

**Connecticut**  
**Medicaid Managed Care Council**  
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**June 14, 2002**  
**Meeting Summary**

*Present:* Senator Toni Harp (Chair), Rep. Vickie Nardello, David Parrella & Rose Ciarcia (DSS), Barbara Geller for Paul DeLio (DMHAS), Thomas Deasy (Office of the Comptroller), Marie Roberto (DPH), Dr. Victoria Niman, Naida Arcenas for Gary Blau (DCF), Barbara Parks Wolf for David Guttchen (OPM), Dr. Edward Kamens, Dr. Wilfred Reguero, Rev. Bonita Grubbs, Lisa Sementilli, Judy Solomon, Phyllis Rotella, Ellen Andrews, Patrick Carolan (Benecare), Elaine Bernier for Janice Perkins (Health Net), Jeffrey Walter.

*Also Present:* Paula Armbruster, Tejas Patel (FirstChoice/Preferred One), Deborah Hine (Anthem BCFP), Sylvia Kelly (CHNCT), Martha Okafor (DSS), Maria Cerino (ACS, formerly Benova), M. McCourt (Council staff).

**Department of Social Services**

*Managed Care Audited Financial Report*

The Department presented the audited Revenue/Expense report CY 2001 of the HUSKY health plans. The report includes Medicaid lines of business, although the CT 2000 report included both lines of business, where appropriate, at a past Council request:

**HUSKY Revenues and Expenses, All Plans, CY 2001**

	<b>Anthem</b>	<b>CHNCT</b>	<b>FirstChoice/P1</b>	<b>Health Net</b>	<b>Total all Plans</b>
Member months	1,246,868	492,200	235,198	1,044,802	3,019,068
Revenue	195,787,457	\$79,800,464	\$39,030,444	\$173,081,179	\$487,699,544
Medical Expense	181,859,073	69,050,763	36,144,430	160,599,274	447,653,540
Administrative Expense	14,662,500	8,738,301	5,048,411	13,882,233	42,311,445
Total Expense	196,521,573	77,885,498	41,192,841	174,481,507	490,081,419
Net Income	(477,176)	1,914,966	(2,623,928)	(1,008,236)	(2,194,374)
Medical Loss Ratio	93%	87%	93%	93%	92%

Administrative Loss Ratio	7%	11%	13%	8%	9%
Margin	0%	2%	-7%	-1%	0%

*\*FirstChoice audited HUSKY line of business report is not yet complete. Their report is based on audited report less revenue & expenses for non-HUSKY clients.*

*\*\* Anthem report includes \$256,940 and HN \$1,400,238 federal income taxes*

Financial Reports 1997-2001\*

All Plans	1997**	1998***	1999	2000	2001
Member Months	NA	2,594,181	2,726,260 (A&B)	NA	3,019,068
Revenue	\$355,891,806	\$371,857,435	\$391,718,968	\$438,048,971	\$487,699,544
Medical Expense	\$321,211,261	\$318,870,962	\$357,912,361	\$381,003,060	\$447,653,540
Administrative Expense	\$5,483,081	\$45,806,348	\$37,459,038	\$43,869,414	\$42,331,445
Total Expense	\$326,694,342	\$364,677,310	\$395,371,399	\$424,872,474	\$490,081,419
Medical Loss Ratio	90%	86%	91%	88%	92%
Administrative Loss Ratio	16%	12%	10%	10%	9%
Margin	Range of 4% to -25%	1%	-1%	2%	0%

\*Data source: R & E reports to MMCC by DSS over past 5 years; not reported at the 6/02 meeting.

\*\*Unaudited HUSKY reports and audited reports on all line of business CY 1997 for 7 MCOs

\*\*\*Unaudited reports from MCO quarterly reports; CY report not reported.

Discussion highlighted several issues:

- Break out of administrative costs, especially among subcontractors, unclear in the reports. According to the MCOs, the inclusion of administrative costs varies by MCO. Administrative costs may be reported separately or put in with medical expenses depending upon the type of contract the MCO has with the vendor:
  - o In a contractual ASO capitation arrangement such as Anthem BCFP has with ValueOptions, the vendor fee is in the administration expense category.
  - o Risk based capitated payments to vendors (i.e. dental) would be reported under medical

expenses.

o Rep. Nardello commented that the current financial reports never get at the vendor's administrative cost in any consistent manner. Legislation passed in 2002 (PA No 02-3) { *requires "on or after July 1, 2002, each managed care subcontractor paying claims for mental health or dental, paid by a Medicaid managed care plan shall submit a report on a quarterly basis to DSS on the proportion and amount of its monthly payment received from the plan for that which has been 1) paid directly to providers of health services and 2) used by the subcontractor for its own administrative costs and profit".* } may provide the information requested by the Council.

