-
Connecticut Chapter

Enc.

cc: Governor M. Jodi Rell
Governor-Elect Dannel Malloy
Lieutenant Governor-Elect Nancy Wyman

Commissioner Michael Starkowski
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