

Connecticut
Medicaid Managed Care Council
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Meeting Summary: December 19, 2003

Present: Rep. Vickie Nardello, Rep. Peter Villano, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Thomas Deasy (Office of Comptroller), Dr. Victoria Niman (DCF), James Turcio (DMHAS), Dr. Alex Geertsma, Ellen Andrews, Dr. Edward Kamens, Janice Perkins (Health Net).

Also Present: Hilary Silver, Lee VanderBaan (DSS), William Diamond (ACS), Mary Beth Bonadies (OHCA), Christine Bianchi (Staywell CHC), Judith Solomon, Jody Rowell (Child Guidance Clinics), Douglas Hayward (POne), Deb Poerio (SBHC), Sylvia Kelly (CHNCT), Paula Smyth (Anthem BCFP), Council staff.

Department of Social Services

Update- HUSKY Program Changes

- State Plan Amendments:
 - o The State plan amendment for the Medicaid non-exempt adult co-pays (> pharmacy to \$1.50 and added outpatient co-pays of \$2.00 effective 11/1/03) is in the CT Law Journal and has been sent to the Centers for Medicare & Medicaid Services (CMS) Boston Regional Office for approval. This office approved the amendment and has forwarded it to Baltimore for final approval.
 - o Client notices for the HUSKY B premium increases, effective 2/1/03, were sent out Nov. 25, 2003. A formal amendment change to the State CHIP plan has not yet been submitted to CMS.
 - o An amendment is planned to clarify non-emergency medical transportation related to Medicaid covered services versus medically necessary services.
 - o Medicaid premiums for “medically needy” recipients, effective 4/1/04, and the HIFA waiver are draft documents in progress

The DSS publishes amendments in the CT Law Journal for public comment. Previously the DSS also published State plans/amendments in several local newspapers but had stopped because of budget issues. The DSS is planning to add this information to the DSS web site at the same time of publication in the CT Law Journal. Council recommendations related to the public process:

- Ø Rep. Villano strongly urged the DSS to reconsider publication in several large State newspapers in order that there be timely public input. The DSS will consider this in the future.
- Ø Advocacy groups would also be useful in eliciting public input; for example the DSS could use existing organizations’ list serves. The CT Health Policy Project meets regularly with consumers and offered to share input from these meetings with the DSS.

- Adult HUSKY coverage: approximately 18,000 parent/caregivers will remain covered in HUSKY A to January 2004, or longer, pending the 2nd Court of Appeals decision.

- The DSS/MCO contract status:

- o MCO rates increased by 4% retroactive to October 1, 2003.

- o Contract amendments related to state and federal mandates are included in the contract extension through September 30, 2004.

- o The DSS expects to implement the targeted program carve-outs for dental and possibly behavioral health by **October 1, 2004**, which will require new MCO contracts and rate changes for the revised service delivery system for HUSKY A/B. Regarding the dental carve-out, an evaluation committee has been selected to review and score the proposals from the Administrative Service Organization (ASO) bidders in the first week of February 2004. The ASO will have a non-risk contract with the State Agency and will be responsible for administration of dental services, including network development and clinical criteria for services.

- o The litigation related to Medicaid dental access continues with a possible trial date in the fall 2004.

The Behavioral Health Partnership Status

Legislative meetings were held in October and on December 17th, with further meetings expected in January & February 2004 that will identify the ultimate scope and design for services and scheduled implementation. While the DSS expects to move to a BH carve-out in October 2004, this is subject to the Administration's final decision.

Council comments/questions targeted the ASO review committees, in particular the composition of the committees. The DSS stated that the dental committee includes DSS and DPH representatives as well as 4 external dental professional members that include representatives from the State Dental Association, UCONN dental program and CT Oral Health organization. Rep. Nardello stated that it is important to ensure that representatives have a clear understanding of the public health programs that provide many of the Medicaid dental services. Jeffrey Walter asked if 'external representatives' would participate in the BH ASO bidder selection. The DSS stated that a committee of State Government representatives would elicit input from the BH Advisory Committee that has been involved with the BHP initiative before finalizing the bidder decision.

