

Meeting Summary: November 14, 2003

(Next Meeting: Dec. 19 at 9:30 AM in LOB RM 1D)

Present: Sen. Toni Harp (Chair), Rep. Villano, David Parrella & Rose Ciarcia (DSS), Jeffrey Walter, Dr. Henry Goldstein, Dr. Victoria Niman (DCF), Dr. Ardel Wilson (DPH), Thomas Deasy (Comptroller's Office), Terry Nowakowski (DMHAS), Dr. Edward Kamens, Dr. Alex Geertsma, Kim Turner for Rev. Bonita Grubbs.

Also Present: William Diamond (ACS), Dr. Mark Schaefer (DSS), Martha Okafor (DPH), Chet Brodnicki (Child Guidance Clinics), Deb Poeia (FQHC's), Judith Solomon, Sylvia Kelly (CHNCT), Paula Smyth (Anthem BCFP), Naida Arcenas (DCF), Joan Morgan (Preferred One), Council staff.

Department of Social Services

HUSKY Program Changes

The DSS reviewed the program changes and expected implementation dates:

Program	Populations	Implementation date	Details
Outpatient Co-Pay*	Medicaid FFS & Husky A adults	11/1/03: Medicaid State Plan Amendment	\$2 per outpatient visit
Pharmacy Co-Pay	HUSKY A adults, Medicaid FFS & SAGA	11/01/03 Medicaid State Plan Amendment	\$1.50 per script
HUSKY B Premiums & co-pay maximum: <i>Band 1: 185-235%FPL</i> <i>Band 2: 235-300%FPL</i>	HUSKY B (SCHIP)	2/1/04 State SCHIP Plan amendment	<u>Band 1:</u> new monthly premium \$30/child, \$50/family maximum <u>Band 2:</u> > to \$50/child, \$75/family maximum Maximum proposed co-pays \$760/year
HUSKY B Benefit Restructuring, & co-pay increase	HUSKY B	7/1/04 State SCHIP Plan amendment	Benefits & co-pays similar to largest CT HMO.
Medicaid FFS Premiums	'Medically Needy' adults (> 65 years and/or the disabled)	4/01/04 Medicaid State Plan Amendment	Premiums range \$11-21 per month; loss of eligibility for failure to pay co-pays for 2 consecutive months.

HUSKY A benefit restructuring, co-pays	Medicaid dual eligibles, HUSKY A, SAGA	Possible date: 7/1/05 HIFA 1115 waiver	Benefits similar to State Employee POE plan Premiums/co-pays possible
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***Note: Pharmacy or outpatient services cannot be denied to recipients for failure to pay co-pays**

Service carve-out updates:

- Dental services to HUSKY A, B and Medicaid FFS recipients is planned for 7/1/04.
- Behavioral health services could *potentially* be carved-out in July 2004.

Medicaid eligibility groups were outlined in the DSS handout (see attachment A). The DSS stated that traditional Medicaid services defined by federal regulations (i.e. EPSDT) would need to be retained for mandatory populations under a Health Insurance Flexibility & Accountability (HIFA) Sec 1115 waiver. A list of *Mandatory versus optional services* were also included in the handout (see attachment A). States determine the optional services that will be provided through their Medicaid State Plan.

The Department was asked to identify services currently provided that MAY not be covered under the State Employee-POE (SE-POE) benefit package {for HUSKY A recipients}:

- Medical Equipment/supplies including eye glasses, wound care supplies outside of home health, incontinence supplies
- Intermediate Care Facility/MR
- Long-term care
- Non-Emergency Medical Transportation
- Over-the-Counter Drugs
- EPSDT including case management, interperiodic encounters, screenings in excess of those in the periodicity schedule, Personal Care Services, appointment-scheduling assistance.

This list does not reflect what would ultimately be excluded in covered services in a final plan.

