

**Quarterly Reports: Last Half of 2005**

*Date Accepted: March 2006*

*This report of the Medicaid Managed Care Council is submitted to the General Assembly as required under CGS 17b-28. This report is for the time period of **July through December 2005**. The Medicaid Managed Care Council is a collaborative body established by the General Assembly in 1994 to advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program. Specifically, the law charges the Council with "advising the Commissioner of Social Services on the planning and implementation of a system of Medicaid Managed Care and shall monitor such planning and implementation and shall advise ... on matters including, but not limited to, eligibility standards, benefits, access and quality assurance". The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans and state agencies. The Council has several working subcommittees: Consumer Access, Quality Assurance and the Behavioral Health Committee.*

The Medicaid Council met monthly with the exception of August over the last six months of 2005. Key issues addressed during these meetings included:

- The implementation process and timelines for legislative changes in the HUSKY program.
- HUSKY program administration topics, including 2004 managed care organizations' revenue & expenditures, MCO rate adjustments for SFY 05, change in the HUSKY Behavioral Health delivery system January 1, 2006.
- Enrollment losses, reasons
- Quality and service access in the HUSKY A and B programs
- Special reports.

***2005 HUSKY/Medicaid Legislation & Program Change Implementation Timelines***

At the June-November 2005 Medicaid Managed Care Council meetings DSS reviewed the legislative changes in HUSKY A/B (**PA05-280**), Medicaid and HUSKY program changes summarized below:

<b>Policy Change</b>	<b>Description of Change</b>	<b>Probable/Actual Implementation dates</b>
Increase HUSKY A adult/caregiver income eligibility level to 150% FPL	Parent/caregivers of HUSKY A children income eligibility level is increased from 100% FPL to 150%, allowing the state to insure more families.	<b>July 1, 2005</b>
Reduction of transitional medical assistance (TMA)	TMA enrollment reduced from 24 months to 12 months, impacting clients as of <u>June 30, 2006</u> .	<b>TBA.</b> Requires State Medicaid plan amendment and CMS approval.

Elimination of self-declaration of income in HUSKY application.	In 2001, applicants could state their income on the application without pay stubs. DSS matched this with Labor data and F/U with clients if income discrepancies. Self-employed clients had to submit accompanying income verification. As of <u>July 18, 2005</u> <b>all</b> applicants must submit income verification along with their applications.	<b>July 18, 2005</b>
Re-implementing children's presumptive eligibility (PE).	Qualified entities apply HUSKY A PE to children seeking medical services, with coverage for 30 days. Completed full application has to be submitted at the PE time for HUSKY eligibility determination.	<b>November 2005</b>
Expedited Eligibility for pregnant women	Provision for 1) emergency eligibility determination in 24 hours; 2) within 5 days for other pregnant women.	<b>November 2005</b>
Re-implementation of HUSKY B (children) monthly premiums	-Band 1 (185-235% FPL) <u>new</u> - \$30/child/M to \$50/family max/M. -Band 2 (235-300% FPL) incr. to \$50/child/M to \$75/family max/M - <u>Dis-enroll for non-payment</u> of Oct premiums <b>starts 11/1/05</b> , associated with a 3-month lock out, re-enroll when past due & pre-payment. of 1 <sup>st</sup> enroll month made.	<b>-Start date: October 1, 2005 Repealed in November by CGA Special session 2005 (PA05-1)</b>
HUSKY A adult premiums/outpatient (OP) co-pays	HUSKY A adults with incomes >100%FPL, \$25/adult/M premium & \$1.00/OP visit co-pays	Requires waiver from CMS. <b>Anticipated implementation date:</b> Spring/summer 2006
HUSKY A health plan lock-in	Enrollee has a 90-day free-look period with chosen HUSKY A MCO. They can remain or change MCO during that time and then remain in their chosen plan for the remainder of the 12 M (plan change with 'good reason' allowed)	Requires CMS waiver approval & additional support needed from DSS systems. <b>Anticipate implementation towards the end of 2006.</b>
SAGA Pilot	2-year pilot for 100 individuals ages 19-20, with chronic medical and BH conditions who live with their family & are uninsured.	DSS will begin with identifying youth aging out of HUSKY A that meet guidelines, consider young adults referrals from advocates, etc.
Family Planning (FP) 1115 Waiver	Provide FP services to uninsured women up to 185% FPL.	TBD