· Senator Harp asked DSS to comment on how this financial report is used by DSS in the administration of the program. David Parrella stated that the data suggests that while the program is not now financially robust, it is not headed toward disaster. There has been significant program growth in 2001-02. The main area of concern in maintaining capacity to enroll members is dental. The Department hopes that by moving dental and mental health out of the program, as a carve-out, the program will be more viable and current MCOs as well as those attracted by the marketing material distributed throughout the country will be willing to participate in the HUSKY program. The dental carve out time line: complete the RFP, issue it in September, select ASO vendor by April 2003, implement July 1 2003. The BH process will be similar, with an RFP released in the Fall and a July 2003 start date.

## **University of Connecticut Health Center (UCHC) Dental Pilots**

There are two dental project sites; a private practice in Newington and another site moved from the University of New Haven Dental Hygiene School to the Hill Health Center in May 2002. The General Assembly allocated \$250,000 to DPH for the development of innovative dental projects and DSS set aside an additional \$350,000 for case management fees. As of January 2002, \$155,000 of the \$350,000 was released to UCHC for case management. From September 2001 to May 2002, the following enrollment numbers were reported by UCHC:

	Enrollment #'s	Case Management Fee
New Haven 9/01-5/02	71	\$1670
Newington 9/01-5/02	1092	\$26,590
Pilot Totals	1163	\$28,260
<b>Projections for FY2003</b>	<b>3700</b>	<b>\$127,500</b>

The report indicates that at an average cost of \$24.30 incentive fees per child, 1163 children have been enrolled in a permanent dental home.

Council comments/questions:

- A total amount of \$500,000 was allocated to DPH in the 2000 legislative session, of which \$250,000 would be used by DPH for provider oral health education and \$250,000 to develop the dental pilot infrastructure.
- These expensive pilots needed established evaluation measures prior to releasing the funds.
- Unclear what the case management services are, request UCHC to attend the next Council

meeting to define this service within the pilot program.

- The case management fees appeared to be an indirect way to increase overall dental fees.

Dental Projects in the HUSKY Program

The Department of Social Services has:

- Applied for a Robert Wood Johnson \$1M grant for innovative programs to improve access for Medicaid and SCHIP populations across urban, suburban and rural areas. Five communities have been targeted: Manchester, New Haven, Stamford, Torrington and Willimantic. The Governor has designated DSS as the lead agency for the grant, with collaboration by DPH, UCONN Dental School, Dept. of Education and community groups. The grant will target school children, using portable hygiene equipment for preventive services; a UCHC dental fellow will provide restorative care at safety net sites with cost-based reimbursement. The Department is working with community groups to further define the program and interface with existing services over the next 9 months, if CT receives the grant.
- Developed a Dental Policy Guide that will be mailed to dental providers, which describe the services covered under HUSKY and prior authorization.
- Worked on a state loan forgiveness program for dentists, dental hygienists that require work in the public sector part time (federal programs require full time work). This program has been allocated \$350,000 through DPH beginning July 2003.
- Worked with the Dental Hygienist Association to disseminate and clarify the Medicaid regulations that allow the hygienists to work unsupervised in public health settings.
- Continued work on the HUSKY dental carve-out and the RWJ grant application.

**HUSKY Managed Care Projects**

## **DBP, the dental subcontractor for Anthem BCFP**

The objectives of the 2002 work plan are to increase member access to services, increase follow up of screens to ensure restorative care services and improve communication between the dental community and the health plan. The plan focused on utilization follow up improvement goals for three age groups: increase follow up care by 10% for 2-5 year olds and 6-9 years old members and by 5% for 10-14 years old members. The plan initiatives included:

- Build provider collaboration through DBP monthly office visits/calls, information in the provider newsletter about cultural diversity, language interpreter access, and transportation access.
- Dedicated outreach staff for provider (dentists & dental hygienists) in Hartford, Tolland, New Haven counties.
- Send members appointment reminder postcards, phone reminders and appointment assistance.
- Anthem donated \$20,000 to the Hartford school clinics for additional sealants.
- Provide oral screens, dental caries check at summer camps, send restorative recommendations to the parents; HealthReach staff track these children for access to the recommended services.
- Studying the no-show rates in New Haven, Hartford & Fairfield counties, provide this information to HealthReach staff for connecting child to dental care. No-show rates vary by areas: Torrington 4%, Newington 30-45%. Anthem has recorded an overall 60% no show rate.

