

Consumer Access Meeting Summary: January 19, 2005

Co-Chairs: Irene J. Liu Christine Bianchi
(Next Meeting: Wednesday March 2, 2005, LOB RM 2600)

2004 Subcommittee Focus (see attachment) & Updates

- ü Address change pilot: it is expected that the CHNCT pilot will begin at the end of January. There was a slight delay in CHNCT access to the EMS system for client caseworkers.
- ü On-line applications update: the DSS is engaged in a fact-finding survey from other states. At the Nov 2004 meeting with DSS, Sen. Harp, SC Co-Chairs, it was suggested that a meeting be convened in January to further discuss the DSS intention about on-line applications.

2005 Subcommittee Focus

Subcommittee participants discussed focus issues for 2005 that included:

- ü Dental Access: suggestion that Infoline provide information from their report on calls related to key areas such as dental access. (*At the January 21, 2005 Medicaid Council meeting, the DSS stated the planned carve-out of dental services in HUSKY A & B will not be implemented. Dental services in HUSKY A & B will remain as is, with dental subcontractors for each managed care plan.*)
- ü HUSKY A member plan changes: HUSKY A members can change health plans once/30 days while HUSKY B members are “locked” in to their health plan choice after a 90-day ‘look’ period. Questions were raised as to what drives the plan changes (members that change plans in a month account for about 1-1.5% of the enrolled members, which can be about 3500-4500 members/month and about 45,000 in one year). The reasons vary:
 - o If the member’s PCP no longer participates in the MCO, the member may change to follow their provider. For example, in December 2004 2200 PONE members changed to CHNCT because of the loss of the Physician Health Alliance practitioners in the PONE provider network.
 - o Members may have trouble getting an appointment with their PCP, or specialist and change to another provider that is not in their MCO provider panel. Question was raised as to whether the member first contacted their MCO Members services for access to another practitioner in their plan.
 - o Members may change plans in response to health plan marketing and may receive mis-information, finding that their PCP is not in that MCO network and change back or to another plan.

This is a topic the subcommittee participants want to focus on. It is important to have more information for plan changes, in light of future possibility of HUSKY A lock-in. Next steps include:

- ACS review and consider possible changes in the menu items used to aggregate plan change reasons.
 - Consider a voluntary phone survey of members when they call to change their health plan, identifying reasons, aggregating results, identifying those problem areas that can be resolved.
- ü Timely transfer of applications/renewals from HUSKY A to B or HUSKY B to A via ACS and regional DSS offices. (Applications received by ACS that require Medicaid eligibility determinations are sent to DSS offices. This represents about 45% of monthly applications & renewals). The DSS is looking at this and this was noted in the Program Review report on Medicaid eligibility). The DSS has rewritten notices in simple language and the next step is coding this into the MMIS system.

Discussion will continue at the March meeting. **The Chairs asked participants to consider specific issues related to health care access (health coverage and access to services in the managed care program).**

Other Updates

HUSKY A adult coverage for those parents/caregivers (about 13,000) of HUSKY children that were part of the TRO and remain covered under Transitional Medical Assistance (TMA) through March 31, 2005 was discussed. The DSS stated these HUSKY members would receive first renewal notice at the end of January, which will be a pre-filled form of client information that the client will be asked to update and return to DSS. Another notice will be sent mid-March. The adults would lose Medicaid eligibility if 1) they do not respond to the notices, 2) are ineligible for Medicaid based on income; however these clients could participate in Medicaid spend down.

Deferred discussion of the special transportation information to March.

Medicaid Council Consumer Access Subcommittee Marketing Ad Hoc Work Group

(Next meeting March 2, 2005 12 noon in LOB RM 2600)

Background

The BBA led to CMS regulations that state Medicaid agencies develop an external Medicaid Advisory Committee (42 CFP 431.12), one task of which would be to review and advise the agency on managed care marketing materials. While the CT DSS has advisory committees related to specific initiatives (i.e. Medicaid drugs, dental & Behavioral Health restructuring advisory & clinical committees) an inclusive Advisory Committee to address all components of Medicaid had not been implemented because of budgetary issues.

Role of the work group

The work group will review HUSKY managed care organizations' marketing plans and make recommendations to DSS. The marketing material review will be based on:

- Federal and State marketing requirements and contract provisions
- Cultural sensitivity, reading level (7th grade level)
- Other issues that affect the DSS provisions.

Process

The work group comprised of community practitioners and family/children advocates, received the marketing requirements and provision materials prior to this meeting. Members will refer to these documents when reviewing information sent to them by DSS. The Department (Theresa Rugans) will send members the MCO 2005 marketing plans via email and receive work group members' comments back via email.

The work group will meet after the 10:30 **March 2, 2005 CA SC meeting, from 12-1:15 PM** to discuss the materials sent to them and allow for a Q&A time.