HUSKY Data Reports

HUSKY A/B Claims for 1-3 Quarters 2003

The data presented show that approximately 99% of the MCOs' claims inventory was paid within 45 days during these three quarters. The DSS adopted contract language, at the request of the Medicaid Council, to evaluate the reasons for rejected/denied claims; however system differences among the four MCOs in describing the denials complicates the development of a uniform report across the 4 plans. Plan differences include claims processing systems, Explanation of Benefits catalogue of reasons for rejected claims, differences in terminology in software tracking programs and functional terminology definitions, claim denials, which are based on claim "lines" details rather than individual claims, and MCO/provider contracts that

include global billing or capitated provider rates. The Department requested the Medicaid Council establish a work group that would narrow the focus of the denied claims reports and define the data format for a meaningful report. The Council will respond in January 2004.

Comments:

- This work group may want to consider:
 - o Clarifying when a health provider can bill a member as well as the billing process for individual services if the provider MCO payment is capitated.
 - o Developing some level of uniformity among the MCOs in the above areas; however this may not be possible with MCOs that have both commercial & Medicaid business lines that use one system throughout CT or across other states.
 - o The claims issues (rejected/denied claims) would unlikely be as prevalent in generalist practices, but rather be more prominent in specialty practices. In some areas there is decreasing access by generalists to subspecialty services. This is also true in BH outpatient practices, where the number of providers is decreasing and added administrative burdens in resolving claims take away from service time. Practitioners assert that service access is directly related to the payment issues.
- The CHNCT and Anthem BCFP noted that the claims reports presented reflect all claims within the MCO.
- There may be software that could translate coding differences into a more uniform reporting system. Dr. Kamens noted that the federal government created software for providers that promoted improved coding; however most providers did not use this system. The Department noted that carving out dental and BH will improve the problems associated with the current diversified system.

HUSKY Network Capacity as of Nov. 1, 2003

Ratios used to determine plan capacity for 5 key provider categories (Primary care for adults, children, women's health providers, mental health providers and dental providers) are based on historic FFS provider to client ratios. Monthly enrollment information and the quarter's MCO provider panels determine the capacity per MCO per county (out-of-state providers are not included). Provider panel changes are reported by the MCO to the DSS EDS monthly. The EDS provides the DSS with a database on enrolled Medicaid managed care providers twice monthly.

| County | Anthem BlueCare | | CHNCT | | Health Net | | Preferred | One |
|-------------------|-----------------|-----------------------------|--------|--------------------------------|------------|-------------------------------|-----------|----------------|
| | 2/02 | 11/03 | 2/02 | 11/03 | 2/02 | 11/03 | 2/02 | 11/03 |
| Fairfield | 39.62% | 50.5% Child | 61.51% | 74.7% <i>Dental*</i> | 85.1% | 90.1% <i>Dental</i> | 36.7% | 46.0% Adult |
| Hartford | 87.55 | 85.5 <i>Child</i> | 27.4 | 30.0 Dental | 63.8 | 53.5 Dental | 9.14 | 26.9 Child |
| Litchfield | 63.54 | 67.8 Child | 17.7% | 27.4 Child | 83.4 | 75.0 <i>Dental</i> | 13.2 | 17.2 Child |

| | | | | | | | | |
|-------------------|-------|------------------------|-------|------------------------|-------|------------------------|------|----------------|
| Middlesex | 64.72 | 73.9 Child | 43.6 | 48.1 Child | 37.3 | 37.4 Child | 25.3 | 51.5 Child |
| New Haven | 88.66 | 83.8 Dental | 69.98 | 85.3 Dental | 91.92 | 78.9 Dental | 54.5 | 45.5 Adults |
| New London | 57.75 | 63.7 Child | 34.98 | 66.9 Child | 95.5 | 78.9 Child | 12.1 | 18.5 Child |
| Tolland | 63.61 | 87.5 Dental | 8.30 | 10.5 Dental | 95.99 | 72.5 Dental | 3.71 | 7.3 Child |
| Windham | 66.07 | 64.7 Child | 73.3 | 40.8 Dental | 94.8 | 85.3 Dental | 15.8 | 31.5 Child |

* Identifies which of the five categories (see above) is most limiting.

