

Meeting Summary: September 17, 2004

(NEXT MEETING: OCTOBER 15, 9:30 AM)

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Thomas Deasy (Comptroller Office), Dr Victoria Niman (DCF), MaryLou Fleissner (DPH), Martha Okafor (DPH), Dr. Edward Kamens, Dr. Alex Geertsma, Ellen Andrews, Janice Perkins & Linda Pierce (HMO representatives).

Also present: William Diamond (ACS), Sylvia Kelly (CHNCT), Paula Smyth (Anthem), Douglas Hayward, James Gaito (Preferred One), Judith Solomon (CTVoices), Chet Brodnicki (Child Guidance), Deb Poeria (SBHC), Dr. Patricia Leebens & Aurele Kamm (DCF), M. McCourt (Council staff).

The Council recognized Judith Solomon (CT Voices, formally the Children's Health Council) for her significant contributions to the Medicaid Managed Care Council and the HUSKY program. Ms Solomon will be leaving Connecticut to take a position as Senior Policy Analyst for the Center on Budget & Policy Priorities.

Department of Social Services State Administered General Assistance (SAGA) Program Update

This State-funded program has undergone major changes since 1998, including change from municipal to state administration, SFY02 elimination of non-emergency transportation services (dialysis, chemo and radiation therapy exceptions), SFY03 elimination of optional Medicaid services, SFY04 co pays added, SFY 05 co pays removed and SFY04-05 restructuring of the service delivery system. This last budget initiative significantly changes the program to a financial state 'block grant' entitlement program. There is no limitation to enrollment numbers but the medical expenditures are capped. For SFY05 (July 1, 2004-June 30, 2005) SAGA funding by medical service type is:

- Hospital - \$47million plus ancillary adjustment, 12 months
- Ancillary services - \$7.6M
- Primary/specialty care - \$16.5M
- Pharmacy - \$33.9M

The purpose of the restructuring is to contain costs within appropriated funding through effective management of services that includes coordination of health services. To achieve this end, the

DSS contracted with Community Health Network of CT, a HUSKY Medicaid managed care organization, as the Administrative Service Organization (ASO) to manage SAGA client enrollment for primary care, specialty, ancillary and pharmacy services. The DSS will administer hospital inpatient and specific outpatient services (i.e. emergency visits, ancillary services not associated with clinic visits). Behavioral health services remain under the Dept. of Mental Health & Addiction Services (DMHAS); however psychotropic medications are in the DSS SAGA budget. To date:

- CHNCT has contracted with 11 of 12 FQHCs (the Community Health Clinics-CHC- have not yet agreed to contractual terms), 10 of the 10 hospitals that provide clinic services, 468 primary care providers (PCPs) with an additional 28 in process, 1,066 specialty providers with 08 additional in process and 275 ancillary service providers (labs, DME, dental, radiology) and 230 dentists. In the CHC service areas, CHNCT has contracted with community PCPs. Providers interested in participating in the SAGA program can call CHNCT @ **1-800-440-5071**. CHNCT also has a mechanism to pay non-participating providers.
- SAGA clients have been assigned a PCP effective 8/1/04; however clients can request reassignment to other available PCP by calling CHNCT @ **1-866-361-7242**.
- As of **October 1, 2004**, it is expected that SAGA clients will remain with their chosen or assigned PCP. Out-of-network and non-PCP authorized services will require prior authorization after September 30, 2004.

The CHNCT, as the ASO, is responsible for member services, utilization & quality management, provider enrollment & credentialing. The CHNCT will reimburse primary care, specialty services and specific hospital- based clinic services, ancillary and pharmacy services. The DSS will reimburse hospital inpatient and hospital outpatient services.

