

## Meeting Summary: October 10, 2003

*(Next meeting: November 14, 9:30 AM in LOB RM 1D)*

Present: Rep. Vickie Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Janice Perkins, Henry Goldstein, Gary Blau & Dr. Victoria Niman (DCF), Jeffrey Walter, Dr. Wilfred Reguero, Dr. Edward Kamens, Dr. Alex Geertsma, Ellen Andrews, Martha Okafor (DPH), Thomas Deasy (Comptroller Office), Terry Nowakowski (DMHAS), Doreen Elnitsky. Also Present: Mark Schaefer (DSS), Douglas Hayward & Joan Morgan (Preferred One), Mark Scapellati (CHNCT), Paula Smyth (ABCFP), Jesse White Fresse, Judith Solomon, Irene Liu, M. McCourt (Council staff).

### Department of Social Services (DSS)

## **Benefit Comparisons**

The Department provided benefit comparisons of HUSKY A with the State Employee POE and HUSKY B with the two largest CT HMOs (see attachment for materials presented). The comparisons are based on the implementing language in **PA03-3**:

· Regarding **HUSKY A**, Sec 72: “*..the Commissioner of Social Services, in consultation with the Office of Policy and Management, shall enter into contracts with managed care organizations to provide services for eligible individuals enrolled in a managed care plan under the HUSKY Plan, part A. The managed care plan shall be substantially similar to the state Employee Non-Gatekeeper POE Plan as of the effective date of this section and shall comply with all Medicaid federal law and regulations*”.

· Regarding **HUSKY B**, Sec 56: “*The services and cost sharing requirements under HUSKY Plan, part B shall be substantially similar to the services and cost sharing requirements of the largest commercially available health plan offered by a managed care organization,..*”

Highlights of discussion related to **HUSKY A/SE-POE**:

· The covered benefits under the state Employee POE (SE-POE) plan will be defined in the details of the waiver, which has not yet been configured. It is unclear if the benefits would literally be the same as the SE-POE package. The State is about a year away from the waiver implementation.

· Cost sharing is higher in the SE-POE model than the HUSKY A program (for adults), however the scope of services is similar, according to DSS. **The DSS will send a list of excluded services to the staff prior to the Nov. Council meeting.** Specific questions related to federally mandated services and co pays included:

o The inclusion of the federal mandates for transportation services, case management (and possibly EPSDT?) in the waiver-covered services has not yet been determined.

o Based on the legislation that mandates the conversion to the SE-POE plan, co pays could be assigned to services for pregnant women and children under the waiver. **Pharmacy &**

**medical service co pays apply only to non-exempted adults in HUSKY A, Medicaid FFS, SAGA (pharmacy only) beginning November 1, 2003.**

- o Federal law defines standard caps in Medicaid for the maximum individual/ family premium cost sharing. Future family/child cost-sharing in HUSKY A will have to be identified within the HUSKY waiver plan. Current federal Medicaid rules allow ‘nominal’ cost sharing amounts: an 1115 waiver allows states to create initiatives that do not conform to existing federal standards and options.
- o The DSS will identify differences in cost sharing between HUSKY A & the SE-POE as part of the waiver development process, noting where there is no co pay under the SE-POE and there is a co pay HUSKY.
- The Council noted that the configuration of the current HUSKY B program, based on the SE health plan (per 1997 legislation), includes additional services and provision for wraparound services. This precedence can be considered in the HUSKY A service benefit restructuring.

Discussion related to the **HUSKY B** restructuring:

- The HUSKY B benefit changes, based on PA 03-3, will be done under a SCHIP State Plan amendment change that is subject to CMS approval.
- The current HUSKY B benefit plan was configured in 1997 by taking the most generous components of the three SE health plans. The benefit plan comparison information of the 2 CT HMOs & HUSKY B provided at this Medicaid Council meeting reflects the narrowest view of the legislation in identifying just what the HMO benefits look like.
- Dental, vision and pharmacy services have the highest co pay increases compared to the current HUSKY B co pays. The DSS stated that what is shown is the strict interpretation of the 2 largest State HMO benefit plans applied to HUSKY B.
- Cost sharing in HUSKY B cannot exceed 5% of the family’s gross income. The increase in the HUSKY B cost sharing mandated in PA 03-3 will mean that families may reach that 5% cap earlier than under the current co pays. The MCOs currently monitor the cap in HUSKY B and inform the health provider that the member has reached the 5% cap and cannot be charged the co pay for the rest of the year. The additional cost sharing in HUSKY B will require additional effort by the MCO. Those with high utilization patterns will reach that cap sooner than those with infrequent health care utilization.
- The DSS was encouraged to consider creating different co pay levels for low income families, as there already exists an administrative system within some health plans that deal with the different co pays for State Employee and commercial benefit packages.
- The DSS is working on a monitoring system for the cost sharing so that families will be not be charged costs above the 5% cap. This is especially important in high utilization populations such as children with special health care needs. Under SCHIP program, there is no co pay for well childcare.
- The DSS was asked to provide a template for out-of-pocket expenses for families in HUSKY A & B. Current semi-annual utilization reports in HUSKY B could identify the average number of visits per child. **The DSS can report on this in November.**

