

Connecticut  
Medicaid Managed Care Council  
Legislative Office Building Room 3000, Hartford CT 06106  
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307  
www.cga.state.ct.us/ph/medicaid

---

**Meeting Summary: December 13, 2002**

**Present:** Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella & Rose Ciarcia (DSS), Naida Arcenas(DCF), Dr. Ardell Wilson (DPH), Thomas Deasey (Office of the Comptroller), Barbara Parks Wolf (OPM), Dr. Edward Kamens, Lisa Sementilli, Judith Solomon, , Phyllis Rotella, Ellen Andrews, Irene Jay Liu, Patrick Carolan, Janice Perkins & Patrick Carolan (MCO representatives) and Jeffrey Walter.

**Also present:** Mark Schaefer (DSS), William Diamond (ACS), Jack Huber (Qualidigm), Mark Scapellati (CHNCT), Joan Morgan (FirstChoice/P-1), Lois Berkowitz (Anthem CHCS), Dr. Kurt Koral (CSDA), Chet Brodnicki, (Child Guidance Clinics), Melody Bonjour (SBHC), Mary Alice Lee (CHC), Mary Beth Bonadies & Michael Sabados (OHCA), M. McCourt (Council staff).

**Department of Social Services**

David Parrella announced that Deborah Hine, Anthem BCFP, will be leaving Anthem January 3, 2003. Ms. Hine stated she has accepted a position as Chief Operating Officer of URIX, a data reporting company founded by John Farrell. The Council applauded Ms Hine for her long work with the HUSKY program.

***HUSKY A Dental & Behavioral Health Revenue/Expense Report***

Pursuant to PA 02-3, which requires HUSKY managed care organizations to report to DSS the revenue and medical/administrative expenses for their (risk-based) dental and BH subcontractors, the Department provided information for behavioral health that includes 1) FirstChoice/Preferred One and CompCare, 2) Health Net/ValueOptions; dental financial reports are from 1) Anthem/DBP and 2) Preferred One/BeneCare. The reports for 1Q02-3Q02 were the average of the two risk-based subcontractors for each of the two services. The behavioral health report **did not** include the Department's reinsurance payments to the BH subcontractors; the Department will present these reports at the next meeting.

Report summary (copies available in LOB RM 3000) for **2002 YTD**:

	<b>Dental</b>	<b>Behavioral Health</b>
Member Months	1,290,472	1,055,166
Revenue	\$11,419,814	\$15,615,637
Medical Expense	8,065,961	15,098,939

Administrative Expense	1,580,164	3,479,700
Total Expense	9,646,125	18,578,639
Net Income (Loss)	1,773,689	(2,963,002)
Medical Loss Ratio	73%	97%
Administrative Loss Ratio	14%	22%
Margin	16%	-19%
PMPM Revenue	\$8.85	\$14.80
	<b>Dental</b>	<b>Behavioral Health</b>
PMPM Medical	\$6.25	\$14.31
PMPM Administration	\$1.22	\$3.30
PMPM Expense	\$1.37	\$17.61
PMPM Margin	\$1.37	(\$2.81)

The DSS response to questions about the report:

- The administrative cost items are based on the National Association of Insurance Commissioners standards, so the reports should be comparable across plans. Patrick Carolyn (BeneCare) stated that the simplest way to consider administrative costs are those costs representing anything that is not a claim cost.
- The negative margin (-19%) in BH, based on the two risk-based plans' report, suggests this is not a viable economic endeavor. Mark Schaefer (DSS) stated these reports are the best evidence of sub capitation amounts that under estimate BH spending. The absence of the reinsurance payment, which is not counted as revenue, does not provide the full information on the actual cost of BH services. *(For the plans, inclusion of the reinsurance payments would seem to alter the loss margins).*
- The average BH administrative costs of 22% (ranging across quarters from 21-24%) could argue for the BH carve-out. While Dr. Schaefer could not comment on the anticipated BH carve-out administrative rate because of the ongoing procurement process, he restated the rationale for the carve-out:
  - Improve administrative efficiencies by reducing the current multiple infrastructures in place across the MCOs.
  - Change the funding arrangement that currently provides a disproportionate incentive for hospitalization versus community-based care when reinsurance is added in.
  - Under a capitated For Profit system, there is a fundamental cost shift to the State

through the DCF system. The goal of the carve-out is to create a single pool of funds for BH.