Council questions:

- ü *Has the SAGA changes affected behavioral health services?* The DSS stated there is no impact on BH services, as DMHAS remains responsible for SAGA BH. Clients seeking BH services call **211, the CT Infoline, for SAGA BH resources**. The SAGA BH program has two contractors for ASO and claims functions; however currently there is no client service number within either of these entities or at DMHAS. The DSS is working with DMHAS on this.
- ü *PCP Assignment:* Yale Primary Care has just signed a contract with CHNCT for SAGA clients. According to one report, of 700 SAGA clients only 100 were assigned to Yale PCC. The CHNCT stated that of the 700 clients, only half are currently eligible for SAGA, based on the DSS eligibility reports. These members have been notified they may voluntarily change their PCP; however most of the eligible members have chosen to remain with the FQHC in the area. (See attached response from CHNCT-Letter 2).
- ü *Why did the 300+ clients lose SAGA eligibility?* The DSS stated that SAGA has more changes in eligibility than HUSKY, in part due to client's failure to renew their eligibility. Many SAGA clients have disabilities and enroll in SAGA until they receive SSI/SSD determinations: they would then be eligible for Medicaid Title XIX.
- ü *Pharmacy issues:*

- Prior authorization (PA) for drugs >\$500 is difficult. The DSS stated that while the PA process is similar to the DSS Medicaid process the DSS will review the policies, as some changes may be needed (See attached response CHNCT-Letter 1).
- Are certain drugs paid by Medicaid not paid in the State programs? The BH drugs are part of the Medicaid preferred drug list (PDL). Drug manufacturers agree to rebates for the Medicaid program; however the manufacture negotiates rebates for individual state programs such as SAGA. Sen. Harp noted that Buprenorphine, an alternative drug to methadone that can be dispensed at primary care sites, is reportedly not available for SAGA clients. The DSS will check on this drug and provide the Senator with information.

HUSKY Program Restructuring: Dental Services

The effective date for the dental carve-out is February 1, 2005. The DSS reviewed key components of the carve-out:

- The purpose of the restructuring is to streamline the dental service administrative process and improve access to services.
- The service carve-out will include **HUSKY A (child & adult) and HUSKY B members**. Medicaid fee-for-service (FFS) clients may be phased in at a later date.
- Responsibilities:
 - o The **DSS** is responsible for the program and contract monitoring, including the ASO contractual performance standards and sanctions. Dr. Donna Balaski is the DSS dental manager.
 - o **Two ASOs** will receive per member per month fees for administrative services only, which include provider enrollment & credentialing, claims processing, utilization management, program improvement initiatives, culturally sensitive client and provider education, member services, data reporting and management reports to DSS.
 - o The **HUSKY plans** will continue to be responsible for member transportation to dental services and pharmacy services associated with dental care.
 - o A DSS Dental Advisory Committee and Clinical Advisory Committee will review administrative, procedural policies and recommend changes to the DSS.
- Client enrollment in the dental carve-out:
 - o Client enrollment, through DSS, will offer client choice between a) 2 statewide ASOs with proprietary networks and b) a primary care dentist (PCD). During the early phase, clients may initially be assigned to an ASO (& PCD) but can change this assignment prior to the 'lock-in' period. It is administratively difficult to initially provide choice: clients will receive educational materials on the opportunity to change PCD, and ASO based on that ASOs proprietary network.
- Implementation schedule of the dental carve-out:
 - o DSS to conclude contract negotiations with 2 ASOs 10/04
 - o 1915(b) waiver amendment for the dental service delivery change sent to the legislative Committees of Cognizance 10/04 for approval.
 - o Provider education about the carve-out begins 10/04.
 - o Waiver amendment submittal to CMS 11/04.
 - o Client education begins 11/04.
 - o Client assignment 12/04.
 - o ASOs operational 12/04.

- o Client change period (ASO, PCD) 1/05.
- o Effective date of carve-out & lock-in 2/05.

Council comments, questions:

- ü The DCF and SBHC representative requested participation on the DSS Dental Advisory Committee.
- ü The ASOs will be required to provide geo-mapping of their provider networks as one of the ASO performance indicators.
- ü There will be no changes in scope of service for the carve-out populations.
- ü Providers already credentialed with the ASOs as a HUSKY dental subcontractor (**United Health Care** – previously Anthem’s DBP, and **Doral Dental**, Health Net’s current dental subcontractor) will continue in the ASOs provider networks. Dental providers will be encouraged to participate in both ASOs and the ASOs will seek new dental providers for their panels.
- ü Service rates will be derived from a weighted average (blending rates with procedures); rates will be higher than FSS, unchanged from the HUSKY rates.
- ü Similar to the SAGA program, the dental ASOs will have an out-of-network provider authorization process. The ASO will pay the non-assigned PCD, then eventually move the client into a PCD home.
- ü Rep. Nardello recommended the DSS carefully track clients in the enrollment period, ensuring they have access to their regular source of dental care. Dr. Balaski noted that the dental home and client change process would be the first issue taken up by the Dental Advisory Committee. Rep. Nardello stated the Medicaid council and the legislature support this initiative.