## **BeneCare, the dental subcontractor for CHNCT and FirstChoice/Preferred One**

BeneCare, and the two health plans developed a dental project in West Haven, with the University of New Haven Dental Hygienist school, targeting 5 schools, identified by the numbers of students involved in the school lunch program. The Board of Education, the municipality, and the teachers' union all supported the project that provided dental education, dental screens and case management for follow up restorative dental care.

- 1200 students in 5 schools received dental screens.
- Of the 272 BeneCare children requiring restorative care, BeneCare made dental appointments, and 212 children received complete care. There was a 90% appointment 'show' rate, credited to strong case management by the Benecare, CHNCT and Preferred One outreach staff. The school nurses referred children enrolled in other health plans that were screened and required further dental services to these other health plans for appointments. The cost for the pilot, excluding dental service costs, is approximately \$60-70,000.
- BeneCare and ACS (formerly Benova) attended WIC programs, kindergarten sign-up days, and summer camp programs to provide information on dental care and HUSKY enrollment to parents.

**Current** projects include:

- Expand the program (begun in West Haven) with the collaboration of the newly created New Haven Oral Health Coalition, targeting specific sites, use screening forms to identify children who have had recent services under BeneCare, and follow up treatment as appropriate.
    - o Case management, screens, education and follow up treatment services will be the focus of the expansion.
    - o Work with 8 dental offices that do not presently take Medicaid members, who have agreed to do follow up dental treatment and become the pilot member's 'dental home'.
  - Identify members with no oral health care, link oral health with EPSDT pediatric services/PCP.
  - BeneCare has developed a central call center for available dental appointments within their provider network in the community, notifies members of new available dental providers.
  - Both CHNCT and Preferred One have targeted prenatal dental care, as studies suggest a correlation of maternal poor oral health and a higher incidence of low birth weight babies. Pregnant women are also given information on the importance of infant oral health.
- Senator Harp commended the managed care organizations for their creative approaches to increasing dental care access, collaborating with community-based organizations, noting that the Spring National Oral Health Conference selected the West Haven project as an exemplary practice for presentation. Senator Harp thanked Martha Okafor (DSS) for her leadership in working with the MCOs to develop creative pilots.

## Other

It was reported that one Regional Perinatal Care Center had refused a HUSKY MCO member access to level 2 ultrasound, as the facility no longer has a contract with that MCO. The question was raised as to the obligation of a "designated" center that provides specialized services to high-risk pregnant women and newborns in order to reduce duplication of costly services and ensure consistent quality of care, to provide such care to Medicaid women and newborns. The Department of Social Services commented that while medical centers and individual MCOs may not have contracts, specialized, critical services cannot be withheld based on contractual issues. Senator Harp stated that there are other funding streams to pay for services outside the MCO/institution contract, such as the uncompensated care pool and questioned if that reimbursement is at a higher rate than HUSKY. Senator Harp stated that this practice (refusing services by a "designated center") is appalling in a competitive market place where hospitals request rate increases from the State as well as increased uncompensated care pool funding, and yet refuse to provide care, even though there are other reimbursement mechanisms. The Department is working to resolve this and the Council will request an update on the resolution of the issue.

The Department agreed to report in July on the HUSKY MCO case management quarterly data,

submitted by health plans since the 4<sup>th</sup> quarter 2000.

Senator Harp requested Tejas Patel, FirstChoice/Preferred One, to inform the Council about the recent newspaper report of changes in the plan. Mr. Patel stated the plan has reached agreement with a private investor group for the New York and CT lines of business. The investment group will infuse capital into the company over the next 90 days; Mr. Patel will remain in the CT company and there will be no structural changes in the company for 1-3 years.

**HUSKY Enrollment Report: ACS (formerly Benova)**

Maria Cerino reported on the monthly HUSKY A & B enrollment numbers and the HUSKY application time frames, as requested by the Council in May. Summary of enrollment, comparing June 2000 and 2001 with 2002:

**2002 Compared to 2000 2002 Compared to 2001**

	Enrollment # Change 00-02	Enrollment % Change 00-02	Enrollment # Change 01-02	Enrollment % Change 01-02
HUSKY A & B	50,105	> 17%	39,953	> 14%
Total HUSKY A	42,780	> 15%	35,440	> 13%
HUSKY A Adults**	22,793	> 28%	17,393	> 22%
HUSKY A <19	19,987	> 10%	18,047	> 9%
HUSKY B			4591	> 35%
HUSKY Applications(May)	1144	> 47%	181	>7%*

\*April 01 -May 01, applications received >490 in one month; a 22% increase from the previous month.

