

Meeting Summary: March 12, 2004

Chair: Sen. Toni Harp

(Next meeting: April 16, 2004, 9:30 AM in LOB RM 2D)

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Martha Okafor (DPH), Thomas Deasy (Comptroller Office), Naida Arcenas (DCF), Barbra Parks Wolf (OPM), Ellen Andrews, Dr. Wilfred Reguero, Dr. Edward Kamens, Janice Perkins (MCO), Dr. Alex Geertsma, Marjorie Eichler, Doreen Elnitsky.

Also Present: William Diamond (ACS), Dorothy Pacyna (DPH), Sylvia Kelly (CHNCT), Paula Smyth (Anthem), Douglas Hayward (Preferred One), Christine Bianchi, Judith Solomon, Jody Rowell (Child Guidance Clinics), Tanya Barrett, Kristine Dowdy (HUSKY Infoline), Deb Poerio (School Based Health Clinics-SBHC), M. McCourt (Council staff).

HUSKY Infoline Data Summary

At the request of the Council, Tanya Barrett and Kristin Dowdy of CT United Way HUSKY Infoline reviewed the data summary for July 1 – December 31, 2003 and January 1-February 29, 2004.

	July – December 2003	January/February 2004	Comments
Implementation of Legislative changes that impact HUSKY A & B	*Elimination of Continuous Eligibility (4/03) & presumptive eligibility children 9/03 *Adult co-pay for pharmacy & OP visits, 11/1/03	New premium for HUSKY B band 1 (186-235%FPL) & increase premiums to band 2 (>235-300%FPL)	
Incoming calls to Infoline	19,503 (6% less than 6-month period 02)	5,973 (17% less than Jan 03)	High call volume in 03 due to elimination of adult optional services
Outgoing calls	14,930 (> 74% from 2002)	4929 (>30% from Jan 03)	Increase in access to care calls, require > out calls

Mailed Applications	6935	1711 (< 15% of Jan 03)	
Caller language	94% English	94% English	
Call reasons: 1) HUSKY info/referral	70% of calls	67% of calls	04: *71% program info, check application status, etc *13% other insurance info *16% non-HUSKY info such as child care, WIC, etc.
2) HUSKY A access to care issues	*52% Maintenance of ins. coverage * 11% Dental access *8% PC access *7% Pharm/med access *6% billing	*50% Maintenance of cov. *14% Dental access *8% PC access *6% Pharm/med access *5% billing	*Maint. of cov. = getting MCO plan info *Pharm =scripts filled, 2 nd to PA, eligibility changes, *Of billing calls, 94% involved a Pt. billed for Medicaid services.
3) HUSKY B access to care issues	*49% Maint. of coverage *15% provider call-ins *6% dental access *13% billing issues	*43% Maint. of cov *9% provider call-ins *7% dental access *29% billing	* Getting MCO card, plan info * 82% of billing calls related to premium paymt.
Eligibility/Enrollment	*80% HUSKY A *14% HUSKY B *5% A & B cross-over	*81% HUSKY A *14% HUSKY B *5% A & B	*HUSKY A : loss of coverage, apps > 45 days, *HUSKY B: loss of cov. Member canceled HUSKY, apps > 45 days *>A & B transition calls since 4/03 (no CE).

Comparing this Infoline report with the June 2003 Council report, there seems to be a temporal relationship between the volume of calls and program changes. The call volume in 1st 4 months in 2003 (average 3713/month) may have been impacted by optional Medicaid service changes. Adult pharmacy and outpatient co-pays, implemented in Nov. 2003, may have contributed to the average monthly volume (3250/m) in the last half of 2003. The HUSKY B

premiums did not result in higher call volumes in 2004 compared to the first quarter 2003, however the number of adult HUSKY members affected by the optional services and co-pays is far greater than those impacted by the HUSKY B premium changes. It is important to continue to track the call volume and content patterns following major program policy changes and consider the capacity of the HUSKY Infoline to respond to any future planned major changes.

- The percentage of calls related to general HUSKY information was lower in the last half of 2003 (70%) and the first two months of 2004 (67%), compared to the last half 2002 (78%) and early 2003 (71%).