The categories limiting capacity by county & MCO were highlighted:

- ü Fairfield: dental for two of the plans.
- ü Hartford: child/dental for two plans.
- ü Litchfield: child PCP 3 of 4 plans
- ü Middlesex: child PCP for all 4 plans
- ü New Haven: dental for 3 plans.
- ü New London: child for 4 plans
- ü Tolland: dental for 3 plans.
- ü Windham: both dental and child PCP

Council comments included:

- ‘Behavioral health services’ include children & adults: approximately 11.5% of HUSKY A clients >18 years used MH services and about 4% used substance abuse services in 2002. Of all HUSKY A clients < 18 years, 10% used MH services and 1.6% of youth aged 13-17 years received substance abuse treatment in 2002.
- Dental providers include general and pediatric dentists as well as dental hygienists (counted as .5 of a provider position).
- Limitations of assessing health care access with the adequacy of network capacity:
 - o Providers may/often participate in more than one MCO,
 - o The ratios of the 1994 Medicaid Fee-for-service (FFS) client/provider network, used as a baseline for measuring managed care provider adequacy, had limited provider participation.
 - o Providers listed in the MCO panels may not be taking new Medicaid patients for short or long periods of time.
 - o Specialists in a MCO panel may be adult practitioners and see older children aged 13-21 years but not younger children.
- Ellen Andrews stated that families have reported difficulty in obtaining appointments for children with possible flu symptoms. The MCOs noted that the member should call their plan’s member services number and the MCO will identify a provider who can see them. Dr. Geertsma noted that there has been an increase in flu-related visits at his hospital-based primary

care clinic over the last two weeks. In order to accommodate the increase in episodic visits, some well child visits have been delayed. While there is a seasonal component to PCP service demands, it is worsened by fewer providers (outside clinics) willing to take Medicaid clients, an overall shortage of 'generalist' providers and viral illness among practitioners.

Rep. Nardello stated that the adequacy of the current measurement of managed care network panels and HUSKY clients' access to care has been debated since 1995: the Council would welcome ideas on how to better measure this important indicator of health care access.

Annual HUSKY B reports

- ü Well Child Care visits for SFY 03 (7/1/02-6/30/03) averaged 75%.
- ü Percent receiving any dental services was approximately 25%, less (about 18%) received dental preventative care. (HUSKY A preventive care for 1st half 2002 was 23%).
- ü Prescriptions per 1000 member months averaged about 300 (compared to HUSKY A 6-months average of more than 550).

HUSKY A MCO Case Management

The DSS reviewed the MCO clinical case management reports, identifying changes that will need to be made in order for the reports to be more uniform:

- Case management (CM) case numbers vary by health plan in part because of different inclusion criteria. In particular, some plans may include all cases where CM was offered versus only those cases where the member accepted CM and the member actually participated in the CM.
- Referral source for CM varied among plans (i.e. Health Net had the highest number from the MCO member services/outreach staff, UM management services and client request but no referrals from DCF). Sixty-four percent (447) of the total CM referrals (702) were initiated by the MCO/UM management/service use patterns. Approximately 18% (126) of the total number of CM referrals came from health providers. Case management by health plans is most effective with early intervention through Primary Care provider referrals.
- The health plans observed that CM numbers do not reflect a population perspective on managing health care in the population. Each health plan offers Disease Management programs for those with chronic conditions (i.e. asthma, diabetes); CM targets those at risk or with the most acute health problems. The majority of their member population is individuals who are generally healthy and access preventive visits or episodic care for acute illnesses.
- The Council suggested that at a future meeting the health plans could describe their individual CM processes and criteria as well as data that support the efficacy of the MCO CM interventions.