The Department was asked to provide PROJECTED co-pay costs for HUSKY A and B under the benefit restructuring legislation. HUSKY A benefits would be substantially similar to the SE-POE plan and HUSKY B benefits would be substantially similar to the largest State commercial HMO plan. The following provides a summary of the PROJECTED co-pays:

	Total Co-Pays for children aged 6-11 years	
Child's Health Status	HUSKY A	HUSKY B**
Basically healthy child	\$46*	\$77
Managed moderate Asthma	\$192	\$585
Child with Serious Chronic Illness	\$601	Mental illness: Co-pay could be \$3,065, but co-pays are capped at \$760/child as of 2/1/04

* PCP visits for preventive care do not require co-pays.

** A family's total yearly health care cost sharing including premiums cannot exceed 5% of the family's gross income and co-pays are capped at \$760/year. Families that have children with high health care needs as compared to the family with a basically healthy child may reach the co-payment cap earlier. The MCO will identify when the family reaches the yearly capped co-payment level and inform the provider that for the remainder of that year the family is not liable for any further co-pay costs.

Key questions/discussion related to this information included:

- Ø Under the HUSKY B chronic illness scenario, is the provider at risk for the loss of co-pays

beyond the cap? The DSS stated that the provider and MCO would need to consider this in contract negotiations. The client cannot be billed for the co-pays beyond the capped amount.

Ø The State may remove children with special needs (CSHCN) from the commercial-like benefit package in the HIFA waiver or place them in the PLUS wraparound program.

Ø Are dual eligible recipients (Medicare & Medicaid) exempt from the current co-pays? The DSS stated only adults exempted from co-pays by federal regulation (institutionalized) are exempted; otherwise co-pays apply to the dual eligibles.

Ø Without a waiver, premiums cannot be applied to those in the “categorically needy” group (i.e. newborns, pregnant women, children, TANF recipients, SSI) but can be imposed on the medically needy category recipients (includes those >65 years and/or the disabled). Within this category individuals that exceed the income and assets of the mandatory population become eligible for Medicaid once their medical expenditures over 6 months meet the medically needy income limit (MNIL). Premiums will also be imposed on those in the “zero spend down” category (eligible for Medicaid based on income, not medical expenditures). The State estimated this legislative mandate would impact 25,000 individuals; however some of these recipients should actually be classified as categorically needy, thus exempt from the premiums (without a waiver). The DSS is evaluating this.

Ø The DSS expects to apply for a HIFA waiver in the 2004 summer and possibly implement an approved waiver in July 2005. This time line is probably overly optimistic as two CT Sec 1115 waivers have been waiting for CMS approval for about 1.5 years from the time of final submission. While there is no indication that CMS may delay approval of state HIFA waivers, two other CT cost containment waivers have not yet been approved.

Ø The Department commented that the Centers for Medicare & Medicaid Services (CMS) is under scrutiny from the federal OMB to contain costs in their programs in the face of federal deficits related to the economic downturn, the pending \$400 billion Medicare program revision, the war costs. Therefore CMS is scrutinizing states’ funding in relation to appropriate leveraging of federal match, looking for evidence that states are taking advantage of loopholes or duplication of federal matches. The CMS is revisiting states’ waiver configurations and more closely assessing new waivers. The CMS approach of identification of and reduction of state-level abuses and spending could remove states’ need for continued enhanced state federal matches. The enhanced FMAP is available to states until July 2004 and while the National Governors Association may request an extension to this enhanced match, it is unclear if this would be granted.

DSS/MCO contracts have been extended through November 2003 and may require another extension through December as the State waits for final CMS approval of the fiscal soundness of the rates. The Department is going forward with rate adjusts that reflect the new/increased co-pays for HUSKY A adults.