HUSKY Program Restructuring: Behavioral Health (BH) Services

Dr. Mark Schaefer (DSS) reviewed the key components of the September 8 memorandum to legislators from the Commissioners of DSS & DCF and Secretary Ryan (OPM):

- **The BH service carve-out timeframe is April-June 2005.**
- The BH partnership has been narrowed to focus on populations originally included in the KidCare statute. The service carve-out will place HUSKY A (child & adult), HUSKY B, HUSKY PLUS and DCF voluntary services clients under a BH ASO managed system of care. Populations NOT included in the ASO are the Medicaid adult FFS and SAGA BHP clients.
- The DSS will release a new RFP for the single ASO because of changes in the covered populations, with a rapid bidder response and selection time planned in order to meet the SFY05 timeframe.
- The ASO will not be at risk for BH services, only for administrative performance; the DSS/DCF will pay service claims appropriate to that agency.
- Key features of the program include: care management, quality management, re-focus on young adult transitional care, coordination of physical and BH care, and establishment of new wraparound services for children (therapeutic mentoring, behavioral consultation and comprehensive global assessments). The Partnership agencies will now access the \$250,000 grant from the Center for Health Care Strategies to develop a performance measurement system.
- The agencies and OPM agreed to program oversight through a Behavioral Health Oversight Council (as outlined in LCO 5424, an uncalled bill in the 2004 session) that has broad

representation from legislators, state agencies, parents, consumers and providers. The existing Medicaid Council BH Subcommittee, with reconfigured representation, will serve as the interim oversight body until such legislation establishes a BH Council.

Medicaid Council Action/comments

- ü Sen. Harp requested formal action from the Council approving the BH Subcommittee interim oversight designation. It was moved and seconded that the BH Subcommittee will be the interim oversight committee for the implementation of CT KidCare and the BH service Carve-out. The motion was approved by voice vote.
- ü The HUSKY MCOs will continue to be responsible for pharmacy & transportation.
- ü The DSS, DCF, MCOs and ASO do need to focus on integrating primary care/medical care with BH services.

HUSKY Enrollment September 1, 2004

HUSKY Program	May-July 04 Change #	July-Sept 04 Change #	Sept 04 Chg - % of July04 #
HUSKY A < 19 Yrs.	Decrease: 1202 enrollees	Increase: 421 enrollees	35% gain of July 1202 loss
HUSKY A adults	Decrease: 479 enrollees	Increase: 75 enrollees	16% of July 479 loss
All HUSKY A	Decrease: 1681 enrollees	Increase: 496 enrollees	30% of July 1681 loss
HUSKY B	Increase: 30 enrollees	Increase: 94 enrollees	May-Sept 04: 124 enroll inc.

HUSKY A Enrollment Jan-Sept 2002-2004

The HUSKY signed applications received - 12 month totals (Sept-Aug):

- The lowest number was in 2003-04 (18,292) of the 4 years reported.
- Signed applications received over 12 months decreased by 5,680 (03-04) from 23,972 (02-03.)
- The highest number of signed applications received was 28,379 in the 12 month period of 9/01-8/02.

Other Medicaid Council Actions

Ø The Quality Assurance Subcommittee of the Medicaid Council provided the Council with Pediatric Obesity recommendations reviewed at the July 04 meeting. The recommendations were moved and seconded and approved without further discussion.

Ø The Medicaid Council 2nd Quarterly 2004 report (April-June 2004) was accepted without change.