Other

Connecticut statute requires (at-risk) behavioral health (2) and dental (2) subcontractors report quarterly to the DSS on revenue and expenses in HUSKY A. The first report was presented

December 2002; however the DSS stated it cannot provide these reports to the Council while the agency is still involved in the selection of the dental and BH Administrative Service Organization (ASO) contractor. The DSS will present aggregate revenue/expense reports for dental and behavioral health services that includes all four MCOs at either the January or February 2004 Council meeting.

HRSA State Planning Grant Update

Mary Beth Bonadies (Office of Health Care Access – OHCA) stated that CT is one of 23 states that received a supplemental grant (\$185,000) from the Department of Health & Humans Services to support states’ efforts to develop options to increase health insurance coverage for the uninsured. In 2001 OHCA contracted with UCONN to complete a phone survey of CT residents related to their health insurance coverage. Another survey will be undertaken that includes recommendations from the Medicaid Managed Care Council (i.e. Spanish speaking surveyors, over sampling of urban areas). The DSS, OPM and the Institute of Health Policy Solutions, Washington, D.C will review the 2004 survey data, which will assist the State in developing policy options for increasing health insurance coverage to uninsured residents. Stakeholders will be brought together to look at options, including the affordability of small business employer-based insurance. In response to a suggestion that School Based Health Clinics could provide ‘hard-copy’ surveys to families since many do not have telephones, Ms. Bonadies stated she would discuss the feasibility of this with UCONN. Rep. Nardello thanked Ms. Bonadies for bringing the Council this information and looks forward to a report on the latest household survey at a future Council meeting.

HUSKY Enrollment (see Dec. enrollment by MCO by County)

Enrollment Summary December 2002-December 2003

| | Dec 02 | Jan 03 | Feb 03 | Mar 03 | Apr 03 | May 03 | Jun 03 | Jul 03 | Aug 03 | Sept 03 | Oct 03 | Nov 03 | Dec 03 |
|---------------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| Total HUSKY A | 287,241 | 289,333 | 291,016 | 295,420 | 297,303 | 299,057 | 294,331 | 287,442 | 288,260 | 290,484 | 293,106 | 295,352 | 297,192 |

| | | | | | | | | | | | | | |
|----------------|---------|---------|---------|---------|---------|----------------|---------|---------|---------|---------|---------|---------|---------|
| A > 19 Adults* | 85,172 | 85,950 | 86,768 | 88,836 | 88,823 | 90,433 | 88,811 | 86,354 | 86,235 | 86,926 | 87,702 | 88,305 | 88,805 |
| A < 19 | 202,069 | 203,383 | 204,248 | 206,584 | 208,480 | 208,624 | 205,520 | 201,088 | 202,025 | 203,558 | 205,404 | 207,047 | 208,387 |
| HUSKY B | 13,942 | 14,153 | 14,292 | 14,352 | 14,493 | 14,617 | 14,665 | 14,773 | 14,938 | 15,061 | 15,445 | 14,723 | NA |

· From October to November HUSKY B had an enrollment drop of 518; however the ACS computer system change may have contributed to the enrollment number reduction. The ACS & DSS will be reviewing the November numbers and report these with the December enrollment when available.

· HUSKY A enrollment by race & ethnicity was reported: Caucasian-39.6%, Hispanic-33%, African American-24.7%, and Asian and Native American-2.6%.

Council Quarterly Report

Jeffrey Walter requested clarification from DSS on the BH service carve-out. The DSS stated that assuming the carve-out proceeds before the implementation of an 1115 HIFA waiver, the 1915(b) waiver that the HUSKY A program is currently operating under would be amended. Notice of the 1915(b) waiver amendment would be given to the Legislative Committees of Cognizance. These Committees would have 30 days to comment or hold a public hearing, before the final amendment is submitted to CMS. The Council Quarterly report (2nd & 3rd Q 03) was accepted without change.