\*\* HUSKY Family expansion for parents/caretakers of HUSKY children to 150%FPL began 1/2001.

The Department of Social Services and ACS were requested to review the application processing time frames (see attached flow charts).

- Total application processing time is 45 days for applications received either through ACS or DSS.
- If the application received is complete, disposition is completed within 7 days with approved, referred, denied, withdrawn or canceled letter sent to the applicant.
- If there is missing information on the application, ACS works within a 30-day time frame to obtain the information. According to ACS, many applications aren't complete. ACS follows up with the applicant in obtaining the information required for a completed HUSKY B application; DSS follows up with incomplete HUSKY A applications. Some incomplete applications are referred to the regional DSS offices (i.e to clarify self-reported income versus income information from linkage to other income systems).

- Completed HUSKY A applications are screened for other related program eligibility. Those that may be eligible for other programs are sent to the regional DSS office and the decision letter is sent to the applicant. If the applicant is not eligible for related programs, the DSS presumptive eligibility unit reviews the presumptive eligibility forms and the decision letter is sent to the applicant and forwarded to the regional DSS office for maintenance.

Sen. Harp commented that she had the privilege to present an overview of the CT Medicaid program and enrollment strategies at a Washington, D.C. Kaiser Foundation meeting. Senator Harp described the positive initiatives of DSS, ACS, Children's Health Council and the Medicaid Council to ensure that eligible families, especially those transitioning from TFA, retain enrollment or become enrolled in the HUSKY programs. The Department has been responsive to the recommendations of advocates, the Medicaid Council and the CHC and has secured extra resources through grants to improve the enrollment process. These efforts have received national recognition.

Council comment:

- The Senator requested the Department discuss current initiatives to better inform clients of maintaining continuous health coverage and changes in coverage for those transitioning from welfare.

- Can the HUSKY MCOs alert their members of approaching renewal times? Rose Ciarcia stated that a MMIS system request had been made to include providing MCOs with the 12 month expiration/renewal dates for their members. The work cues for the MMIS department are long; moving this up to the front of the work cue without additional resources is difficult.

## **Qualidigm Report: Psychotropic Medications in Young HUSKY Children**

Tierney Sherwin reported on Phase II of the study of psychotropic medication use in HUSKY A children that focused on children newborn through age 4 years identified in Phase I that had been prescribed psychotropic drugs. The Phase II purpose was to verify the pharmacy database with medical records and describe the documented rationale for prescribing practices in this age group:

- Study set included 123 children, with a 48% match (59 children) between the database and the medical record. Of those matched sets, 91.5% of the children had a documented rationale for the medication use.

- The most frequently documented diagnoses among the 59 children were attention-deficit or disruptive behavior disorder (64.6%) and seizure disorder or treatment of spasms (25%).

- The drugs most frequently prescribed were stimulants (52.1%) and alpha-2 agonists (12.8%) for ADDH and mood stabilizers (20.8%) for seizure disorder/spasms.

The Qualidigm team is currently studying children who appear to have received two or more medications simultaneously (polypharmacy).

Council questions/comments:

- Of the 500 children less than age 5 identified in Phase I as having been prescribed psychotropic medications, 123 were included in the study, but matched data (pharmacy database & chart match, documentation of medication reason) brought the number down to 59. The small study numbers represent lack of concordance with the study criteria for the majority of identified subjects. Whether there are similarities among the actual study subjects to the larger group could not be determined.

- Identification of the prescribing provider was not possible because of incomplete data: pharmacy database has drug, DEA institution name rather than individual provider. Similar

problems arise in identifying the providers when the Tax ID is used: this usually references the institution, not the individual provider, in clinic practices.

- There is evidence that some of the psychotropics are prescribed for medical diagnoses rather than behavioral/mental health problems.

The Council members expressed concern about the ability to match databases, chart documentation and provider type identification. Qualidigm has identified aspects of these problems in previous studies.

**The Medicaid Council will next meet on Friday July 19, 9:30 Am at the LOB. There will be no meeting in August.**