

Connecticut  
Medicaid Managed Care Council  
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## Meeting Summary: July 16, 2004

Chair: Senator Toni N. Harp

*Present:* Senator Toni Harp (Chair), Rep Vickie Nardello, Rep David McCluskey, David Parrella & Rose Ciarcia (DSS), Thomas Deasy (Comptroller's office), Dr. Patricia Leebens (DCF), Barbara Parks Wolf (OPM), Marge Eichler, Ellen Andrews, Dr Edward Kamens, Dr. Alex Geertsma, Janice Perkins, Linda Pierce, Jeffrey Walter.

*Also Present:* Maria Cerino (ACS), Sylvia Kelly (CHNCT), Paula Smyth (Anthem), Douglas Hayward, James Gaito (POne), Paula Armbruster, Christine Bianchi, Irene Liu, Jody Rowell, Judith Solomon, Naida Arcenas, M. McCourt, Staff to the Council.

## Department of Social Services

### HUSKY Program Updates

Ø *1915(b) waiver renewal:* The CMS has verbally informed DSS that the waiver renewal has been accepted, covering a two-year period July 1, 2004-June 30, 2006. The program is currently operating under this waiver renewal.

Ø *Service Carve-outs:* The DSS is moving forward with a dental carve-out. Dr. Donna Balasky will be responsible for the management of the dental program. While it is the intention of DSS to proceed with a BH carve-out, the Governor still is reviewing the BH carve-out plan. The DSS has been working with the MCOs on transitional plans, which includes facilitating resolution of provider outstanding receivables. A 1915(b) waiver amendment for carved-out services is expected to be submitted to CMS in the fall. Significant waiver changes are required by statute to be submitted to the legislative Committees of Cognizance prior to the submission to CMS.

o Rep. McCluskey requested DSS consider submitting the waiver amendments to the legislature after the November elections. The DSS will take this into consideration.

o The DSS has offered the opportunity to two bidders to negotiate contracts for the HUSKY dental services Administrative Service Organization (ASO). **United Health Care (previously DBP), the dental subcontractor for Anthem and Doral Dental, the dental subcontractor for Health Net** could negotiate a contract with DSS for the two statewide, non-risk dental ASOs. About 90% of the contract provisions are in the ASO RFP. The DSS, in response to questions about the fiscal administrative efficiency of two ASOs versus one, stated that the decision to have more than one ASO was based on the importance of client choice, the agency's leverage for ensuring ASO contract compliance and performance and non-reliance solely on one ASO

vendor. HUSKY members will choose a dental ASO through the HUSKY enrollment broker ACS, which will require a DSS/ACS contract amendment.

Ø *HUSKY B Consumer Cost Sharing:* The DSS, in response to 2004 legislation, reviewed the impact of new/increased premiums on HUSKY B Band 1 and Band 2 members and determined that in light of the number of children (about 3700) that would be disenrolled for failure to pay the 2/04 premiums, the premium rates would return to pre-Feb 1, 2004:

HUSKY B Band	<b>Pre-Feb. 1, 2004 rates</b>	Feb. 1, 2004 Rates (eliminated)
<b>Band 1 (185-235%FPL)</b>	<b>0 premiums</b>	\$30/child /M to \$50/familyM
Band 2 (235-300%FPL)	<b>\$30/child/M to \$50/family/M</b>	\$50/child/M to \$75/family/M

- o HUSKY clients who paid the increased rates as of 2/1/04 would receive a refund; Band 2 members could apply their refund to future premiums payments.
- o The DSS will reimburse the MCOs for premiums that were deducted from their PMPM capitation rates.
- o Band 2 families that have not paid either the pre-Feb 1 rate or the 2/1/04 increased rates will be given the opportunity to pay the balance owed or arrange payments with their MCO by **July 15, 2004.** Those Band 2 families that do not respond to this notice will be **disenrolled effective 8/1/04.** The DSS predicts about 200 children in Band 2 could lose HUSKY B coverage, which is the average attrition of families that do pay their monthly premiums, regardless of the premium changes.

***SAGA Program Operations:***

The DSS reviewed the SAGA restructuring, based on 2003 legislation that capped the funding for this state-funded entitlement program. The SAGA program currently enrolls about 28,000 clients, mainly single adults. The SAGA enrollment is steadily increasing.