Special Reports

Early Childhood Partners Grant: DPH

Martha Okafor (DPH) reviewed the intent and scope of work of this 5-year grant. Federal funding is \$100K/year for two years of strategic planning. The funding for three implementation years is to be determined. Highlights of the presentation:

- *Early Childhood Partners (ECP)* is CT's DPH response to the federal requirement to develop an integrated system to improve the health and school readiness of children 0-5 years in every CT family. The mission of *ECP* is to develop a strategic plan for a comprehensive early childhood system in CT.
- The *ECP* focus areas are 1) medical home & health care access, 2) childcare & early education, 3) socio-emotional health, 4) parent education and 5) family support.
- The spheres of influence of these focus areas include state and local programs that touch the child, parents/families, the community and caregivers.
- The *ECP* core planning committee work is informed by and linked with these state/local programs as well as the State Prevention Council, state/local planning activities. The latter will contribute to the *ECP* strategic plan and local pre-testing of an *ECP* implementation.
- The *ECP* logic model identifies the population served with associated eligibility areas, the existing service delivery spheres and measurable benchmark outcomes. The Strategic financing model identifies federal programs, funding streams and looks to develop state/local finance mechanisms that provide dollars to key services/settings.
- The strategic plan focuses on the overlapping components of health & well being for all CT children 0-5 years, including medical home, family support and early learning and child care.
- The time line in the 2nd year of the strategic plan is:
 - o Provide a draft plan to communities and planning partners (10/04)
 - o Solicit feedback from these entities and revise the strategic plan accordingly (11-12/04).
 - o Field test the implementation plan (12-6/04), revise based on feedback and submit the implementation plan to MCH 8/04.

Council comments:

- ü Various members applauded the DPH initiative in this area, noting that the status of the health and well being of very young children is a major factor in life success as they move through their childhood into youth and young adulthood.
- ü DCF asked DPH for more information on the total federal revenues that target early childhood in CT.
- ü The representative for School Based Health Centers suggested linkage with SBHC (medical and BH) as well as Community health clinics (FQHCs) in this initiative.
- ü Further questions can be directed to Martha Okafor (DPH) martha.okafor@po.state.ct.us.

CT Lead Action for Medicaid Primary prevention (LAMPP)

Ronald Kraatz, Project Director of the LAMPP project, provided information about this innovative State of Connecticut early intervention and prevention program to reduce lead hazards for Medicaid enrolled children under 6 years. The DSS is the primary sponsor for LAMPP along with DPH and the CT Dept of Economic and community Development. The goal

is to protect children before lead poisoning occurs, intervene at lower blood lead levels (10-19 ug/dl) as well as prevent lead exposure to children occupying the same housing in the future. In CT, landlords must legally abate household units where a child has lead levels at 20ug/dl; however private landlords seldom reduce lead hazards in rental units where children may have lower lead levels.

Key components of the project:

- LAMPP is funded by two grants (\$5.6M) from the US Dept of Housing and Urban Development (HUD) and by over \$5M matching contributions from state and community partners.
- Project participants, in addition to the three state agencies, are six target communities – Bridgeport, Danbury, Meriden, Norwalk, Waterbury and West Haven – plus Enfield, Hartford, New Britain, New Haven and Stamford, and multiple lead coalition members, health care providers, community organizations, HUSKY families and managed care plans.
- The DSS has contracted with the CT Children’s Medical Center to operate the program along with the two regional lead treatment centers at Yale New Haven Hospital and Hartford.
- Health and housing measures in LAMPP include;
 - o Education and risk assessments of families with Medicaid enrolled children under age 6 years who live in pre 1978 housing as well as landlord and contractor education on low cost lead hazard interventions, lead safe work practices and disclosure rules.
 - o Low-level lead hazard reduction for 433 units, more intensive lead hazard abatement in 129 additional units.
- Property owners that participate in the project contribute \$600/unit & assist with temporary relocation of occupants. The LAMPP project will provide on average \$6,500 per unit for lead reduction.
- The owner agrees, for a 3-year period, to give rental priority to families with children <6 years, maintain affordable rent levels and rent to lower-income families (defined by HUD) and maintain the units in accordance with the federal Housing Quality Standard.

LAMPP contact information: Project Manager: david.parrella@po.state.ct.us; Project Director: Ronal Kraatz rkraatz@ccmckids.org; Project Coordinator: Amy McLean Salls asalls@ccmckids.org.