- The dental margins reported range from 12-22%, averaging 16% across the three quarters for the two plans. This could support the argument for a self-insured dental carve-out that would reduce this margin, yet maintain a positive administrative rate. The DSS was asked if a dental carve-out would make less money available for other services, considering the extent of the dental margin. David Parrella (DSS) noted the two reports represent under funding in one service and not enough dollars spent on services in the other. In either area, the State is not meeting the mark of where the State wants to go in funding services.
- The MCOs have resubmitted a revised subcontractor financial report that **includes BH reinsurance dollars for each quarter**, which the Department will report on at the next meeting. Health Net requested an opportunity to review the report submitted by Health Net and comment at the January meeting.

The Dental Management ASO RFP with linked procurement with the State Employee dental plan can be obtained from the DSS web site early in the week of 12/16:

[www.dss.state.ct.us/rfps/index.htm](http://www.dss.state.ct.us/rfps/index.htm).

## HUSKY MCO Drug Formulary

The DSS reviewed the HUSKY contractual pharmacy access standards (section 3.15 of the DSS/MCO contract – copies are available in LOB RM 3000). Three MCOs (Anthem BCFP, Health Net Healthy Options and CHNCT) have prescription drug formularies in place.

- Health Net changes **were effective 10/1/02**, with advance letters sent to members 9/1/02, written instructions to providers on the changes and the Prior Authorization (PA) process prior to 10/1/02 and a one page guide was sent to Pharmacists and Physicians prior to the date change.
- Anthem BCFP changes were effective 11/15/02; however physicians were mailed the revised date of **January 1, 2003** for drug(s) deleted from the formulary and notice that **their patients would be able to continue the medications now off formulary for another year without any action on their (the prescribing practitioner's) part.**

The Department outlined the drug formulary process from the DSS/MCO most recent contract: The DSS shall, according section 3.15 of the DSS/MCO contract:

- Review the MCO's submitted formulary changes, reserving the right to identify to the MCO the deficiencies the DSS notes with the MCO formulary.
- Determine if there is a pattern of denials for authorization of particular drugs by the MCO or any other patterns suggesting the MCO's authorization process does not appropriately consider the individual member's medical needs. The DSS may require notices of action beyond what is specified in contract or may require the addition of a particular drug (S) to the formulary as drugs that do not require prior authorization (pg.38 of the 3.15 section).

**The MCO shall, according to section 3.15:**

- Include only FDA approved drug products that are broad enough in scope to meet the member's needs and consist of a selection of drugs which do not require Prior Approval (PA) for each specific therapeutic drug class.

- Permit access, at a minimum, to all medically necessary and appropriate drugs covered for the Medicaid Fee-For-Services population. If the drug is not on the MCO formulary, it may be obtained via PA.
- Have a timely PA process for non-formulary drugs and formulary drugs requiring PA.
- Provide written advance notice of no less than 30 days to members using *maintenance* drugs of changes in the formulary that will now require PA for the continued use of the drug.
  - If the MCO or the Pharmacy Benefit Manager (PBM) does not approve the PA for the maintenance drug, a 10-day advance written notice by the MCO/PBM to the member will be sent.
  - The MCO is to continue to authorize a drug for those members that appeal the PA decision within the 10-day period of the NOA issuance until a grievance and administrative hearing decision is rendered.
- (The MCO/PBM shall) Authorize a **30 day temporary supply of the drug** on the day when the prescription is presented at the pharmacy when:
  - The prescribing practitioner certifies that the drug is needed for an urgent /emergent condition or
  - The MCO/PBM or local pharmacist cannot contact the prescribing practitioner to discuss the prescription that requires PA.
  - If the prescribing practitioner elects to prescribe the alternative drug during the PA process or in discussion with the pharmacist, the MCO is not required to issue a NOA to the member, nor supply a temporary supply of the initial drug prescribed when the practitioner agrees to prescribe an alternative medication.
  - If the prescribing practitioner and the MCO cannot reach an agreement that another drug is equally effective other than the one prescribed, the MCO shall issue a NOA and the member shall receive the prescribed drug.
- Submit to the DSS a quarterly report detailing the prior authorization process, based on the format developed jointly by the DSS and the MCO.