- o As of **August 1, 2004** Community Health Network of CT (CHNCT) has contracted with DSS as a non-risk ASO, managing non-inpatient medical services for primary and specialty services, pharmacy and ancillary services. CHNCT is responsible for medical, provider network and pharmaceutical management, as well as claims processing.
- o Hospital inpatient and outpatient services will continue to be paid by DSS under the capped appropriation. **Effective August 1,** CHNCT will be responsible for hospital primary care and OB/GYN clinic services and associated ancillary services provided under the SAGA medical program. SAGA provider-related policy and reimbursement changes are on the DSS web site: [www.ctmedicalprogram.com](http://www.ctmedicalprogram.com). ; policy transmittal 2004-21 and 2004-16
- o DMHAS will continue to manage behavioral health services for SAGA clients.

The following highlights Council questions/comments:

- *How will SAGA clients be notified of the changes?* The DSS stated letters have already

gone out to clients and an official letter will be sent out informing eligible clients of the August 1 effective date of CHNCT service management. CHNCT will provide clients with a member care and assign clients a PCP, which will mainly be Federally Qualified Health Centers (FQHCs) but could be a hospital or private provider. CHNCT has reviewed current members' PCP utilization, with the goal of maintaining continuity of care with the member's usual provider. About 99% of SAGA clients live within 20 miles of a FQHC and 94% are within 20 miles of hospital clinics. Members can change their PCP through CHNCT.

- *Was additional funding provided to offset the hospital SAGA payments?* There was no specific legislation to offset the SAGA funding reductions, however:
  - o In June 2004 the State did rebase the discharge rates for some hospitals, establishing a base floor for payments. The DSS will be submitting a Medicaid State Plan amendment retroactive to Jan 1, 2004 to CMS.
  - o Disproportionate Share Hospital (DSH) pools take into account hospital shortfalls. The 25-30% decrease for SAGA hospital expenses may be accounted for in the DSH pools. These have to be claimed separately as the State cannot claim twice on the same item to CMS. The quarterly hospital DSH report will be in the September Office of Health Care Access report. Hospital payment adjustments were provided:

SAGA Hospital Payments Adjustments

Month	Adjustment Factor	Adjusted	Unadjusted
April ( <b>Jan-Apr</b> ) <b>04</b>	173%	\$7,673,001	\$4,435,468
May 04	64%	\$1,779,314	\$2,2780,508
June 04	75%	\$1,791,611	\$2,388,961

- o *Will services such as transportation be in the CHNCT contract?* The DSS stated no new services previously eliminated as Medicaid optional services have been added. (*see policy transmittal 2004-16 – CHNCT will pay for emergency ambulance transportation and may also provide non-emergency medical transportation for radiation, chemotherapy and dialysis. Transportation requests go to CHNCT @ 1-866-361-7242, not Logisticare*).

- The DSS was requested to consider the Medicaid Council as a vehicle for future tracking of CHNCT data in SAGA.

- A provider observed that changes in health care sites in a state program (i.e. SAGA) may impact providers that see the children under HUSKY as well as the SAGA parent (though most SAGA clients are single adults) in that families may access the same health care site.

## HUSKY Revenue/Expense Report for CY 2003

	Anthem 02	Anthem 03	CHNCT 02	CHNCT 03	Health Net 02	Health Net 03	Preferred One 02	Preferred One 03
Member Months	1,473,116	<b>1,582,182</b>	590,578	<b>654,018</b>	1,177,576	<b>1,241,202</b>	231,494	<b>237,104</b>