Discussion related to the **November 1st Medicaid co pays:**

The Council members questioned the DSS about the November 1, 2003 implementation of the pharmacy & medical service co pays. The most recent legislation will increase pharmacy co pays to \$1.50/script and apply a \$2.00 co pay for medical services (outpatient). These co pays will be applied to non-exempted adults in HUSKY A, Medicaid FFS programs and State

Assistance (SAGA- pharmacy co pays only). Based on federal law, the DSS configuration of the co pay amounts were based on the:

- Identified office/facility services that meet the dollar threshold and the average value of the services over \$50 dollars. Based on this evaluation, the medical service co pays were set at \$2.00 rather than the legislative mandate of a co pay not to exceed \$3.00.
- Average payment per prescription for generic, over-the-counter and brand name drugs.

Initially, premiums will apply to Medicaid FFS recipients, (see Sept Special Session, PA 03-1, sec. 11) ranging from \$7–19 dollars per month. The calculation of these premiums has to be done on an individual basis, (unlike the income bands in HUSKY B).

*Addendum: The DSS was later asked to clarify those FSS groups that will be assessed a monthly premium. Current federal regulations allow premiums to be applied to the Medicaid medically needy category that includes those in medical ‘spend down’ and ‘Zero spend down’ groups.*

- *The medical spend down Medicaid eligibility is based on the amount of income exceeding the medically needy income limit (MNIL) within a six-month period. Medical out-of-pocket (OOP) expenditures are used to offset the excess income, which allows the recipient to meet Medicaid income eligibility requirements. The premiums will count toward the OOP expenditures and recipients may become eligible for Medicaid FFS more quickly than if premiums were not applied.*

- *The zero spend down category eligibility is also based on the MNIL, which varies according to income level per state region. However for zero spend down, there is no excess income to be offset. Income levels are compared to net monthly income. For example:*

	<i>Region C - Hartford</i>	<i>Region A - Fairfield</i>
<i>Individual income limit</i>	<i>\$476/month</i>	<i>\$575/month</i>
<i>Two adults</i>	<i>\$629/month</i>	<i>\$737/month</i>

*The recipients in these categories are generally over age 65 years or disabled. Some of these individuals live in group homes; the DSS has not been advised as to whether any individuals in group homes would be required to pay monthly premiums. This legislative mandate may begin January 2004, as it requires development of a DSS system that links premium payments and eligibility status. Recipients that are delinquent in paying premiums for two months will receive a notice in the 3<sup>rd</sup> month that their eligibility will be terminated that month if the premium payments are not made. The recipient can be reinstated in Medicaid once DSS receives payment of the back premiums).*

Rep. Nardello thanked the DSS for the information presented at the request of the Council and stated that there would be ongoing discussion of these issues in future meetings. Judith Solomon stated a report on Medicaid cost sharing & enrollment will soon be available.

## **HUSKY A Adult Reinstatement Status**

Approximately 18,000 adults with earned income, under the 2<sup>nd</sup> Court of Appeals temporary restraining order, remain enrolled in HUSKY A as there has been no court decision on the appeal. These members will retain eligibility at least until the end of November or until the

Court decision is released. The DSS stated this involves in \$4-5M per month unbudgeted expense.

## **Behavioral Health Service Carve-Out in HUSKY A & B**

Without legislative approval within the next month to implement the Behavioral Health Partnership it would not be possible to meet the carve-out date of July 1, 2004 when the DSS would re-contract with the MCOs.