Katie Beckett Waiver Expansion	Expand slots by 55 from <b>125 to 180 slots</b> . Model waiver based on child's income eligibility, not family income.	CMS requires waiver amendment. <b>Implemented late Fall 2005</b> with an increase from <b>125-180 slots</b> (not 200 per initial appropriations budget).
Behavioral Health Partnership (DSS & DCF)	BH service carve-out for HUSKY A adult/child, HUSKY B & some DCF voluntary services, other DCF children.	<b>January 1, 2006</b>
Medicare Part D: Medicare Modernization Act (MMA)	Affects Medicaid dual eligibles, ConnPace, as well as other Medicare eligibles. No plans for State wrap around drug coverage or State payment Medicaid co-pays.	Federal government implementation date January 1, 2006. More information see: <a href="http://www.medicareadvocacy.org">www.medicareadvocacy.org</a>

### ***HUSKY Program Administration***

- ✓ DSS/MCO contracts had been extended through Dec. 31, 2005. DSS has since secured the four MCOs participation in HUSKY for SFY 06 and into FY 07; however MCOs could choose to withdraw from the program January 1, 2007 if the SFY 07 dollars budgeted for HUSKY do not meet the MCOs' expectations. Previous MCO contracts had been amended for 6 month periods. DSS wants to provide more stability to the plans and the program through longer contract periods. It was noted by the Council that HUSKY program changes, enacted for short term savings, make it difficult to maintain program stability. State economic changes (either increases or decreases) coupled with the spending cap create public program instability. Political will is needed to look at public program stability by addressing the complexity of the budgetary cap issues.
- ✓ SFY 2005, MCOs had a 4 % rate increase (commercial insurers were charging employers 12% rate increases). SFY 06 a 2 % rate increase was in the budget.
  - DSS used Mercer's MCO financial review in negotiating additional individual MCO rate adjustments retroactive to July 2005. The adjustments ranged from 5.5% to 2%.
  - Individual plans will negotiate rates with DSS on the deduction of BH carve-out dollars prior to Jan 2006.
  - HUSKY rates are based in part on member age, gender and county. A summary of the current MCO capitation rates as of 7-01-05 were provided in December. The total capitation rate was \$188.58 from 10/1/04-6/30/05 and was increased by 4% to \$196.89 as of 7/1/05.
- ✓ **Behavioral Health services** WILL be carved-out of the managed care delivery system as of 1/1/06: the dental services carve-out was NOT implemented in 2005 and there are no plans in the future to do so. DSS and DCF reviewed the key components and organizational progress of the CTBHP, the behavioral health “carve-out” program at the December Council meeting. The statutory Behavioral Health Partnership (BHP) Oversight Council has been meeting since September 2005 to review the BHP activities and make program recommendations to the agencies.
- ✓ Anthem dental vendor transition to WellPoint Dental Services was made effective November 1, 2005. Anthem is now a part of the WellPoint Corporation but retains the Anthem name in CT.

MCO Revenue/Expense Report (July 05 MMCC meeting): Summary of “all Plans” R/E reports\*  
2000-2004 CY:

All Plans	2000	2001	2002	2003	2004	03-04: Calculated % Change
Member Months	NA	3,019,068	3,472,764	3,714,506	<b>3,814,039</b>	>2.6%
Revenue	\$438,048,971	\$487,699,544	595,415,309	647,012,614	<b>\$698,919,818</b>	>7.4%
Medical Expense	\$381,003,060	\$447,653,540	531,288,294	588,667,069	<b>\$628,984,044</b>	>6.4%
Administrative Expense	\$43,869,414	\$42,331,445	52,993,196	59,654,084	<b>\$69,658,661</b>	>14%
Total Expense	\$424,872,474	\$490,081,419	584,281,490	648,321,153	<b>\$698,642,705</b>	>.07%
Medical Loss Ratio	88%	92%	89%	91.0%	<b>90.0%</b>	<1%
Administrative Loss Ratio	10%	9%	9%	9.2%	<b>10%</b>	>0.8%
Margin	2%	0%	2%	(0.1%)	<b>0.2%</b>	>0.1%

\*Data source: DSS R & E reports to MMCC over the past 3 years; 2000-2003 not reported at the 7/05 meeting

Council questions:

- WellCare/Preferred One (PONE) has fewer member months, higher revenues and the highest PMPM margin compared to other MCOs. Preferred One has the highest administrative loss ratio of 15.5% (national average 14%) and lowest medical loss ratio (80% compared to the national average of 90%). DSS is reviewing the plan's medical & administrative loss ratios. PONE developed a 'turn-around' plan that includes expanding dental services through more open access and active recruitment of specialty services, including the CCMC faculty practice. In September, PONE outlined the plan's actions steps in response to DSS concerns including:

✓ Quality:

- Increased fees for teen preventive services and dental services as part of a focused attempt to improve service access in this area.
- Worked on Mercer audit areas, developing a corrective action plan.