Revenue	\$252,477,000	<b>\$273,720,273</b>	\$100,832,084	<b>\$115,755,706</b>	\$204,851,951	<b>\$218,338,116</b>	\$37,254,274	<b>\$39,198,519</b>
Medical Expense	228,767,000	<b>256,948,573</b>	87,455,478	<b>101,093,663</b>	184,226,235	<b>199,317,309</b>	30,839,581	<b>31,307,524</b>
Administrative Expense	22,327,000	<b>22,342,088</b>	11,134,039	<b>12,643,249</b>	14,208,931	<b>18,629,117</b>	5,323,226	<b>6,039,630</b>
Total Expense	251,094,000	<b>279,290,661</b>	98,589,517	<b>113,736,912</b>	198,435,166	<b>217,946,426</b>	36,162,807	<b>37,347,154</b>
Net Income* (loss)	\$899,000	<b>(\$3,620,798)</b>	\$2,242,567	<b>\$2,018,794</b>	\$4,023,324	<b>\$252,815</b>	\$1,035,266	<b>\$37,347,154</b>
Medical Loss Ratio	91%	<b>93.9 %</b>	87%	<b>87%</b>	90%	<b>91.3%</b>	83%	<b>79.9 %</b>
Administrative Loss Ratio	9%	<b>8.2 %</b>	11%	<b>11%</b>	7%	<b>8.5%</b>	14%	<b>15.2%</b>
Margin	0%	<b>(1.3%)</b>	2%	<b>1.7%</b>	2%	<b>0.1%</b>	3%	<b>2.1%</b>

\*Net income is after taxes, except CHNCT which in not-for-profit (see other notes on R/E report attached)

Financial Reports 1997-2003\* All Plans

All Plans	1997	1998	1999	2000	2001	2002	2003
Member Months	NA	2,594,181	2,726,260 (A&B)	NA	3,019,068	3,472,764	<b>3,714,506</b>

Revenue	\$355,891,806	\$371,857,435	\$391,718,968	\$438,048,971	\$487,699,544	595,415,309	<b>647,012,614</b>
Medical Expense	\$321,211,261	\$318,870,962	\$357,912,361	\$381,003,060	\$447,653,540	531,288,294	<b>588,667,069</b>
Administrative Expense	\$5,483,081	\$45,806,348	\$37,459,038	\$43,869,414	\$42,331,445	52,993,196	<b>59,654,084</b>
Total Expense	\$326,694,342	\$364,677,310	\$395,371,399	\$424,872,474	\$490,081,419	584,281,490	<b>648,321,153</b>
Medical Loss Ratio	90%	86%	91%	88%	92%	89%	<b>91.0%</b>
Administrative Loss Ratio	16%	12%	10%	10%	9%	9%	<b>9.2%</b>
Margin	Range of 4% to -25%	1%	(1%)	2%	0%	2%	<b>(0.1%)</b>

Data source: DSS R & E reports to MMCC over the past 7 years; 1997-2002 not reported at the 7/04 meeting

Council comments:

- There are variations on PMPM medical and administrative costs among the MCOs. Is this related to utilization? Administrative costs reflect plan volume. Preferred One noted that as the smallest plan, they have more variability compared to larger plans. The 15.2% Adm. Costs relate to fixed costs.
- Anthem stated that their losses for CY 2003 relate to the plan's attempt to keep hospital rates higher in order to maintain an adequate provider network. The plan's medical trends exceed the FY05 2% rate increase. Additionally, the plan anticipates higher administrative costs related to co-pay and premium changes in the next CY 2004 report.
- CHNCT noted that last year there was a significant reduction in pregnant women and newborns in the plan, which impacted their medical expenditures. Since January the plan has had a higher numbers of enrolled pregnant women, which increases their medical costs.

**Total Dental and Behavioral Health Expenditures 2002-03**

	2002	2003	Percent Change
Member months	3,441,027	3,575,789	3.9%

Net BH Expenditures	\$49,463,122	\$57,726,691	16.7%
\$ per member per month	\$14.37	\$16.14	12.3%
BH Reinsurance \$	\$23,107,956 ( <i>47% of all BH Expenditures</i> )	\$27,837,092 ( <i>48% of all BH expenditures</i> )	20.3%
Dental Expenditures	\$26,282,728	\$28,057,622	6.8%
\$ PMPM	\$7.64	\$7.85	2.7%

The data presented shows that while member months increased by 4%, the BH expenditures (minus the reinsurance) increased about 2 & 1/2 times that of dental and State BH reinsurance expenditures increased 20.3% in one year. Per member per month (PMPM) dental rates increased by \$.21 PMPM compared to \$1.77 PMPM BH increase. The audited CY 2003 reports are based on national standards, which form the basis of MCO reports on administrative and medical expenditures.

