

## **Council Meeting Summary: September 12, 2003**

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Gary Blau (DCF), Thomas Deasy (Comptroller's Office), Dr. Ardel Wilson (DPH), Terry Nowakowski (DMHAS), Barbara Parks Wolf (OPM), Jeffrey Walters, Dr. Edward Kamens, Rev. Bonita Grubbs, Vanna Francia, Ellen Andrews, Dorothy Allen, Janice Perkins (Health Net), Doreen Elnitsky.

Also Present: William Diamond (ACS), Debbie Poerio (SBHC), Sylvia Kelly (CHNCT), Paula Smyth (ABCFFP), Dr. Kurt Koral (CSDA), Judith Solomon, M. McCourt (Council staff).

## **Department of Social Services Report**

### **HUSKY DSS/MCO contract status**

The current contract was scheduled to terminate 6/30/03; however the State budget process was not finalized at that time necessitating three contract extensions and probably a fourth from 9/30-10/31/03. The extension from 8/13-9/30 included an amended contract with federal regulation changes and other agreed upon changes, which include:

- Terminology changes (i.e. grievance vs. complaint that refers to non-action complaints, appeal vs. grievance that refers to internal review of MCO right to hearing action).
- Requirements for grievance resolution within 90 days, new timeframes for Utilization Management decisions, Notice of Action (NOA) issuance and action timeframes for UR decisions.
- Expanded definition of MCO "action" that refers to NOA and Fair Hearing triggers.
- Added standards for expedited appeals, resolution timeframes.
- CMS payment standard: 90% of clean claims within 30 days, 99% within 90 days.
- Clarification of process for member notices about formulary changes that affect a member's maintenance drug.
- Added sections on member rights (i.e. receipt of medical record), HIPAA privacy and transaction rules compliance.
- Addition of claims denied by reason report and development of action plan to improve delivery of comprehensive well care visits to adolescents (MMCC requests).
- Requirement of state certification of rates as 'actuarially sound' (based on incurred costs, projected rates) and CMS approval of the rates and the state certification. The DSS did submit the rate certification with a rate range dependent on the final outcome of the budget to the CMS.

Next steps in the contract process include rate negotiations with the MCOs and CMS final approval of rates. This will require the fourth contract extension to 10/31/03.

## **Implementation of Legislative Changes in HUSKY/Medicaid**

The Department described a phase-in implementation approach for the numerous legislative changes in the HUSKY programs, Medicaid and State Assistance (SAGA). To summarize:

| Public Act; Provisions  | Implementation Date  | Implementation Vehicle   | Details  |
|---|--|--|--|
| (Pa 03-3, sec 72)<br>*Medicaid pharmacy/ambulatory care service <b>co pays</b><br>*Pa 03-1, sec 11 SAGA                         | November 1, 2003<br><br>11/1/03  | State Medicaid Plan amendment<br>State Plan Change   | <ul style="list-style-type: none"> <li>• Prescriptions: increase from \$1 to \$1.50/script</li> <li>• Medical Services: \$2.00 per visit.</li> </ul> SAGA same co pay levels   |
| PA 03-3, Sec 69:<br>consistent failure to pay Medicaid pharmacy co pays   | Requires further discussion with CMS   | May be State Plan amendment if DSS can ID recipient categories by some factor (i.e. household income) to satisfy CMS/federal law | Pharmacies are allowed to deny filling scripts for Medicaid recipients who consistently fail to pay co pays over 6 months. Initially thought to require waiver authority to deny care in Medicaid, CMS may allow this under the State Plan if DSS can identify recipient categories.   |
| PA 03-3. Sec. 55,56:<br>HUSKY B benefit restructuring/cost share increases<br><br>(See attached DSS income guidelines for 4/03) | November 1, 2003   | State SCHIP Plan Amendment   | <ul style="list-style-type: none"> <li>• Benefit &amp; cost sharing structure similar to largest CT HMO commercial plan</li> <li>• &gt;Premiums for families with income 235-300% FPL (band 2).</li> <li>• Add per month premiums to families with income 185-235% FPL (band 1).</li> </ul> Aggregate cost sharing not to exceed 5% of family's gross annual income. |
| PA 03-3, Sec 72 HUSKY A benefit & cost sharing per month (PM)   | When waiver application process, including public comment & GA approval, completed | Requires CMS approval of waiver authority  | <ul style="list-style-type: none"> <li>• Benefits similar to State Employee non-gate keeper POE plan.</li> <li>• Cost sharing:<br/>*0-50%FPL – 0 \$<br/>*50-100%FPL - \$10 Individual PM, \$25 family PM max.<br/>*&gt;100%FPL -\$20 individual PM, \$50 family PM max.</li> </ul>   |