The Pharmacy informs the prescribing provider of the PA requirement for those drugs required by the MCO formulary, when the member presents with the prescription if PA was not received prior to the member's presentation of the prescription at the pharmacy.

The prescribing practitioner would, in the interest of ensuring the member receive the prescribed medication, obtain PA for prescriptions for non-formulary drugs, formulary drugs requiring PA or a brand name drug where a generic substitution is available from the MCO/PBM *prior* to the member's presenting the prescription at the local pharmacy.

The Council discussion about HUSKY drug formularies included different participants' perspective on the drug formulary issue:

- The DSS stated that prescription spending increased 20% in the past year in the Medicaid (FFS & HUSKY) programs. The DSS is establishing a preferred drug list for Medicaid FFS members (PA 02-7). The Department recognizes the challenges in effectively providing patient, practitioner and pharmacy education about program changes complicated by the pharmacist work force shortages and the recent 10% reduction in the

DSS work force. Mr. Parrella stated that a Statewide preferred drug list common to all Medicaid programs might simplify the implementation of the process.

- The HUSKY MCO Anthem stated that everyone involved in the process has a responsibility to ensure that the member receives the appropriate medication; practitioners need to obtain PA before the member reaches the pharmacy to reduce delays in filling prescriptions and the pharmacies need to contact the practitioner if PA is required and not obtained. Anthem has 120,000 members with 20,000 scripts submitted per week. Deborah Hine strongly urged practitioners and members to contact the MCO as soon as possible with problems. HUSKY members that pay for a prescription out-of-pocket should immediately notify the MCO in order to receive full reimbursement from the MCO.
- The health practitioners/representatives outlined their experiences that interfere with the member receiving the appropriate drug ordered by the provider including:
  - Families present prescriptions for drug renewals at the pharmacy (referring to psychotropic drugs here) and (some) pharmacists are unwilling to provide the 30-day temporary supply.
  - Child psychiatrists need to be included in the MCO pharmacy advisory group that determine drugs included in the formulary or require PA. Clients experience difficulties when long-acting psychotropic drugs (i.e. drugs for Attention Deficit Disorders) are changed in the formulary to the short-acting drugs, necessitating several more doses a day be taken, often during school time.
  - While Advanced Nurse Practitioners (APRNs) are considered primary providers in the Medicaid FFS program and in some HUSKY plans, APRNs not included in one HUSKY MCO provider panel do not receive notices of plan practice changes, yet the APRN may see that plan's member in the clinic setting, unaware of formulary changes.
  - The prescribing practitioner would not know that a patient has not received the prescribed drug (or the 30-day temporary supply) unless the patient themselves call the practitioner or tells the practitioner at the next health visit.
- Pharmacists may either 1) not be familiar with the HUSKY temporary supply provision and their role in contacting the practitioner if the drug requires PA and 2) may not have the staffing to comply with the DSS/MCO policy.
- The HUSKY member may not have received the MCO letter about the formulary changes for maintenance drugs or the NOA, or may not understand the content because of language or literacy barriers. Foster parents of children in the DCF may be less apt to receive notices from the MCO than the biologic parent.
- Within State agencies, HUSKY or Medicaid policy changes are communicated to administrative staff; however there is lack of participation by clinical staff in State agency meetings. For example, David Parrella (DSS) noted that while the Behavioral Health Partnership has been meeting monthly for two years, the problems encountered by children in the DCF system in obtaining medical and psychotropic drugs, as well as other clinical issues, never came up for discussion. Input from the DCF clinical staff will now occur in order to resolve some key issues.

Rep. Nardello stated that while agency resources are eroding and pharmacy costs continue to climb, patients often bear the brunt of what essentially is a communication problem in that their

drug regimens are interrupted or their access to medications is compromised. The following suggestions were made:

- ü The DSS bring a forum of health practitioners, MCOs and pharmacists together to identify the key barriers in HUSKY to medication access and steps to resolve the problem.
- ü Bring information to community-based (CB) groups on health care access, including medications. Dr. Wilson (DPH) offered to work with DSS on identifying CB grass roots coalitions including faith-based groups that can inform Medicaid clients of program changes that impact access to care.
- ü Senator Harp requested that the Department continue to closely monitor policy compliance within the system. The DSS has a mechanism that requires the MCOs to report quarterly on the temporary drug supply dispensing, percentage of approved PA. The Department will report on this at the January or February Council meeting.