## HUSKY Enrollment: ACS Report

- ü Call volume increased in June to 17,000 reportedly related to premium changes. Previous peaks were in January and March (about 20,000).
- ü Overall HUSKY A enrollment has steadily increased over the past 3 years. Enrollment has historically dropped after May each year during June & July (due to timing of children's 12-month continuous enrollment {CE}), then gradually increased back to the May enrollment numbers over the following 6 months. The exception to this pattern was June/July of 2002, when the enrollment increased during those months by 1.4% (3982). The most significant HUSKY A member loss was in 2003 related to policy changes (reduction of adult eligibility to 100%FPL, elimination of children's presumptive and continuous eligibility-CE). The June-July 2004 member losses are less remarkable than 2003. It is unclear why 1202 children lost eligibility in July 2004 since CE has been eliminated..
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Year/category	Peak May enrollment	July enrollment	% Change May to July
<b>2002 HUSKY A: ALL</b>	<b>273,476</b>	<b>277,458</b>	<b>&gt;1.4% (+3982)</b>
Adults	78,889	80,821	>2.4% (+1932)
<19 years	194,587	196,637	>1% (+2050)
<b>2003 HUSKY A: ALL</b>	<b>299,057</b>	<b>287,442</b>	<b>&lt;3.9% (-11,615)</b>
Adults	90,433	86,354	<4.5% (-4079)

< 19 years	208,624	201,088	<3.6% (-7536)
<b>2004 HUSKY A: ALL</b>	<b>304,633</b>	<b>302,952</b>	<b>&lt;0.6% (-1681)</b>
Adults	91,256	90,777	<0.5% (-479)
<19 years	213,377	212,175	<0.6% (-1202)

- ü HUSKY B enrollment remains fairly stable with slight increases in May (14,523) and June (14,571) followed by a small decrease in July (14,553).
- ü HUSKY B applications (new & renewals) referred to DSS for HUSKY A consideration have been about 44-46% since January but were 38.5% in June 2004.
- ü HUSKY A member plan change reasons were reviewed. Members are asked to report reasons when they request the plan change. About 1-1.5% of the total HUSKY A members change plans monthly. “Other” change reasons constitute about a third of the reasons for plan changes. These reasons include disenrollment by error, or the member changes MCO in response to health plans’ community outreach. The Council suggested providing more detail in this category.

## Medicaid Council Subcommittees

Quality Assurance Subcommittee: Chair – Paula Armbruster

### **Next meeting is on September 16 10:30 AM**

- ü A HUSKY Obesity work group of the subcommittee was formed after the 2003 Pediatric Obesity Forum. A provider informational matrix of MCO obesity covered services for HUSKY A children & adults and HUSKY B children was completed and will be sent to providers through professional associations, DPH and MCOs.
- ü Drs. Karen Dorsey and Alex Geertsma, pediatricians that work with the subcommittee and Council developed Pediatric Obesity Medical Recommendations for the Council consideration (see attached summary). While the recommendations address surveillance in the HUSKY program and possible quality improvement initiatives, recognition of the complexity and multifaceted factors in obesity led to broader system recommendations. **Senator Harp requested the Medicaid Council members review the Subcommittee Pediatric Obesity recommendations and plan to discuss and vote on the recommendations at the September meeting.**
- ü The SC is working with DSS, MCOs and other stakeholders to develop:
  - o Reports on reasons for hospitalization and ED use by age, gender and ethnicity and appropriate use of asthma meds for children & adults.
  - o Clearer adolescent anticipatory guidance items and provider-friendly voluntary adolescent EPSDT tool.

Behavioral Health Subcommittee: Chair-Jeffrey Walter

### **Next meeting is on September 21, at 2 PM**

- ü Continue to receive briefings from DSS and DCF on the BH carve-out and KidCare.

- ü BH Claims work group is developing a reporting standard for denied claims that would lead to strategies to reduce the percentage of denied claims in BH as well as serve as a template for other services in HUSKY.
- ü The Pharmacy Work Group has not met, waiting on the direction of DSS.