Council comment/questions:

• *Will Medicaid co pays apply to all HUSKY A income levels and FFS recipients?* The DSS: yes. The **11/1/03** implementation of co pays will follow existing federal law and will not be applied to pregnant women or child services. As with the initial implementation of pharmacy

co-pays in PA 03-2, these co pays apply to those Medicaid recipients >20 years of age. Exempted individuals include those institutionalized, pregnant or receiving family planning drugs & supplies. Under a waiver authority, there would be fewer exempted recipients, based on the SE POE benefit package parameters, although the co pay amounts will remain at Medicaid levels for FY 04 & 05.

- *PA 03-3 sec 69* requires DSS to amend the State Medicaid plan to allow pharmacies to deny filling prescriptions for those with a “documented continuous failure” to pay 6 months of their pharmacy co pays. Federal law prohibits denial of services because of client inability to pay. Therefore implementation of this mandate would require waiver authority. However, recent discussions between DSS and CMS indicate this could be done under the State Plan change if DSS can identify the affected recipients by some factor (i.e. family income) in order to establish recipient categories for those that could be held accountable for co pays (& denied drugs) and those for whom this would not be applicable.

- *How many Medicaid recipients are in the 50-100% and > 100%FPL income range?* The DSS will have to disaggregated recipients by household income rather than coverage groups to determine this.

- *Will provider FSS rates reflect the \$2 /visit co pay?* The State service fee will be reduced by \$2.

- *Would a waiver eliminate the current federal mandate for EPSDT services?* Yes.

- *When will the waiver be submitted?* Waivers are complex in design, controversial in content and held to a new level of federal scrutiny of ‘actuarial soundness’. The DSS will present a concept paper for Executive (branch) review in October. The waiver may be submitted before the end of the year, with legislative review (17b-8) by the committees of cognizance prior to CMS submission.

- *What is the extent of recent DSS staffing reductions?* There has been a 21% decrease in DSS staff in the past year.

- *Are the projected biennial budget savings realistic?* While the Office of Fiscal Analysis projections were sound, the main issue in realizing savings is the reality of the Agency being able to achieve the time lines. For example, implementing co pays requires a State Plan change, publication of changes, client (165,000) & provider (12,000) notice mailings; meeting the October deadline was not possible. In addition, the HUSKY B State Plan changes need to be made and preliminary work on the HUSKY waiver that includes the SAGA population is in progress.

- **The Department will provide a side-by-benefit comparison based on the legislation at the October Council meeting.**

## **Other:**

## **Service Carve out Status (Dental & BH)**

Decisions about the service carve outs were dependent on the final budget resolution:

- Dental: The Governor’s proposal included the elimination of adult Medicaid dental services, which was NOT approved by the legislature. Now that the Medicaid dental population is defined as including HUSKY A & B and Medicaid FFS recipients (SAGA dental services will be under the grant funded medical services plan), **the DSS will proceed with plans to carve out dental services July 1, 2004.**
- Behavioral Health Partnership (BHP) and HUSKY BH: legislative authority was sought to place BHP funds into special accounts in DSS & DCF. This authority was denied, which

effectively ends the BHP restructuring process of BH in the Medicaid program & within DCF. The BHP language could be reassessed in the October special session; this was not included in the September special session. If there is legislative approval to move forward with the BHP and program restructuring, the BH carve out could be implemented July 1, 2004. If there were no action or approval in October, it would be impossible to carve out BH services by July 2004. Future implementation of a carve out could be more difficult once the FY 05 HUSKY MCO reprocurement is completed.

