

Connecticut
 Medicaid Managed Care Council
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Meeting Summary: July 18, 2003

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Rep. David McCluskey, Megan Collins for Rep. Mary Ann Carson, David Parrella & Rose Ciarcia (DSS), Gary Blau & Dr. Victoria Niman (DCF), Tom Deasey (Comptroller's Office), Dr. Ardel Wilson (DPH), Terry Nowalkowski (DMHAS), Dr. Edward Kamens, Ellen Andrews, Rev. Bonita Grubbs, Patrick Carolan, Romana Grimshaw for Janice Perkins (MCO representatives), Henry Goldstein.
Also present: Kevin Loveland, Lee VanderBann, Hilary Silver (DSS), Mark Scapellati (CHNCT), Paula Smyth (Anthem BCFP), Doug Hayward & Joan Morgan (Preferred One), Jesse White Fresse (SBHC), Jody Rowell (Child Guidance Clinics), Judith Solomon, M. McCourt (Council staff).

**Department of Social Services
 HUSKY Managed Care Organization
 Revenue/Expense Report CY 2002
 CY 2002**

	Anthem BCFP	CHNCT	FirstChoice/P-1	Health Net
Member Months	1,473,116	590,578	231,494	1,177,576
Revenue	\$252,477,000	\$100,832,084	\$37,254,274	\$204,851,951
Medical Expense	228,767,000	87,455,478	30,839,581	531,288,294
Administrative Expense	22,327,000	11,134,039	5,323,226	14,208,931
Total Expense	251,094,000	98,589,517	36,162,807	198,435,166
Net Income (loss)	899,000	2,242,567	1,035,266	4,023,324
Medical Loss Ratio	91%	87%	83%	90%
Administrative Loss Ratio	9%	11%	14%	7%

Margin	0%	2%	3%	2%
Fed.inc.taxes incl	\$484,000		\$56,201	\$2,393,461

Financial Reports 1997-2002* All Plans

All Plans	1997	1998	1999	2000	2001	2002
Member Months	NA	2,594,181	2,726,260 (A&B)	NA	3,019,068	3,472,764
Revenue	\$355,891,806	\$371,857,435	\$391,718,968	\$438,048,971	\$487,699,544	595,415,309
Medical Expense	\$321,211,261	\$318,870,962	\$357,912,361	\$381,003,060	\$447,653,540	531,288,294
Administrative Expense	\$5,483,081	\$45,806,348	\$37,459,038	\$43,869,414	\$42,331,445	52,993,196
Total Expense	\$326,694,342	\$364,677,310	\$395,371,399	\$424,872,474	\$490,081,419	584,281,490
Medical Loss Ratio	90%	86%	91%	88%	92%	89%
Administrative Loss Ratio	16%	12%	10%	10%	9%	9%
Margin	Range of 4% to -25%	1%	-1%	2%	0%	2%

*Data source: R & E reports to MMCC by DSS over the past 6 years; notreported at the 7/03 meeting

Highlights of Council comments/questions:

- Are administrative expenses calculated in the same manner across all health plans? While the DSS auditing firm confirms that administrative (and outstanding receivables) reports comply with auditing formats, there are differences among MCOs in that non-risk subcontractor administrative expenses are part of the main MCO administrative expense line item, whereas risk subcontractor administrative reports are included under MCO medical expenses. When dental and behavioral health services are carved out of HUSKY,

there will no longer be these variances among plans' revenue/expense reports related to these services. **Rose Ciarcia stated the Department would estimate the actual administrative/medical costs related to BH and dental for the September Council meeting.**

- How does the DSS use these reports and do they lead to improved cost and quality management among the MCOs? David Parrella replied that the DSS uses the financial reports as a basis for rate setting, identification of cost increase trends, comparison with HEDIS accrediting guidelines (i.e. administrative costs should be close to 15%), targeted auditing if there are unusual expenditure levels and general comparisons with other state Medicaid spending patterns. The latter is a broader comparison as states differ in their covered populations, inclusion of optional services, and carved-out services. The DSS would like to be more visibly engaged in the MCO process of managing the HUSKY program but staff resources limit their degree of management.
- Sen. Harp requested an explanation of the differences in the federal tax amounts reported by the two largest MCOs: **DSS will provide this information after consultation with the actuarial firm.**

HUSKY A Pharmacy Report

Below is a summary of the data presented by Lee VanderBaan (DSS).