Dr. Mark Schaefer (DSS) reviewed the *Behavioral Health Partnership (BHP) status*. The Office of Policy Management (OPM) and the three state agencies have provided answers to legislators’ questions, which will be presented at the legislative/public meeting **Wednesday December 17, at 1:30 in the LOB RM 2A**. The discussions will include concepts on alternative rate structures and the inclusion of adult FFS in the BHP. The DSS was asked to explain the BH data discrepancies and how the BH subcommittee could work with DSS & BH MCOs in improving data reporting. Dr. Schaefer stated that the Mercer (State Actuarial contractor) is re-analyzing the projected costs of the BHP program policy changes. While current baseline data does not

indicate excessive costs thus keeping the goal of cost neutrality, more recent 2003 data is being used in the re-analysis.

One preference, according to the DSS, is to carve-out BH HUSKY services prior to the implementation of the HIFA waiver, thereby creating a broader benefit than what is in the SE-POE benefit plan (i.e. home-based intensive BH services). The DSS, DCF, BH MCOs and providers have developed a uniform Prior Authorization and reimbursement process for these services.

Senator Harp spoke of the legislature concerns about linking adult mental health services to the BHP. While there is support to carve out children's services and support KidCare, there must be careful assessment of the impact of the BHP on inclusion of appropriate adult services and realistic funding that does not create infrastructure instability nor do harm to patients.

Connecticut is the first state to bring child and adult mental health programs together in a statewide initiative. The financial and program impact of this has not been clearly identified.

HUSKY Enrollment: November 1, 2003

Enrollment Summary November 2002-November 2003

	Nov 02	Dec 02	<u>Ja</u> <u>n</u> <u>03</u>	Feb 03	Mar0 3	Apr03	May 03	Jun0 3	Jul03	Aug0 3	Sept 03	Oct 03	Nov 03
Total HUS KY A	285,0 44	287,2 41	289,3 33	291,0 16	295,4 20	297,3 03	299,0 57	294,3 31	287,4 42	288,2 60	290,4 84	293,1 06	295,3 52
A >19 Adult s*	84,39 4	85,17 2	85,95 0	86,76 8	88,83 6	88,82 3	90,43 3	88,81 1	86,35 4	86,23 5	86,92 6	87,70 2	88,30 5
A<19	200,6 50	202,0 69	203,3 83	204,2 48	206,5 84	208,4 80	208,6 24	205,5 20	201,0 88	202,0 25	203,5 58	205,4 04	207,0 47
HUS KY B	13,92 8	13,94 2	14,15 3	14,29 2	14,35 2	14,49 3	14,61 7	14,66 5	14,77 3	14,93 8	15,06 1	15,44 5	14,72 3

Over the past month:

- Total HUSKY A enrollment increased by 2,246 enrollees (603 adults and 1643 children).
- HUSKY B enrollment decreased by 518. ACS has attributed the November decrease is due to a backlog of applications as a result of implementing a new eligibility system. ACS feels that December enrollment will once again show an increase as a result of reducing the backlog of applications (*information received after the 11/14/03 meeting*).

Recent overall enrollment changes:

- Overall Husky A enrollment numbers decreased by **11,615** members during June and

July 2003 (4079 adults and 7536 children (>19)).

- Enrollment for adults and children has begun to *increase* after July, with a gain of **7092** enrollees (2070 adults, 5022 children) in August through November 1, 2003. This increase represents approximately 61% of the total enrollment losses from June-July 2003 (67% of child enrollee losses, 51% of adults).

- HUSKY B enrollment increased by **828** children from May through October 1, 2003.

Comments:

Sen. Harp noted that adult enrollment continues to increase and asked the DSS if the adults associated with the court appeal with earned income (16,000) and over the 100%FPL (new state eligibility level) remain in HUSKY A. The Department stated there has been no court decision to date; these adult parents/caregivers remain in the HUSKY A program.

The DSS stated that the process currently in place in HUSKY B Band 2 for non-payment of premiums will apply to Band 1: there is a 3 month health coverage lock out unless there is good cause reason for late payments. The MCOs give families some leeway for late payments, (i.e. accept a member's call that the payment is forthcoming), before notifying ACS.