Consumer Access Subcommittee: Co-Chairs Irene Liu and Christine Bianchi

*Next meeting is July 28 followed by September 22, 10:30 AM.*

- ü Developing pilots at the provider (Waterbury, Middletown FQHC) level and within CHNCT to test out an effective communication process with clients and DSS offices in order to input client address changes into the EMS system. Without a current address in the system, clients will miss agency notices about policy change and HUSKY coverage renewals.
- ü The SC requested data be sent to DSS from Healthy Start regions and Preferred One related to when the pregnant client first accesses prenatal care, the HUSKY application date and date when eligibility has been granted to begin to assess the reasons for the lateness of some pregnant women's access to PNC, enrollment into HUSKY and reasons for eligibility delays.
- ü A work group is developing key points to support the rationale for developing an on-line Medicaid/HUSKY application system, which will be discussed at an August meeting with the Commissioner of DSS convened by Sen. Harp. The work group will continue to work with DSS on this important project.

The Medicaid Council is scheduled to meet Friday September 17, 2004 at 9:30 AM at the LOB

## **Appendix A: DSS HUSKY A Revenue & Expense Report CY 2003**

Appendix B: Quality Assurance Pediatric Obesity Recommendations

**Childhood Obesity: Pediatric-Medical Recommendations:  
Prepared by: Karen Dorsey, M.D. & M. Alex Geertsma, M.D.**

## **Executive Summary**

The prevalence of obesity among adults in the US has been steadily increasing over the past several decades. This trend among adults has been mirrored by a simultaneous increase in obesity among US children. Since the 1970's the proportion of obese children has risen from 5 to 15%. According to the Centers of Disease Control and Prevention, in 1999 9.1% of adolescents in Connecticut were overweight, and 15% of youth between 10 and 24 years old were at risk of overweight (data from the BRFSS).

The burden of obesity among US adults has been well described with regard to widespread obesity-related diseases, and health care and societal costs. Obesity among adults has been shown to dramatically increase risk of mortality, risk of heart disease, risk of diabetes, and risk of many forms of cancer.

The consequences of obesity among children are less well understood. There is mounting evidence of the increased prevalence of serious health conditions, such as hypertension, lipid disorders, diabetes, and pre-diabetic conditions among overweight children and adolescent. A study screening children referred to a weight management clinic with a BMI over the 95<sup>th</sup> percentile showed that 21% had previously undetected pre-diabetic conditions, and 7% had type II diabetes. Larger studies are needed to quantify the numbers of overweight children with these health conditions and to better describe health risk among overweight youth.

Racial/ethnic disparities in obesity and related diseases also need to be considered. The prevalence of obesity and related diseases has been shown to be higher among racial and ethnic minority groups compared with whites, in particular among certain Hispanic groups and African-Americans. Economic disparities have also been found, particularly among adult women. Currently the best-known predictor of a child's risk of obesity is maternal BMI. The relationship between maternal and child obesity is thought to be in part genetic but largely due to family environment and dynamics.

Traditionally obesity had been considered an individual's failure to show discipline in choosing an appropriate diet and engaging in adequate activity. Recent thinking recognizes the environmental context of obesity. This "ecological model" assumes a complex interaction of individual physiology, family, social environment in communities, cultural influences, and larger social influences on the development of obesity. Interventions framed in this model would not focus on individual solutions, but rather systematic change of factors that promote risk of obesity including the influence of family, community and social circumstances (worksite, school, healthcare), cultural factors, and the larger social policy environment.

## **Recommendations**

Given the epidemic of childhood obesity, experts have emphasized the need for policy initiatives that support identification of overweight youth, correlates of obesity-related morbidity, and education for children and families regarding healthy diets and physical activity.

Obesity is a complex problem with a multi-factorial etiology that crosses all aspects of lifestyle and environmental circumstance. The solution depends on coalitions and systematic partnerships to encourage and support lifestyle improvements. The Subcommittee recommendations related to childhood obesity address the existing HUSKY health care delivery system but more largely look to the development of a statewide integrated obesity prevention and intervention approach. While the latter is beyond the purview of the Medicaid Managed Care Council, it is important to recognize that families enrolled in HUSKY do move to the private insurance sector, live in communities that have or would benefit from local initiatives and the limitations of interventions focused solely within the medical system of care on population impact change.