Anthem	1Q03	4Q02	3Q02	2Q02
Total # scripts filled	192,415	183,321	166,746	169,570
Total # PA Requests	5,402 (3% of total scripts)	5,253(3%)	4,934 (3%)	5,156 (3%)
Total # PA with TS granted	2,016 (37% of all PA req.)	1,866 (36%)	1,646 (33%)	1,406 (27%)
Total # PA approved	4,595 (85% of total PA)	4,592 (87%)	4,463 (90%)	4,712 (91%)
Total # PA denied	807 (15% of total PA)	661 (13%)	471 (10%)	444 (9%)
CHNCT				
Total # scripts filled	90,724	94,776	75,796	76,274
Total # PA Requests	4,377(4.8% of total Scripts)	4,733 (5%)	4,366 (6%)	1,869 (2.5%)

Total #PA with TS granted	4,377(100% of all PA req.)	4,733 (100%)	4,366 (100%)	1,516 (81%)
Total # PA approved	3,667 (84% of total # PA)	4,309 (91%)	4,322 (99%)	1,869 (100%)
Total # PA denied	710 (16% of total # PA)	424 (9%)	44 (1%)	0
Health Net				
Total # scripts filled	195,953	186,140	179,859	182,752
Total # PA Requests	4,053(2% of total Scripts)	5,911 (3%)	5,971 (3%)	6,157 (3.4%)
Total #PA with TS granted	1,472(36% of all PA req.)	1,580 (27%)	5,679 (95%)	5,884 (96%)
Total # PA approved *	1,960 (48% of total #PA)	3,571 (60%)	5,791 (97%)	5,998 (97%)
Total # PA denied	633 (16% of total # PA)	907 (15%)	147 (2.5%)	142 (2 %)
Preferred One **				
Total # scripts filled	19,033	21,745	19,102	24,431

*Number of approved & denied PA do not total to the reported # of PA requests

** Preferred One does not use a drug formulary

Similarities among the 3 health plans included:

- The low number percentage of Prior Authorization (PA) requests, which ranged from 3-6%.
- The percentage of approved PA were >90% for the 2 & 3Q02 for the 3 plans; over the last 2 quarters the percentage ranged from 48% (Health Net) to 91% (CHNCT).
- PA denials followed a similar pattern in that the percentages were lower in the 2 & 3Q02 (average of 4.2%), increasing to an average of 14% across the 3 plans.

The one area of more noticeable variability among MCOs is the granted temporary supply (TS) for those PA drugs. CHNCT reported that 100% of the requests with TS were granted. The other MCOs differed, in that Anthem showed a range of 27-37% across the 4 quarters, Health Net had

>95% granted in 2 & 3 Q02, and 27% and 36% respectively in the 4Q02 and 1Q03.

The Health plans provided pharmacy co-pay reports for May & June 2003. This co-pay applies to Medicaid clients, including those enrolled in HUSKY, over age 20 years. Individuals *exempted* from the co-pay include individuals in institutions, pregnant women, family planning drugs and supplies. The pharmacist collects the \$1.00 per prescription; however Medicaid clients cannot be denied medications if they indicate they cannot pay the co-pay. The mix of the 'exempt' and co-pay of the total prescriptions filled were about 40% exempt and 60% co-pay across the 4 MCOs; however CHNCT, the Medicaid –only plan had a 53-57% co-pay mix.

Council questions highlighted the efficacy of policies related to managing pharmacy costs and the management process:

- Would pooled purchasing for pharmacy management be more cost effective than applying a co-pay that carries administrative costs? For example, Anthem provides pharmacy benefit management (PBM) for all state employee health programs (SEHP). The DSS noted that partnering Medicaid with SEHP has not been successful in the past. The DSS has begun the fee-for-service preferred drug program on a limited basis on 7/16/03. At this time it is not clear that a single PBM is advantageous.
- Sen. Harp stated that the pharmacy co-pay, collected by the pharmacy involves a complex relationship, which may result in the pharmacy's loss of the \$1.00/prescription and that the co-pay may cost the state more on many levels.
- Across MCOs, the non-sedating antihistamine drug class was one of the more frequently denied drugs. Sen. Harp questioned if 1) practitioners are aware of the use of more efficacious drugs and how are they informed and 2) are over the counter drugs paid by the HUSKY plans? Over-the-counter drugs are reimbursed by HUSKY MCOs. The DSS could not elaborate on the process the MCOs use to inform providers of which drugs are more effective. Common antibiotics such as amoxicillin, in the penicillin therapeutic class, are frequently denied. The MCO PMB noted that while a temporary supply of amoxicillin would be provided, the PBM would discuss with the provider more effective drugs.
- Dr. Niman (DCF) again noted and was supported by Sen. Harp, that it is important to have pediatricians and child psychiatry included the MCO formulary committees.

HUSKY Enrollment Adult Reinstatement

Kevin Loveland (DSS) discussed the latest status of adults *with earned income* and their coverage in HUSKY. On June 14, the DSS disenrolled 18,800 adults who had remained temporarily enrolled subsequent to the first court injunction associated with the PA-03-2 elimination of parent/caregiver coverage for adults >100%FPL. The 2nd Circuit Court of Appeal issued an injunction to prevent the disenrollment of adults with earned income (16,204) while the Court reviews the appeal that focuses on adults with earned income and access to Medicaid under the federal temporary medical assistance (TMA) guidelines. The Court will hear briefs from both sides on August 4. Mr. Loveland commented that once again the HUSKY MCOs quickly re-enrolled these members to maintain continuity of coverage and services. These parents >100%FPL will remain enrolled until the court decision is made. Ms. Solomon

noted that both Nebraska and Missouri courts found families with earned income eligible for TMA.