Department of Public Health: CT's Title V Children with Special Health Care Needs (CSHCN) Program

Dr. Ardel Wilson and Martha Okafor provided the Medicaid Council with an overview of the Department's initiatives related to CSHCN. There are approximately 120,000 CSHCN in Connecticut. The Federal Maternal Child Health Bureau (MCHB) established federal goals for the Title V program for CSHCN that include:

- Family participation and satisfaction measurement,
- Access to a Medical Home (defined as a community-based primary care practice which is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent),
- Access to affordable insurance,
- Early & continuous screening,
- Easy-to-access community-based service systems,
- Services necessary for children to transition to adulthood.

The CT DPH initiatives targeting these goals include:

- An Internal Needs Assessment performed with key stakeholders.
- Participation in a Medical Home Learning Collaborative, a partnership effort between MCHB and the National Initiative for Children's Healthcare Quality (NICHQ). Three practice sites are involved in the collaborative – St. Mary's Hospital Children's Health Center, Whitney Pediatric & Adolescent Medicine, in Hamden, the Pediatric Center of Stamford. The key accomplishments of the collaborative include systems improvement to identify CSHCN in the practice, a standard screening tool to determine CSHCN in the practice, use of family surveys for suggestions to more effectively meet the family/child needs and the family's level of satisfaction with the office visits, family health information, , and participation in the National Data Bank for the Medical Home project.
- Assessment of Respite Care needs and impact on families with CSHCN and development of a tool kit for families and providers on quality Respite Care.
- Development of a process that utilizes the Child Development Infoline (2-1-1) as a central portal entry point for CSHCN in CT.
- Re-direction of the CT Title V programs through standardized contracts for the two centers (includes linkage to the Infoline, use of standard assessment tools, expansion of the

Medical Home project to 7 new Pediatric PCP locations, continuous Quality Improvement projects that target specialty care coordination, and evaluation of family satisfaction).

Next steps include:

- Evaluation of the Medical Home Model
- Development of CT specific medical home curriculum in partnership with the CT Chapter of the American Academy of Pediatrics (CT-AAP).
- Evaluation of the CSHCN program
- Development of a business plan to implement Integrated Local Systems of Care for CSHCN in Connecticut.

Senator Harp and Council members commended the DPH's work in this important area. It was noted that the DCF KidCare collaboratives have identified non-mental health chronic needs for children, which are outside the BH collaboratives focus; however this may be a source of information and linkage of services. In addition to Infoline data, other sources of information that will inform the State about CSHCN are the Birth-to-Three- assessments, the Help Me Grow program, and the Title V centers information on co-morbidities. The 2-1-1 Infoline is a resource for linking community-based services for both medical and non-medical needs. The Council looks forward to future updates on the DPH progress on these creative initiatives.

Quarterly Council Report & Subcommittee Updates:

There was request for clarification about the carve-out for BH services in HUSKY related to the need for a 1915(b) waiver amendment versus a new HIFA waiver. The report review was tabled until the December meeting when the DSS could clarify this.

Behavioral Health Subcommittee: Jeffrey Walter summarized the activities that included:

- Regular reports from DSS, DCF and DMHAS on the BHP and from DCF on KidCare evaluation reports,
- Follow-up on the intensive home services uniform standards and BH MCO/provider contracts,
- Formation of a pharmacy work group to address access to psychotropic drugs and develop recommendations to the Council to resolve problem areas, in collaboration with the DSS, DCF, MCOs, family representatives and practitioners.

Sen. Harp thanked Mr. Walter and the subcommittee participants for their diligence and work.

The Medicaid Council will meet Friday December 19 at 9:30 AM in LOB RM 1D.