- There was an increase in calls related to:

- o 'Other needs' such as housing, child, care, etc., increased in the last half of 2003 (13%) and the first two months of 2004 (16%) compared to 2002 -03 (10%). Childcare openings were frozen in the last half of 2003.

- o Maintenance of coverage calls represented 52% of calls in the last half of 2003 and early 2004 compared to 34-48% in 2003-2003.

These call percentages may reflect more pressing needs in the community and/or greater awareness of HUSKY Infoline as a resource.

- There has been little change in the percentage of calls involving specific health care access:

- o Dental access calls remain in the range of 12-13% over 2002-03 with a slight increase in 2004 at 14%.

- o Primary Care call percentages also remain fairly stable over 2002-04 at 8-10%.

- o Pharmacy calls, which involve obtaining medications & eligibility issues, remain at 6-7%.

HUSKY Enrollment: ACS & DSS

	Mar 03	Apr 03	May 03	Jun03	Jul 03	Aug 03	Sept 03	Oct 03	Nov 03	Dec 03	Jan 04	Feb 04	Mar 04
Total HUSKY A	295,420	297,303	299,057	294,331	287,442	288,260	290,484	293,106	295,352	297,192	299,056	300,391	302,001
A >19 Adults *	88,836	88,823	90,433	88,811	86,354	86,235	86,926	87,702	88,305	88,805	89,351	89,758	
A <19	206,584	208,480	208,624	205,520	201,088	202,025	203,558	205,404	207,047	208,387	209,705	210,633	
HUSKY B	14,352	14,493	14,617	14,665	14,773	14,938	15,061	15,445	14,723	14,395	14,640	14,168	14,277

- HUSKY call volume increased back to about 20,105, noted during July and September 2003.

- In 2004, the total HUSKY A membership has increased at 1300-1800 per month, Adult

membership has increased by 400-500 members/month, and <19 enrollment increased by 1000 – 1300 per month during January –February 2004.

· HUSKY B enrollment decreased in February and March. New or increased HUSKY premiums were implemented February 1, 2004.

HUSKY B Premiums & Impact on Enrollment

The Department reviewed the HUSKY B cost-sharing changes implemented in PA 03-3, with premium changes begun Feb. 1, 2004, and benefit structure , co-payments anticipated to be implemented in SFY05:

FPL Income Band	Pre -2/1/04 Premium/month	February 1, 2004 Premium/month	Current co-pay max per family	Max annual co-pay per family SFY 05
B1: 186-235%FPL	\$0	\$30/child/M \$50/family max/M	\$650/year	\$760/year*
B2: 236-300%	\$30/child/M \$50/family max/M	\$50/child/M \$75/family max/M	\$650/year	\$760/year**

*Maximum co-pay based on the 186% (lowest income in band 1): cost sharing cannot exceed 5% of the family’s gross income.

**Band 2 cost sharing maximum based on the lowest income range of 236%FPL.

Premium payment process:

- ü MCO collects premiums due by the 15th of the coverage month. The MCO monthly capitated rate received from DSS is reduced by the appropriate premium rate/member.
- ü If no payment is received by the 23rd of the coverage month, ACS is informed and the member is dis-enrolled.
- ü While the member’s HUSKY B *eligibility* remains unaffected, dis-enrollment from the MCO is effective the 1stof the following month and the child is ‘locked-out’ of participation in the managed care program for 3 months. Early re-enrollment (before the 3-month lock-out period) after premiums are paid is allowed for ‘good cause’.
- ü When the family pays the overdue balance and the first prospective month’s premium amount, the child will be re-enrollment in HUSKY B.

Premium changes were implemented February 1, 2004; dis-enrollment due to non-payment would have been effective 3/1/04. **However since monthly premiums are new to Band 1 members (the largest enrollment band), the Department will delay dis-enrollment due to unpaid premiums for several months. Members are still required to pay monthly premiums (and back payments) during this period.**

Council discussion:

- The DSS noted that HUSKY B is not a Title XIX “entitlement “program, therefore members are accountable for the cost-sharing just as members of commercial insurance are.

Band 1 income FPL is 1% away from Title XIX HUSKY A. Members with incomes as low as \$29,353 (family of 2) will pay outstanding monthly premiums and any out-of-pocket medical expenses incurred in the 'lock-out' period. Further, there is concern that some provider sites may refuse 'locked-out' members non-emergent care during this time period.