Sen. Harp commended the State agencies and other participants in developing this very important prevention and early intervention project. Following the meeting Sen. Harp requested the Quality Assurance SC follow up with the project as part of quality lead initiatives.

Addendum: CHNCT Response to SAGA Questions at the 9/17 MMCC meeting Letter 1.

TO: Department of Social Services
Ellen Andrews
Marianne McCourt

FROM: Lynn Childs
Community Health Network of Connecticut

RE: Medicaid Managed Care Council Pharmacy Question Response

DATE: September 20, 2004

In response to a question raised at the Medicaid Managed Care Council meeting on Friday, September 17, 2004, I would like to clarify the CHNCT SAGA Pharmacy Program process for prior authorization of drugs over \$500.

- There is a contractual obligation for CHNCT to follow the State of Connecticut's Pharmacy Drug Program and Prior Authorization Process, which was in place prior to CHNCT becoming the administrative services organization (ASO) for SAGA clients.
- This program includes the requirement to prior authorize any drug over \$500 per prescription for a 30-day supply.
- There is clearly a misunderstanding of this requirement in that we have heard expressions of concern from physicians who believe this needs to be done every 30 days – each time the drug is refilled.
- That is incorrect information. The prior authorization requirement is an initial authorization only and once the prescribing physician has provided the clinical information requested, a long-term authorization is put in place for the medication - for up to six months as clinically indicated. At the end of six months, the process needs to be repeated.
- Because there was a great deal of concern over HIV patients and the possibility that these members might leave without their medications and then not return to the pharmacy on a timely basis, CHNCT put in place a new process for HIV medications. When a member presents at a pharmacy with a prescription for an HIV medication, a 30-day supply will be given automatically. During that 30 day time period, CHNCT will contact the physician, obtain the necessary clinical information and put a long-term override for the medication in the Caremark system before the 30-day time period elapses.
- CHNCT Pharmacy Benefits Manager, Caremark, is identifying physicians who are prescribing HIV medications and will coordinate a mailing to inform them of the new process.

The reasons behind the authorization requirements within the CHNCT Pharmacy Program are multi-fold. Through this process, we are ensuring that the most current clinical practice guidelines and medication recommendations are being utilized by our prescribing network. The process also assists us in monitoring for possible abuse or over-usage of potentially harmful medications. Lastly and most significantly, identification of high-risk members through pharmaceutical utilization is sometimes the earliest point-of-entry into our case management and disease management programs.

Letter 2.

TO: Department of Social Services
Mark Scapellati

FROM:

Community Health Network of Connecticut
RE: Medicaid Managed Care Council Yale PCC SAGA Membership Question

DATE: September 22, 2004

In response to the concern raised at last Friday's Medicaid Managed Care Council meeting, I would like to illustrate CHNCT's actions specific to the request by the Yale Primary Care Center to assign specific SAGA members to their facility.

Since the SAGA contract with the Yale P.C.C. was not completed until the SAGA implementation was already underway, these providers were not a part of the initial assignment process. In the initial process we looked at encounter data from DSS to link members with participating facilities whenever possible, and then assigned based on proximity to a PCP site as the next step. Members were made aware of these assignments via ID cards prior to the 8-1-04 SAGA implementation date.

Because members had already been assigned to PCPs, we were now unable to move a large block of SAGA members to the Yale PCC without the member's agreement.

Yale provided CHNCT with two files of SAGA members, 807 members who have had services at the Yale PCC (of which only 413 were still active) and another 87 who have had services at the Nathan Smith Clinic (of which only 38 were still active). Our Enrollment staff completed a project to contact these members and make them aware that Yale is now a participating SAGA provider. During this contact we explained that if they elected to choose Yale as their PCP we could make this change now, or at any point in the future if they so choose. During these contacts we had approximately 40 members indicate that they wanted to make this change, or around 8%.

Steve Mackinnon, our Director of Member and Operations Support updated his contact at the Yale PCC on the results of this activity upon its completion in late August.

As of today, the Yale PCC has approximately 160 SAGA members assigned to that location with an additional 60 members assigned to the Bridgeport PCC.

Please let me know if you have any additional questions on this activity.