### **Temporary drug supplies**

Jeffrey Walter, Chair of the Council 's Behavioral Health Subcommittee, stated that providers participate in multiple health plans with different drug formularies. This can adversely impact timely patient access to prescribed medications. The Department requested specific case examples be forwarded to Rose Ciarcia, the HUSKY manager, who will work with Mr. Walter and others on this issue. Sen. Harp noted that the HUSKY pharmacy reports (July 2003) demonstrated a difference among the MCOs in complying with the contractual requirements of temporary drug supplies (i.e. CHNCT reported 100% of Prior Authorizations (PA) were accompanied by a temporary drug supply, while other MCOs had lower temporary drug dispensing per PA prescription). There are variations in MCO's formularies that may account for this difference. The DSS will review contract compliance with the MCOs. Mr. Parrella noted that the legislative Program Review Committee will have a public hearing next week (9/16) related to their studies that include pharmaceutical purchasing in the State, which includes the concept of a single Medicaid formulary and joint state purchasing initiatives.

**HUSKY Enrollment:** William Diamond, ACS

Mr. Diamond noted that enrollment dropped off in June & July 2003; however the August & September data suggests an increased trend in enrollment.

#### **Enrollment Summary September 2002-September 2003**

|                | Sept02  | Oct02   | Nov02   | Dec02   | Jan03   | Feb03   | Mar03   | Apr03   | May03          | Jun03          | Jul03          | Aug03          | Sept03         |
|----------------|---------|---------|---------|---------|---------|---------|---------|---------|----------------|----------------|----------------|----------------|----------------|
| Total HUSKY A  | 280,222 | 282,798 | 285,044 | 287,241 | 289,333 | 291,016 | 295,420 | 297,303 | <b>299,057</b> | <b>294,331</b> | <b>287,442</b> | <b>288,260</b> | <b>290,484</b> |
| A >19 Adults * | 82,077  | 83,228  | 84,394  | 85,172  | 85,950  | 86,768  | 88,836  | 88,823  | <b>90,433</b>  | <b>88,811</b>  | <b>86,354</b>  | <b>86,235</b>  | <b>86,926</b>  |
| A <19          | 198,145 | 199,570 | 200,650 | 202,069 | 203,383 | 204,248 | 206,584 | 208,480 | <b>208,624</b> | <b>205,520</b> | <b>201,088</b> | <b>202,025</b> | <b>203,558</b> |
| HUSKY B        | 13,460  | 13,572  | 13,928  | 13,942  | 14,153  | 14,292  | 14,352  | 14,493  | <b>14,617</b>  | <b>14,665</b>  | <b>14,773</b>  | <b>14,938</b>  | <b>15,061</b>  |

## HUSKY B: Disposition of Processed Applications May-August 2003

| Application Status | May 03 | June 03 | July 03 | Aug 03 |
|--------------------|--------|---------|---------|--------|
| Denied             | 14.5%  | 13%     | 15%     | 13.5%  |
| Approved           | 31%    | 36%     | 34%     | 31%    |
| Referred           | 53%    | 51%     | 51%     | 55%    |
| Total #            | 1590   | 1710    | 1768    | 1810   |

Council comments:

- **Request the DSS to provide HUSKY A enrollment by race ethnicity, the DSS agreed.**
- **Provide further information on the reasons for denials, which the DSS will provide in October.** The major reason seems to be failure to provide complete information.

## Healthy Start Program

Grace Damio, Hispanic Health Council, Christine Bianchi, Staywell Community Health Center, Waterbury and Sue Grino, Middletown Health Center provided the Council with an overview of the Healthy Start (HS) program and the program's role in Medicaid 'presumptive eligibility' (expedited eligibility) for pregnant women. The program that has had a community presence since 1989 has a public health focus, working with women to achieve positive pregnancy, maternal and child health outcomes. The program provides linkage to health care coverage and referrals for a broad spectrum of human services, as well as HS staff follow-up and advocacy as needed.

The DSS policy on 'presumptive eligibility' (PE) for pregnant women is "a method of postponing verifications, enabling the DSS to quickly grant assistance... the assistance is authorized no later than the day after receipt of the minimum required verifications". The Healthy Start Program has successfully facilitated this 'expedited' Medicaid eligibility determinations for pregnant women by building effective relationships with DSS staff and clients as well as through effective client advocacy when delays occur. Specifically, the staff assists women in application completion, ensuring all documents are included, assists the client in navigating the eligibility system and following up with clients until the application process is concluded.

Implementation of this policy, the intent of which is to deem pregnant women eligible for Medicaid as quickly as possible so they can access Prenatal care early in the pregnancy (in the first trimester), has been problematic:

- It lacks the formal infrastructure that was associated with children's PE, which allowed trained qualified entities (i.e. SBHC) to make an early assistance determination that provided immediate client access to reimbursable services (under FSS) for a specified time period. Families still needed to complete the application process in order to become enrolled in HUSKY. {*Children's PE was eliminated in PA 03-3*}.
- Misinformation and/or lack of information about the 1991 DSS policy among some of the DSS offices, health providers and advocates creates barriers for implementing expedited Medicaid approvals.