- Collecting the premiums is an administrative and financial issue for the managed care plans. For example, of Anthem's 7000 Band 1 HUSKY B members, 1800 (26%) had not paid their premiums in February. The MCOs will continue to receive a capitated monthly payment per member minus the premium amount.

- Approximately **2400 members (17%) of the total HUSKY Benrollment** would have been dis-enrolled March 1, 2004 if the DSS had not implemented an 'adjustment period' until at least May 2004 (continued premium payments, no dis-enrollments).

- The DSS commented that the pilot Employer-based Insurance Subsidy program would outreach to those that have lost HUSKY B coverage. The family would receive state premium assistance for their cost sharing in commercial insurance offered through their employer. The employers want this process to be invisible.

Department of Public Health : Uninsured Rates in School-Based Health Clinics (SBHC)

Dorothy Pacyna and Martha Okafor (DPH) provided statistics on SBHC over the past several years. There are 61 SBHC funded through the DPH in 18 CT counties. The Centers' goals are to provide comprehensive primary physical and mental health services to enrolled students and increase the capacity of the school and community to provide health education and promote positive physical, mental and developmental health to all students in the school in order to ensure they are able to learn.

Ø The number of enrolled students has increased over the past 3 school years from under 40,000 to slightly over 40,000.

Ø Student health visits increased from approximately 2 visits per enrolled student in 1999-2000 to approximately 3 visits per enrolled student in 2002-2003. The most prevalent reasons for the visits include:

- o Acute illness – 25.9%
- o Mental Health/substance abuse – 23.2%
- o Collateral contacts – 22.9%: this represents care coordination by the SBHC with the community system.
- o Other services such as General medical exam (5.5%), Screen/risk appraisal (2.5%), oral health (3.2%) and reproductive health (4.9%) are less frequently recorded reasons for visits.

Ø Insurance status of students enrolled in SBHC over the past 3 years has varied:

Ø The uninsured percentage has been fairly constant, ranging from **28-26%** of the enrolled students. The DPH agreed to look further at the data, as it not known what percentage of the uninsured are undocumented youngsters or what the role of presumptive eligibility was in insuring youth.

- o The data reported is not a 'snap-shot' view of insurance status, rather it is collected in the beginning of the school year and updated during the year.

- o The SBHC do follow up on HUSKY enrollment applications.

- o Presumptive eligibility (PE) is seen as a major vehicle for connecting students to the HUSKY programs. The Medicaid insured rates increased after 2001 (from **28% to 39%**) when this policy was implemented and SBHCs were one of several qualified entities. (PE was

eliminated in the 2003 implementing bill legislation).

Department of Social Services: Other

State Plan Amendments (SPA) Status & Associated Cost Savings.

The DSS sent a letter to Sen. Harp in response to her information request in February (please see attached letter). The following information in the letter updates the status of the SPA:

SPA	Proposed Effective Date	Projected federal revenue (millions)		Status
		SFY04	SFY05	
Public Hospital DSH (03-009)	7/1/03	\$0	\$1.2	approved
SAGA DSH – Outpatient (03-013)	6/6/03	\$6.6	N/A	approved
GABHP DSH (03-014)	7/1/03	\$4.6	\$5.3	approved
SAGA DSH – New Medical (03-022)	1/1/04	\$11.75	\$23.5	approved
Urban DSH expansion (03-018)	10/1/03	\$1.25	\$1.25	approved
Adult Rehab option (03-021)	10/1/03	\$0	\$2.4	pending

Pharmacy Carve-out

The Medicaid Fee-For-Service (FFS) Pharmacy & Therapeutic Committee has been meeting, as specified in legislation, to guide the implementation of the FFS Preferred Drug List (PDL). The supplemental rebates in FFS could be applied if the State pursued pooled purchasing of pharmaceuticals for about 500,000 covered lives in the Medicaid FFS, HUSKY A & B programs, ConnPace, State Assistance program (SAGA) and CADA program. This was one of the recommendation from the legislative Program Review & Investigation Committee report on pharmacy costs in CT. The Department is considering ‘carving-out’ pharmacy from the HUKSY A & B programs.