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**Comparison Table
HUSKY B and Commercial
Plan Benefits
Tentative Implementation
Date – 7/1/04**

Benefit

HUSKY B

Plan 1

Plan 2

Prescription Drug	\$3 Co-Pay generics; \$5 Co-Pay oral contraceptives; \$6 Co-Pay Brand	\$5 Co-Pay generics; \$15 Co-Pay listed Brand; \$25 Co-Pay non-listed Brand	\$10 Co-Pay generics; \$20 Co-Pay listed brands with no generic equivalent; \$35 Co-Pay non-listed brand
Dental	Plan Allowance: 100%: 6 mo. exam/service; \$725 per orthodontia; \$50 per procedure, \$250 per year for crowns, root canals, dentures, extractions	Plan Allowance: \$1,500 annual maximum 100% - exams, fluoride, X-rays 70% with \$50 deductible/individual and \$150 deductible/family: fillings, root canals, steel crowns, extractions, oral surgery periodontics, repair dentures 50% with deductibles: crowns, post and core, inlays, onlays, prosthodontics	Not Offered
Vision	Plan Allowance: 100% covered - exams; \$100 for lenses and frames / 2 yrs.	\$15 Co-Pay per exam; Plan Allowance: \$50 per exam; Frame \$30 per year; Lenses \$50 per year; Contact Lenses \$80 per year	\$15 Co-Pay per visit; Plan Allowance: Frame \$50 per 24 months; Lenses 100% per year; Contact Lenses \$75 / 2 yrs

Public Act 03- 03 of the June 30, 2003 Special Session requires the Department of Social Services to convert the HUSKY B benefit structure to one similar to that of the largest commercial plan in Connecticut. The plan benefit structures shown above reflect the plans of either the largest number of lives covered or the largest number of commercial policies sold.

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Comparison Table
HUSKY B and Commercial
Plan Benefits
Tentative Implementation Date
– 7/1/04**

Benefit	HUSKY B	Plan 1	Plan 2
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Emergency Care	100% covered -emergency; \$25 co-pay - non-emergency	\$15 co-pay - walk-in center; \$50 co-pay - urgent care center; \$70 co-pay - hospital	\$15 co-pay - walk-in center; \$25 co-pay - urgent care center; \$50 co-pay - hospital
Lab	100% covered	100% covered	100% covered
DME	100% covered	20% Co-Pay	Plan Allowance: 50% cost of item; <\$1500 per year
Prosthetics	100% covered	20% Co-Pay	No Co-Pay internal prosthetics; Plan Allowance: Major limbs - < \$5,000; \$300 annual maximum for external prosthetics

Public Act 03- 03 of the June 30, 2003 Special Session requires the Department of Social Services to convert the HUSKY B benefit structure to one similar to that of the largest commercial plan in Connecticut. The plan benefit structures shown above reflect the plans of either the largest number of lives covered or the largest number of commercial policies sold.

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**Comparison Table
HUSKY B and Commercial Plan
Benefits
Tentative Implementation Date –
7/1/04**

Benefit	HUSKY B	Plan 1	Plan 2
OP Mental Health	\$5 Co-Pay	\$25 Co-Pay	\$20 Co-Pay

Short Term Rehab.	No Co-Pay; 60 day improvement expectation	PA Required In Patient < 60 days - No Charge; OP < 50 visits per year; \$25 per OP visit	PA Required < 90 days - \$250 Co-Pay per IP admission; OP < 90 days (consec.) 30 visits per year - \$15 Co-Pay per visit
Home Health Care	100% covered	PA Required	PA Required; 80 visits per year
Hospice	100% covered	PA Required; \$250 Co-Pay per admission	PA Required; \$250 Co-Pay per admission

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Comparison Table
HUSKY B and Commercial Plan
Benefits
Tentative Implementation Date –
7/1/04**

Benefit	HUSKY B	Plan 1	Plan 2
OP Physician	\$5 Co-Pay	\$15 - PCP \$25 - Specialists	\$15 Co-Pay
Preventative Care *	No Co-Pay	No Co-Pay <12 years; \$15 >11 years	No Co-Pay <19 years