- DSS staff resource reductions have contributed to lack of expedited eligibility processing as well as “auto denials” associated with delayed (> 45 days) application processing.

The Healthy Start programs have had budget cuts, yet have consistently worked to enroll pregnant women as quickly as possible and fill in the gaps in the staff resource-limited DSS system. The program staff will continue to work with DSS on this issue and recommended:

- DSS central office regular communication and training of regional DSS staff on this policy.
- Designated DSS staff for pregnant women’s expedited applications.
- Formalize a DSS/Healthy Start partnership for development of a planning process for systematic implementation of the process and reinstatement of DSS/HS collaborative regional meetings.

The DSS announced that they plan to meet with the Healthy Start staff September 15; HS will provide the Council with information on that meeting. Rose Ciarcia commented that Commissioner Wilson-Coker is committed to addressing this issue and plans to review the impact of DSS regional office staffing reductions. Sen. Harp stated there is a pressing need to consider implementing true PE for pregnant women, mandated in statute 17b-277. Lack of timely access to Medicaid reimbursable prenatal care can have an adverse impact on both the maternal & child’s health and birth outcomes. Sen. Harp asked if DPH could help to communicate the DSS expedited eligibility process to health providers that see pregnant women. Dr. Wilson (DPH) stated that information could be included with professional license renewal forms. The health alert network developed for bio terrorism is another vehicle for disseminating routine updates to health providers. Dr. Wilson will provide the Council with further information.

## **Children’s Health Council Reports (access reports on [www.childrenhealthcouncil.org](http://www.childrenhealthcouncil.org)).**

Mary Alice Lee reviewed the handouts on HUSKY A ambulatory care and emergency care discussed at a previous meeting and described the two newly completed studies on health care disparities and the 2001 Birth DSS/DPH data match.

- Emergency/hospital care: 48% of hospitalizations were attributed to mental disorder. 27% of ED visits were for injuries, 21% for respiratory diagnoses. Of those children <21years continuously enrolled during 10/1/02-9/30/02, 35% had at least one emergency visit (average of 1.8 visit/child). This rate is much higher than the 15% national rate of ED visits for publicly insured children <18 years.

- Health care disparities associated with race/ethnicity remains a persistent problem in HUSKY A: African American children showed lower utilization rates for well care, ambulatory care, preventive dental care, higher ED use and hospitalization for asthma compared to white children. Hispanic children had slightly higher well visit and preventive dental rates, higher asthma rates and higher ED and hospitalizations for asthma. These findings are consistent with HUSKY A 2000 and 2001 findings as well as national trends.

- CT Birth data match 2001: Selected data from DPH birth certificates was linked with HUSKY enrollment data to describe prenatal health and birth outcomes in HUSKY A and compare prenatal risk factors and birth outcomes in HUSKY A to CT and US births. Highlights from the 2001 study:

|                               | HUSKY A 2000           | HUSKY A 2001                    | CT births 2001 | US Births 01 |
|-------------------------------|------------------------|---------------------------------|----------------|--------------|
| # of births                   | 9,630(22% of CT birth) | <b>9,530 (23% of CT births)</b> | 41,648         |              |
| Average maternal age          | 24.2 yrs               | <b>24.3 yrs</b>                 | 30.8           |              |
| % Teen births (15-19)         | 22.8%                  | <b>21.9%</b>                    | 3.2%           |              |
| 1 <sup>st</sup> Trimester PNC | 76%                    | <b>79.3%</b>                    | 91.5%          | 83.2%        |
| Adequate PNC                  | 67.3%                  | <b>74.5%</b>                    | 87.8%          | 74.5%        |
| Late/no PNC                   | 2.9%                   | <b>2.6%</b>                     | 1.4%           | 3.7%         |
| LBW/VLBW*                     | 9.6%/1.8%              | <b>9.1%/1.9%</b>                | 6.9%/1.3%      | 7.7%/1.4%    |
| Preterm (37 wks)              | 13.2%                  | <b>12.2%</b>                    | 10.3%          | 11.9%        |

\*30% of all CT very low birth weight (VLBW) babies were born to HUSKY mothers  
89% of HUSKY A VLBW babies were born in 9 CT hospitals with specialty care.