MCO Rate Increases – Impact on Provider Rates

The managed care plans were asked to comment on the effect of the MCOs' yearly rate increases and other dollars put into the system from the State on their network provider rates over the past 6 years of the Medicaid Managed Care Program. While it is understood that specific rate information is proprietary, the MCOs were asked to discuss their approach to rate changes for providers. FirstChoice/Preferred One and CHNCT represented the four plans, providing a review of the factors affecting health care cost escalation and the impact of this on premium allocations.

- Factors that increase medical costs include:
 - o Available new medical technology and pharmaceutical products,
 - o Increased service utilization related to direct consumer marketing, increased use of home health services, changing clinical practice patterns and use of test for liability protection,
 - o Identification of and interventions for at-risk populations.
 - o Increasing service unit costs related to increased service production costs.
- Factors considered in the determination of reasonable premium levels for health care services to HUSKY members include;
 - o Premium levels should 'reasonably' cover medical and administrative expenses; the latter is more predictable, while the former requires actuarial analysis.
 - o Medical care spending is impacted by a variety of factors including scope of covered services, medical management, payment rates and volume of health services.

Discussion:

- According to the MCOs, there have been rate changes across all providers types, with the most significant in BH and pharmacy. Rates can be re-negotiated with the MCO; initial contact would be through the MCO provider relations staff.
- Rep. Nardello stated there is a need to find a balanced way to address MCO rate issues as well as health provider rates. There appears to be an arbitrary process in increasing practitioner rates. Incremental rate increases to providers can have a positive impact on access to care.
- Identifying and adopting best practices leads to a more effective and efficient delivery system that reduces waste, improves health outcomes. The medical home pilots (DPH) demonstrate positive outcomes for families and children, reduce acute care visits and hospitalizations and improve the overall quality of care. Care coordination by the health provider, currently not reimbursed in managed care, can, if applied appropriately, reduce higher health care spending for special needs children.

Rep. Nardello encouraged providers, MCOs and the state agency(s) to target areas of quality improvement in HUSKY through the adoption of best practices and assessment of the impact of these practice changes.

The next Medicaid Managed Care Council meeting is Friday April 16 at 9:30 AM in LOB RM 2D.

(Attachment to March 12 Medicaid Council meeting summary: letter from Dr. Mark Schaefer (DSS) to Sen. Harp regarding SPA & associated revenues).

March 5, 2004

The Honorable Toni Harp
 State Senator
 Room 2700
 Hartford, CT 06106

Dear Senator Harp:

As you requested, I have attached a summary of the state plan amendments submitted by the medical policy unit in the Department's Division of Medical Care Administration. Please bear in mind that these are only estimates, and that actual revenue may be more or less. The revenues, as noted under the FY 04 column were included as part of the final budget projections under PA 03-1 JSS. Also, all of the revenue associated with these state plan amendments has been taken into consideration in budget projections for SFY05.

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SAGA DSH – Outpatient (03-013)	6/6/03	\$6.6	N/A	approved
GABHP DSH (03-014)	7/1/03	\$4.6	\$5.3	approved
SAGA DSH – New Medical (03-022)	1/1/04	\$11.75	\$23.5	approved

Urban DSH expansion (03-018)	10/1/03	\$1.25	\$1.25	approved
Adult Rehab option (03-021)	10/1/03	\$0	\$2.4	pending

The FY 05 projected federal revenue as submitted under the Governor's Midterm Budget Adjustment scales back the SAGA DSH from the amount submitted to CMS as a result of the recently enacted SAGA Medical program. Additional one-time revenue will be available from payments for hospital inpatient and outpatient services after January 1, 2004 for services rendered on or before December 31, 2003 (i.e., the claims tail) under the old SAGA program.

The adult rehabilitation option is currently expected to generate \$2.4 million in SFY05, although we acknowledge that under existing statute, up to \$3 million dollars of rehabilitation revenue can be reinvested in services through the Community Mental Health Strategy Board. Generating the full \$3 million would likely require an expansion beyond mental health group home and substance abuse residential services that are currently included in the proposed state plan amendment.

This memo does not include the non-emergency medical transportation, outpatient copayment and SCHIP SPAs as none of these were intended to generate revenue.

Please do not hesitate to contact me at 860.424.5067 if I can be of further assistance.

Sincerely,

Mark Schaefer
 Director, Medical Policy (DSS)