## Medicaid Optional Services Reductions

Mr. Parrella state that as of **January 1, 2003**, pursuant to 2002 legislative mandate, the Medicaid program will no longer pay for (**Medicaid optional**) services for clients who are **21 years of age or older** from the following **independently enrolled** providers: podiatrists, chiropractors, naturopaths, other independent therapists including physical therapists, licensed audiologists and speech pathologists, and psychologists. Notification of these changes will be mailed to Medicaid clients and providers December 17, 2002.

In response to questions from the Council, the DSS stated:

- There will be no change in reimbursement for those clients in out-of-state treatment that are over 21 years of age.
- There will be no effect on Medicare reimbursement.
- Under the Medicaid waiver, psychology evaluation services for DMR clients >21 years will remain.
- The above services that are provided and included in health clinic revenue codes will be reimbursed. If a FQHC has a mental health component and bills through the clinic code, the cost will be reimbursed.
- Only independent psychology services provided by outpatient mental health are eliminated.
- Physical therapy provided by home health agencies or institutions will continue to be reimbursed.

The projected savings from this legislation was budgeted at \$2.5M. The HUSKY MCOs will have a reduction in their capitation rates only for the adult population rate cells. Implementation of the elimination of adult Medicaid optional services in the HUSKY A program will probably not be implemented until April 2003, allowing time for the MCOs to incorporate this into their billing systems once their operational questions are answered by DSS. Senator Harp questioned if the DSS will convene a meeting with other State agencies to explain the elimination of services, as there seems to be a high probability for significant confusion among clients, providers and agencies. Mr. Parrella stated they have met with OPM, DMR and DMHAS. The major concern for DMR and DMHAS was the loss of independent psychologist services.

## Children’s Health Council (CHC): Birth to Mothers in HUSKY A CY 2000

Mary Alice Lee described the linkage of the DPH birth data with the HUSKY A data (see PP attachment, access report on the CHC website: [www.childrenshealthcouncil.org](http://www.childrenshealthcouncil.org)). The report, which had been requested and supported in previous Medicaid Council and QA meetings, describes prenatal health care (PNC) and birth outcomes in HUSKY A and compares prenatal risk factors and outcomes in HUSKY A to other CT births and US births. The MCOs can only report prenatal care and births for those women enrolled in the health plan. *(Based on previous HUSKY MCO quarterly data, approximately 42-48% of women who give birth while enrolled in HUSKY A were enrolled in managed care during the first trimester).* Prior to enrollment they may have received prenatal care through Medicaid FFS or other health coverage source.

The DSS, DPH and CHC have been collaborating since Fall of 2000 to develop a data sharing agreement. In order to develop an algorithm for matching CT birth data and HUSKY A enrollment data, DPH released CT birth data to CHC with approval of the DPH Human Investigations Committee in March 2002. The following is brief summary of the shared data outcomes for **CY2000**:

- Of the 43,075 CT Births, 9,630 births (22%) were to HUSKY A enrollees. Sixty percent of these births were in Hartford.
- HUSKY A teen birth rate was 7 times (22.8%) that of teen births in CT (3.3%) and twice that of the US teen birth rate (11.8%). Hispanic teens had the highest rate (28.5%) compared to the CT rate of 10.8%, black non-Hispanic teens births represented 23.6% of HUSKY A births compared to a 9.2% rate in CT and 19.2% US rate. The white non-Hispanic teen birth rate in HUSKY was 18% compared to 1.8% in CT and 8.6% in US births.
- 30% of white non-Hispanic mothers smoked during pregnancy compared to 12% of Black and Hispanic women.
- 76% of HUSKY A women who gave birth in 2000 had 1<sup>st</sup> trimester PNC compared to 88.2% of other CT births and 83% of US births. *(The HUSKY A MCOs reported average rate for 1<sup>st</sup> trimester care in the 3<sup>rd</sup> & 4<sup>th</sup> quarters of 2000 was 61.5 and 64.2% of those women enrolled in HUSKY A).*
- Summary of PNC and Birth outcomes:

	PRENATAL CARE			BIRTH OUTCOMES		
	1 <sup>st</sup> Trimester PNC	Adequate Care	Late/no care	LBW (<2500Gm)	VLBW (<1500Gm)	Pre-term (<37 weeks)
<b>HUSKY A</b>	76%	67.3%	2.9%	9.6%	1.8%	13.2%

<b>CT Births</b>	88%	83.5%	1.5%	6.8%	1.6%	11.1%
<b>US Births</b>	83%	74.2%	3.9%	7.6%	1.4%	11.6%

The DPH/DSS Memorandum of Understanding (MOU) to continue this data linkage is under final review. The Medicaid Council supports similar reporting for the CY2001 birth data that will allow other question to be answered about the HUSKY population (i.e. the impact of LBW on subsequent childhood illnesses, rate of high- risk pregnancy births in Level III Perinatal care centers).