Family Planning	No Co-Pay; 100% covered	Same as OP Physician	Same as OP Physician
In Patient Hospital	No Co-Pay; 100% covered	PA Required; \$250 Co-Pay per admission	PA Required; \$250 Co-Pay per admission
OP Surgical	No Co-Pay; 100% covered	PA Required; \$100 Co-Pay per visit	PA Required; \$50 Co-Pay per visit

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*** Although Plan 1 charges a cop-pay, Federal SCHIP regulations prohibit co-pay charges for well child visits.**

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HUSKY B Premium & Co-Pay Table

FPL Income Band	Current Premium per Month	Current Co-Pay Max	February 1, 2004 Premium per Month	Proposed Maximum Co-Pay
185%-235%	\$ 0	\$650/ year	\$30/child \$50/ family maximum	\$760/ year
235% - 300%	\$30/child \$50/family maximum	\$650/ year	\$50/child \$75/family maximum	\$760/ year

FPL = Federal Poverty Level

Family Maximum: Means that any family with two or more children would have a maximum premium

185% - 235%: A family with an income that exceeds 185% of the Federal Poverty Level (FPL) and does not exceed 235% of the FPL, will be charged a monthly premium of \$30 per child with a \$50 family maximum.

235% - 300%: A family with an income that exceeds 235% of the FPL and does not exceed 300% of the FPL, will be charged a monthly premium of \$50 per child with a \$75 family maximum.

**Medicaid
Eligibility Groups**

Group One – Mandatory with income requirements
<i>Pregnant women and children under age 6</i>
<i>Children ages 6-19</i>
<i>Caretakers of children under age 18</i>
<i>SSI recipients</i>
<i>Aged, blind, disabled who meet more restrictive requirements than those of SSI</i>
<i>Individuals/couples living in medical institutions</i>
<i>Families who today meet State's Aid to Families with Dependent Children eligibility requirements in effect on July 16, 1996</i>

**Medicaid
Eligibility Groups**

Group Two – Optional
Medically Needy: Income and resources exceed the requirements for Group One. Same medical requirements.
States that elect to offer services to medically needy individuals <u>must extend</u> services to the following groups:
· Pregnant women for a 60 day post-partum period
· Certain newborns for one year
· Certain protected blind persons
· Persons required to sign up for their employer's cost-effective health plan
States that elect to offer services to medically needy individuals <u>may extend</u> services to the following groups:
· Children under certain ages (21, 20, 19, 18)
· Caretaker relatives living with and caring for children
· Blind or Disabled Persons
· Persons who would be eligible if not enrolled in an HMO

States may also extend services to working disabled individuals

Medicaid Services

Mandatory Services (unless waived under section 1115) Entitled Services to Group One

Inpatient hospital (not inpatient hospital for mental disease)
Outpatient hospital
Other laboratory and X-Ray
Pediatric and family nurse practitioners
Nursing Facility services (21 and older)
EPSDT
Family planning services and supplies
Physicians' services
Dentist supplies and surgical services
Home Health Services (Nursing Facility eligible)
Nurse mid-wife services
Pregnancy related services
60 days Post-partum services
Entitled Services to Group Two
Prenatal and delivery services
Post-partum services for individuals <18 (institutional)
Specific services for beneficiaries in ICFMR facilities

Medicaid Services

Optional Services
With limits under waiver authority
Chiropractors
Podiatrists
Optometrists
Psychologists
Physician Directed Clinic Services
Home Health Therapies: PT, SL, OT, Audiology
Physical, Speech, Hearing and Language Therapies
Dental
Prescribed Drugs
Dentures, Prosthetics, Eyeglasses
Diagnostic, Screening, Preventive Services
Other Rehabilitative Services
Inpatient Hospital and Nursing Facility for persons 65+
ICFMR, Inpatient Psychiatric Services & Nursing Facility Services <21
Targeted Case Management
PACE (All inclusive care for the Elderly)
Transportation (Not Administrative)