The Medicaid Council will Meet Friday January 16, 2004 at 9:30 AM.

From the DSS December 2003 Enrollment Report
HUSKY A

**CUMULATIVE
NET
ENROLLMENT
BY COVERAGE
GROUP BY
COUNTY**

AS OF 12/01/2003

| Coverage Group | New | | | | | | | | Totals |
|-------------------|-----------|----------|------------|-----------|--------|--------|---------|---------|--------|
| | Fairfield | Hartford | Litchfield | Middlesex | Haven | London | Tolland | Windham | |
| D01 | 754 | 1,609 | 257 | 252 | 1,567 | 586 | 147 | 238 | 5,410 |
| D02 | 496 | 890 | 149 | 337 | 920 | 277 | 68 | 103 | 3,240 |
| F01 | 8,112 | 17,336 | 1,081 | 976 | 17,679 | 2,693 | 701 | 1,582 | 50,160 |
| F03 | 14,469 | 22,118 | 4,015 | 2,773 | 20,153 | 7,051 | 1,990 | 4,078 | 76,647 |
| F04 | 717 | 969 | 199 | 173 | 1,007 | 316 | 121 | 183 | 3,685 |
| F07 | 18,893 | 29,978 | 3,172 | 2,323 | 30,509 | 6,081 | 1,991 | 3,914 | 96,861 |
| F09 | | | | | | | | | - |
| F12 | 546 | 1,115 | 73 | 67 | 1,100 | 130 | 45 | 99 | 3,175 |
| F20 | | | | | | | | | - |
| F25 | 15,704 | 13,170 | 2,372 | 1,712 | 15,295 | 3,628 | 1,288 | 2,092 | 55,261 |
| F26 | | | | | | | | | - |
| F95 | 72 | 90 | 5 | 9 | 102 | 14 | 3 | 15 | 310 |
| M01 | 33 | 22 | 13 | 12 | 7 | 9 | 1 | 6 | 103 |
| M02 | 1 | 15 | 5 | 1 | 26 | 9 | 3 | 6 | 66 |

| | | | | | | | | | |
|---------------|---------------|---------------|---------------|--------------|---------------|---------------|--------------|---------------|----------------|
| P01 | 19 | 36 | 2 | 1 | 10 | 17 | 2 | 7 | 94 |
| P02 | 445 | 491 | 106 | 69 | 674 | 202 | 62 | 128 | 2,177 |
| P95 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Totals | 60,263 | 87,840 | 11,449 | 8,705 | 89,049 | 21,013 | 6,422 | 12,451 | 297,192 |

HUSKY A

**NET ENROLLMENT
REPORT**

**TOTAL
ENROLLMENTS AS OF
12/01/2003**

| County | Blue | Health Net | | Preferred | Total |
|-------------------|----------------|-------------------|---------------|------------------|----------------|
| | Care | CHN | | One/FC | |
| Fairfield | 13,919 | 10,675 | 28,865 | 6,804 | 60,263 |
| Hartford | 54,438 | 10,468 | 18,863 | 4,071 | 87,840 |
| Litchfield | 5,300 | 517 | 5,243 | 389 | 11,449 |
| Middlesex | 5,184 | 1,144 | 2,012 | 365 | 8,705 |
| New Haven | 30,089 | 26,442 | 23,018 | 9,500 | 89,049 |
| New London | 7,058 | 2,398 | 11,055 | 502 | 21,013 |
| Tolland | 3,031 | 357 | 2,816 | 218 | 6,422 |
| Windham | 4,099 | 1,295 | 6,614 | 443 | 12,451 |
| Total | 123,118 | 53,296 | 98,486 | 22,292 | 297,192 |

| | |
|-------------------------------------|--------------|
| Targeted Mandatories | 7,830 |
| Total Default Enrollments | 1,898 |
| Blue Cross | 481 |
| Community Health Network | 509 |
| PHS Healthy Options | 472 |
| Preferred One (FC) | 436 |