## **Healthy Start/DSS Meeting Follow Up**

Rose Ciarcia reported that DSS met with the 5 Healthy Start contractors and some subcontractors to explore two areas of concern and 'next steps for each:

- Clarification of current DSS policy on 'presumptive eligibility' for pregnant women in HUSKY A, which involves expedited processing of the application. Next steps: joint training with DSS staff, Healthy Start and RWJ Covering Kids.
- Communication of policy overlaps the former. Next steps: more frequent regional meetings with DSS regional offices and Healthy Start staff in order to establish collaborative relations.

## **HUSKY A Utilization Reports**

Hilary Silver reviewed the semiannual reports for October 2002-March 2003:

- ü Inpatient days and discharges per 1000 member months (MM) total averages are slightly above 2<sup>nd</sup> & 3<sup>rd</sup> Q 02. There is plan variation, with the most notable difference in CHNCT. The MCO reported that 'sick' newborn stays influenced the total days per 1000MM.
- ü Emergency (ED) visits per 1000 MM remain under the 1994 FFS rates (72.1). Plans vary from the total MCO average ED visit rate, which is now 56.5 visits per 1000MM. The average across plans in 2002 ranged from 58.4 to 54.2 visits/1000MM.
- ü Behavioral Health Service reports include adult & children services:
  - o Most of the MH services are provided in ambulatory care settings.
  - o 1.3% of the clients used substance abuse (SA) services, with most of the services provided in the ambulatory care setting.
  - o Less than 9% of HUSKY A adults and children received MH/SA services over the 6 month period. Individual MCOs report similar access rates (ABCFP at 9.5%, HN at 9% and CHNCT at 8%. Preferred One reported the lowest penetration rate of 4%. The DSS stated this MCO has identified data problems and is working to correct them so their future reports will more accurately reflect MH/SA services.
- ü Prenatal/postpartum care utilization for the 2<sup>nd</sup> half of 2002:
  - o The % of HUSKY A women that receive at least 80% of PNC visits while enrolled in that MCO averages about 85%. Health plan rates vary from 90% (ABCFP & CHN), 78% (HN) and 68% (P-1).
  - o Postpartum visit rates within the 3-8 week time period after delivery is difficult to quantify. Most providers and MCOs prefer billing for prenatal care, delivery and postpartum care under a

global code. Providers are requested to provide additional postpartum visit data to the MCOs as these services cannot be easily identified in the global code. The report footnote indicates incomplete data and/or visits that were outside the rather narrow 3-8 week acceptable reporting period.

## **HUSKY Enrollment**

The enrollment broker, ACS, has undergone a computer system change to a web based system. The October 1, 2003 HUSKY B data is not available at this time during the system change.

### **Enrollment**

Since August 2003 total enrollment in HUSKY A has been increasing (5664). Peak enrollment in May (299,057) was followed by a loss of 11,615 enrollees over two months: the current increase represents 49% of the Jun/July enrollment losses. Eligibility changes were implemented March 31, 2003, including elimination of children's 12-month continuous eligibility, adult 6-month guaranteed eligibility and reduction of parent income eligibility level to 100% from 150% (approximately 18,000 adults with earned income remain in HUSKYA).

- Adult enrollment has increased by 1467 over September & October, representing 35% of the total losses thru August. Peak enrollment in May (90,433) was followed by a loss of 4198 adult enrollees through August.

- Under-19 enrollment began increasing in August after an enrollment reduction of 7536 in June and July. While net enrollment has increased by 4316 since August (57% of earlier enrollment reduction), overall enrollment is 3220 less than the May enrollment. Children ineligible for HUSKY A may be eligible for HUSKY B.

The DSS was asked to provide reasons for HUSKY B denied application and closed renewals. Rose Ciarcia reported that the primary reasons are: client eligibility for HUSKY A (30%), did not reapply at the renewal time (26.2%), incomplete documentation (21.4%), has employer based insurance (13%). The incomplete applications are often related to self-employed families who are required to provide documentation of income.

The Department had been asked to report HUSKY A by race/ethnicity: 40% of enrollees are Caucasian, 33% are Hispanic, and 25% are African American. Health Plan membership shows variation in membership ethnicity distribution.

The Department was asked to clarify how school-based clinics can verify HUSKY B eligibility. Rose Ciarcia will ensure this information can be attained through ACS and provide the name & phone number of the contact person. This eligibility information can be released to the clinic, under HIPAA, when the parent/guardian has signed a release of information in the beginning of the school year.

**The Council will meet Friday November 14, at 9:30 AM in LOB RM 1D.**