**Office of Health Care Access: 2001 Household Health Insurance Survey**

Mary Beth Bonadies and Michael Sabados presented a summary of the CT uninsured survey sponsored by the HRSA State Planning Grant and conducted by the UCONN Center for Survey Research and Analysis (*see PP attachment; the report and additional information on the OHCA web site: [www.ohca.ct.us](http://www.ohca.ct.us)*). Connecticut is usually in the top 5 states with the lowest uninsured rates. This data, collected by random digit dial, provides a useful baseline for the State since the data was collected prior to the 2002 recession and the impact of the events of 9/11. Highlights of the survey:

- 92% of those surveyed were continuously insured and 8% reported being uninsured at any point during the last 12 months. Sixty-four percent of the insured had employer-based insurance, 26% had public insurance. Of all the factors describing the uninsured, family income was most strongly related to insurance coverage, with 21% uninsured having incomes <\$10K. Uninsured adults (age 19-64) were more likely (68%) to work in small firms of 50 or less employees; two-thirds were employed, and more than 70% were permanent full-time employees.
- Only 1.3% of children were continuously uninsured and 7.1% were uninsured at any point in the past 12 months. Seventy-seven percent of children have employer-based insurance, 13% were insured by HUSKY.
- Regular source of primary care differed among insured and uninsured adults and children:

	Physician/HMO	Hospital ED	Hospital OP/Walk-in	Public Clinic
Adults Insured	92%	0%	6%	2%
Adults Uninsured	58%	9%	27%	6%
Children Insured	92%	0%	5%	3%
HUSKY Insured children	78%	NA	13%	9%

Children Uninsured	63%	11%	11%	15%
--------------------	-----	-----	-----	-----

- One in five uninsured adults were less apt to have accessed primary care or acute illness care and one in ten did not use the ED when faced with a health problem because of the concerns about the cost of care and lack of health insurance. Uninsured children were less apt to access primary care (13%) or illness and ED care (7%) compared to insured children. Children in the HUSKY program appeared similar to other insured children in that only 2% did not access primary care or illness and 1% did not access ED care.

Health insurance coverage questions were added to the CT Business Quarterly survey done by CSRA on behalf of CT-DECD that include whether employers offer insurance coverage and if they do not, the primary reasons for this. The results:

- Overall 52% of employers offer health insurance to their employees.
  - 94% of employers with 50+ employees offer health insurance
  - 26% of employers with four or fewer employees offer insurance
  - 77% of employers with 5-9 employees offer insurance
  - 88% of employers with 10-49 employees offer insurance
- 185 of those employers that do not offer health insurance indicated they could not afford the coverage and 50% said they have too few employees.

## HUSKY Enrollment

HUSKY A Enrollment CY 2002

Total Husky A enrollment increased by 27,139 members in 2002, from January 2002 to December 2002, representing a 9.4% increase in total enrollment over the 11 months, averaging an increase of 2467 enrollees per month over the 11 months. Since last December (2001) membership has increased by 30,473, a 10.6% membership increase.

- HUSKY A < 19 years enrollment increased by 16,294, representing an 8.1% increase in enrollment for that age group from January 2002 to December 2002. Since December 2001, enrollment has increased by 17,916 (9%) members.
- HUSKY A adult enrollment increased by 10,845 members in 2002 from January to December 2002, a 13% increase in that group's enrollment. Since December 2001, enrollment has increased by 12,557 (15%) adult members.
- Adults represent 30% of the population enrolled in HUSKY A, while those < 19 years represent 70% of the total HUSKY A population.
- HUSKY B enrollment has increased by 3236 members from January 2002 to December 2002, a 23% enrollment increase.

**The Medicaid Council will meet on Friday January 17, 2003 at 9:30 AM in LOB RM 1D.**