Approximately 30% of white women enrolled in HUSKY smoked during pregnancy compare to 12% of African American women. The LBW rate to mothers who smoked was; 12% white, 21% African Americans, 12 % Hispanic. Smoking has deleterious maternal and child health effects and smoking cessation can reduce adverse birth and maternal health outcomes. Fourteen states, including CT do not cover tobacco dependence interventions in their Medicaid programs. Some of the HUSKY plans do reimburse for smoking cessations. Rep. McCluskey stated that had the State invested some of the state tobacco funds in smoking prevention in HUSKY, the adverse health costs associated with LBW and preterm deliveries may have been reduced.

Judith Solomon stated that the \$100,000 grant from DSS to the Hartford Foundation for Public Giving for the Children's Health Council appropriated in the budget implementer has not been released. The CHC will cease functioning September 30, 2003. Sen. Harp stated that there is grave concern, from a constitutional, & balance of power perspective, when the Executive branch does not release funding approved by the legislature. Rep. McCluskey noted that his questions on the House floor about the purpose of the DSS transfer of \$400,000 to OPM was never answered.

Council comments supported the Children's Health Council as an advocate for children and families and for their special reports that have added a more robust assessment of the HUSKY A program. Rep. McCluskey offered a motion that the Medicaid Council encourages the Chart Foundation of Anthem BCBS to prioritize the decision about grant funding to the CHC. The motion was moved, seconded and approved by voice vote with the abstention by the State agencies still present at the meeting. Ms. Solomon stated that she appreciated the support;

however the CHC will no longer have access to HUSKY enrollment and encounter data at the end of their contract with DSS September. Therefore special reports cannot continue without access to the data.

**The Medicaid Council will meet on Friday October 10, at 9:30 AM in LOB RM 1D**

## HUSKY Family Income Guidelines (effective April 1, 2003) Department of Social Services

| Family of 2               | Family of 3               | Family of 4               | Family of 5               | Family of 6               | HUSKY Plan features<br>(subject to change after June 30, 2003)  |
|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---|
| under \$12,121            | under \$15,261            | under \$18,401            | under \$21,541            | under \$24,681            | <b>Free health care for parents who live with child or for a relative caregiver like a grandparent who lives with the child.</b> \$1 co-payment per prescription, unless pregnant or receiving family planning drugs or in nursing facility.<br>[HUSKY A] |
| under 22,423              | under \$28,232            | under \$34,041            | under \$39,850            | under \$45,659            | <b>Free health care for children under 19; and pregnant women</b> (note: for eligibility of pregnant women, unborn child is also counted as a family member).<br>[HUSKY A]  |
| from \$22,423 to \$28,482 | from \$28,232 to \$35,861 | from \$34,041 to \$43,240 | from \$39,850 to \$50,519 | from \$45,659 to \$57,998 | <b>Health care for children under 19; no cost, except small co-payments at the doctor and pharmacy.</b><br>Eligible for HUSKY Plus.*<br>[HUSKY B]   |
| from \$28,483 to \$36,360 | from \$35,862 to \$45,780 | from \$43,241 to \$55,200 | from \$50,620 to \$64,620 | from \$57,999 to \$74,040 | <b>Health care for children under 19;</b> monthly premium of \$30 for first child; maximum monthly premium of \$50, regardless of number of children; some co-payments.<br>Eligible for HUSKY Plus.*<br>[HUSKY B]   |
| over \$36,360             | over \$45,780             | over \$55,200             | over \$64,620             | over \$74,040             | <b>Health care for children under 19;</b> Group premium rate, currently ranging from \$152 to \$221 monthly per child; some co-payments.<br>[HUSKY B]   |

These are income guidelines only. There may be some adjustments in your family's situation so we encourage you to apply for your children, regardless of household income. Note: child care expenses are deducted from income. Please call 1-877-CT-HUSKY for information and to apply. Income guidelines listed are effective April 1, 2003, through March 31, 2004. HUSKY Part B coverage may not be available if a child has been covered by health insurance through a parent's employer during the past two months. There are exceptions to this waiting period, including loss of employment and financial hardship.

\*HUSKY Plus offers supplemental coverage for special physical and behavioral health needs for children in HUSKY B levels as marked.