Recommendation: Obesity Documentation, Recording and Surveillance in **HUSKY** and the State

Systematic screening and identification of overweight children is essential to understanding the burden of obesity and related diseases including diabetes, hypertension, and lipid disorders; and to ensure that public health services are appropriate and effective in reducing health risk in Connecticut's youth. The subcommittee recommends that a method of documenting, recording, and reviewing both individual and group data on childhood obesity be quickly developed and adopted in the state. This would be accomplished in *HUSKY A & B* by:

- The HUSKY Managed Care Organizations (MCOs) work with their network pediatric providers to ensure documentation of the BMI as part of an EPSDT (HUSKY A) or preventive visit (HUSKY B).
- The HUSKY MCOs collaboration with the CT Academy of Pediatrics and others to train health providers in appropriate diabetes and lipid disorder screening for overweight children in HUSKY A and B.
- The MCOs development, as part of the MCO contract with DSS, an obesity-related quality improvement project that includes evaluation of provider training in obesity assessment and documentation through routine performance feedback and appropriateness of obesity-related treatment.

*Statewide* surveillance would be accomplished by:

- The Department of Public Health audits of school health forms required for all children entering kindergarten, Grades 6 and 9 for overweight/obesity and obesity-related disorders. These forms contain the child's height, weight, age and gender, used to calculate the body mass index (BMI).
- The Steering Committee (see System recommendation 1) collaboration with the professional academies to identify healthcare partners that would also systematically report obesity prevalence and obesity-related morbidity data in aggregate along with the HUSKY A & B data and school health data. An electronic reporting system for surveillance data should be considered.

## **Statewide Integration of Obesity Prevention and Interventions**

### Recommendation 1: Organization and Leadership

Currently there is no funding or central advocacy for obesity prevention initiatives within any one State agency. It is recommended that the Executive Branch create a central Steering Committee comprised of leaders representing the various organizations and systems that impact obesity (i.e. schools, health care providers, managed care organizations, academic research centers, major worksites, key community organizations, local businesses, and policy making agencies) that would guide the development and implementation of a comprehensive state plan to prevent obesity in children and adults. Such a structure would be charged with:

- Providing the necessary collaborative structure to identify the diverse resources that exist or are needed to address this health crisis in Connecticut,
- Serving as a single resource of all information regarding obesity prevalence, obesity-related health risk, prevention and treatment interventions as well as all proposed and enacted legislation and mandates needed by government and non-government bodies to conduct new or ongoing obesity programs.

### Recommendation 2: Continuous Review of Evidenced Based Literature

- Establishment of state policy for the prevention of childhood obesity is hampered by a marked lack of information to policy makers regarding best practices, proven interventions and tested policy strategies. The subcommittee recommends that the Steering Committee designate a subcommittee that includes state agencies and other stakeholders that would:

- Identify existing surveillance data on obesity prevalence and co-morbidities.
- Summarize and update evidenced based best practices for the prevention and treatment of childhood obesity.
- Report this information to the state Steering Committee to form and support its recommendations.

### Recommendation 3: Managed Care Organizations' Obesity Interventions & Testing New Strategies

- Intervention to prevent new cases of obesity and obesity-related diseases must be a primary goal of any central body leading statewide initiatives. The Subcommittee recommends that:

- The departments of Public Health and Insurance develop a tool similar to that developed by the Medicaid Council Quality Assurance Subcommittee that identifies the availability of obesity interventions by commercial insurance carriers licensed in the state. This information would be provided to health practitioners and consumers.
- The Steering Committee develop a systematic strategy to test a series of promising but as yet unproven interventions, identified through literature review and a call for proposals from Connecticut's academic and other non-of profit organizations. This research plan should be sponsored by the state in partnership with philanthropic organizations (both within and out side of Connecticut) dedicated to addressing obesity as a funding priority.

More Information on Childhood Obesity:

**State Approaches to Childhood Obesity: A Snapshot of Promising Practices and Lessons Learned**

Childhood obesity has become an epidemic in the U.S., with serious health and social consequences for millions of children. Medicaid alone now serves some 4 million obese children. States are growing increasingly concerned about the issue and are focusing energy and resources on addressing it. This report details state efforts to combat this complex and growing problem.

J. Rosenthal and D. Chang. April 2004. 33 pp plus appendices. Funded by the Health Resources and Services Administration, The Consumer Health Foundation, and Kaiser Permanente. (GNL54). Free. Also available in PDF at [www.nashp.org](http://www.nashp.org).