HUSKY Enrollment July 2003: Updated: July 2003 (post 7/18 meeting)

	July02	Aug02	Sept02	Oct02	Nov02	Dec02	Jan03	Feb03	Mar03	Apr03	May03	Jun03	Jul03
Total HUSKY A	277,458	278,699	280,222	282,798	285,044	287,241	289,333	291,016	295,420	297,303	299,057	294,331	287,442
A Adults	80,821	81,451	82,077	83,228	84,394	85,172	85,950	86,768	88,836	88,823	90,433	88,811	86,354*
A<19	196,637	197,248	198,145	199,570	200,650	202,069	203,383	204,248	206,584	208,480	208,624	205,520	201,088
HUSKY B	13,145	13,185	13,460	13,572	13,928	13,942	14,153	14,292	14,352	14,493	14,617	14,665	14,773

*HUSKY A adults reflect the total A enrollment minus those <19 years of age.

Other Medicaid issues

Ø Presumptive eligibility (PE) for pregnant women: Senator Harp requested and update from DSS on the improvement of implementing “PE” for pregnant women in Medicaid that involves an ‘expedited eligibility process’ rather than PE as applied to HUSKY children. Mr. Loveland stated that on May 20 the DSS issued a policy reminder to all regional office administrators. The current policy requires that upon receipt of the HUSKY application, income level and health practitioner documentation of the pregnancy and due date, the eligibility determination is to be made within 5 days.

{According to the Social Security Act, “a State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period”. The State Medicaid Manual indicates that states have the option to provide ambulatory prenatal care to pregnant women during a single limited period of PE. A qualified provider would determine PE based on preliminary information. The period of PE begins on the day of determined PE. Upon determination of PE, the woman may receive services from any provider that is eligible for service payment under the State plan. The woman must complete a Medicaid application by the last day of the month following the month when PE was determined. If she fails to submit an application within the stated time period, or is found ineligible for Medicaid, her PE ends. The State would be eligible for FFP (federal match funds) for services

during the PE period.}

Mr. Loveland stated that applying the PE federal law would be difficult during this budget period. The DSS would need to create a separate coverage group (as previously done for children's PE) for prenatal ambulatory services. Mr. Loveland stated it is important to make the current system work, reiterating that pregnant women receive #1 priority in the eligibility process. Senator Harp stated that the Council would invite Healthy Start representatives to the September Council meeting to discuss the expedited application process for pregnant women and their role in assisting women through this process.

Ø HUSKY eligibility for children who have lost coverage due to the elimination of continuous eligibility: Sen. Harp asked if the majority of children no longer insured under HUSKY A due to the loss of CE are really ineligible? Mr. Loveland stated notices have been sent to families to contact their regional caseworker to renew the application. The enrollment broker, ACS, has provided outreach to these families informing them about HUSKY B. Some families chose not to renew the application as some may have obtained employer-based insurance. The HUSKY enrollment numbers (provided in more detail after the 7/18 meeting) show that:

- o Total HUSKY A enrollment dropped by 6889 from June – July, by 11,615 since May 1.

- o HUSKY A enrollment for <19years was reduced by 4432 enrollees from June to July.

There has been a reduction in enrollment of 7536 from May 1, 2003 to July 1, 2003.

- o HUSKY B (children only) increased by 108 enrollees since June, and a total of 156 enrollees since May 1, 2003.

- o CT evaluates eligibility status on an annual basis.

Ø The outcome of presumptive eligibility (PE) for children in HUSKY A: previously the DSS had been requested to provide information on the PE:

- o For the period Jan – December 2002, 5131 were granted PE; of these, 3092 (60%) were eligible for HUSKY A. Of those 2106 denied HUSKY A, 97% of the families did not follow up with the required completed application. Approximately 3% were eligible for HUSKY B.

- o There is limited date for 2003 as the PE unit in DSS was closed and the function was moved into other areas in the agency. Approximately 955 were granted PE from February through June 2003.

Discussion: The lower PE numbers in 2003 may reflect some confusion associated with the disbanding of the central office PE unit, exacerbated by the budget proposal (Governor) to eliminate PE. The Governor's proposal relates to the 40% who do not complete the application process: the question is how many are actually ineligible for HUSKY A, yet received acute illness services paid by Medicaid FFS? The DSS acknowledged that 60% of those granted PE were deemed eligible for HUSKY; however the State needs to make eligibility decisions and assess the impact of dollars spent during this time of resource restraint.

Ø Governor's emergency authorizations pending budget decision: Sen. Harp noted that it was announced today that the Governor released dollars to DMHAS for adult mental health & substance abuse treatment. Some treatment facilities were on the verge of a fiscal crisis. The DSS releases service dollars at the direction of OPM; the last run date was on 7/15; the next cycle is 7/25. The HUSKY MCOs have been paid in full.

Ø Sen. Harp and the Council applauded Patrick Carolan's work with the Council and the

Medicaid program and the special knowledge of dental public health issues that he brought to the Council and PH subcommittee. Mr. Carolan announced he was leaving BeneCare, a dental subcontractor for CHNCT and FirstChoice/Preferred One, to do private consulting.

The Medicaid Council will Meet Friday September 12, at 9:30 AM in LOB RM 1D. The Council will not meet in August.