✓ Access

- Working to expand network, in particular sub specialty care.
- Pilot: provide every other Saturday dental services focusing on families that had no dental care in the last 12 months.

- *What do these R/E reports tell DSS as part of the agency's oversight of the program?*

DSS analysis, which will be the basis of MCO rate negotiations, suggests that established commercial plans with a Medicaid business line (Anthem, Health Net) have broader provider networks that may lead consumers with high medical needs to enroll in these plans. The medical loss ratios for these two plans exceed 90%. Given the state financial resources to fund Medicaid (managed care), a balance of MCO profit and loss is needed.

- Anthem and PONE have **at-risk dental subcontractors** and the department is required by statute to report these revenue/expenses. Total dental expenditures for the 2 dental subcontractors represent 4% of the total expenditures for the two plans; the combined subcontractor medical loss ratio is 77.1% compared to each plan's overall ratio (Anthem 92% and PONE 80%). The combined margin (5.9%) is well above that of the total margin for each plan (Anthem 0.6% & PONE 2.7%). About one-third of these 2 plans' HUSKY A 3-20 year olds received any dental service in a 6 month period and about 25% or less received preventive dental services.

- ✓ Sen. Prague requested DSS consider reports from MCOs regarding prior authorizations, denials and practitioner input into the request/decision. The Consumer Access SC followed up with a recommendation for quarterly reports on services denied, reasons for the denial MCO action and outcome for the member that will be voted on by the Council January 2006.

### HUSKY Enrollment

	June 2005	July 2005	December 2005	Change June-Dec 05
Total HUSKY A	312,208	302,427	301,948	less 10,260 (<3.3%)
Under 19 years	219,224	214,189	212,294	less 6930 (<3.2%)
Adults	92,984	88,238	89,654	less 3330 (<3.6%)
HUSKY B	15,696	15,996	15,301	less 395 (<2.5%)

What the enrollment shows:

- ✓ Between June & July 2005, the **net coverage loss was 5,217 children and 5,151 adults**. The multiple changes in eligibility for HUSKY A adults, while ultimately positive in that the income eligibility was increased to 150% FPL (continued April 1-June 30 through state funds and renewed by the CGA on July 1, 2005), was thought to be confusing to members that were slated to lose Transitional Medical Assistance (TMA) in the family coverage group March 31, 2005. According to DSS, of the 33,150 individuals due to lose eligibility under the family coverage group:

- o 58% remained active,
- o 41% lost eligibility and of those, 61% did not renew their applications. Some/many of these 8,318 individuals (4,230 children, 4,088 adults) could be eligible for HUSKY.

- ✓ While the adult enrollment gradually began to recover by 12/05, **children's enrollment from July – December continued to fall in both HUSKY A & B**, despite the implementation of children's presumptive eligibility at the end of November 2005. Elimination of the family self declaration of income July 18, 2005 re-created a major enrollment barrier and was thought to influence this trend. The impact of this policy can be seen in HUSKY B tracking of applications that are:

- o Denied or closed due to incomplete documentation: these are 4.4 times the number reported in July 2005.
- o Pending due to incomplete application: these are 1.5 times higher than in July 2005.

Senator Harp stated that the origin of the projected budgetary savings (\$2M) associated with the elimination of income self-declaration is puzzling as it does seem there was agency oversight of income self attestations. Given the evidence that elimination of self declaration of income is creating barriers to application processing and reductions in enrollments and renewals in HUSKY, it really makes more sense to go back to the self-declared process.

**Quality & Access Reports: HUSKY A & B**

MCO report to DSS

The department provided HUSKY A & B service utilization in September and HUSKY A data at the December meeting. Highlights of the reports:

	<b>HUSKY A</b>	<b>HUSKY B</b>
EPSDT Screens <b>2<sup>nd</sup> half 04</b>	84%	86%
EPSDT Participation Ratio <b>2<sup>nd</sup> half 04</b>	72%	78%
Any Dental services	32%	22%
ED visits 2004 /member months (MM)	59/1000 MM (FFS 72/1000 MM)	24/1000 MM

- ✓ The good news is the consistent improvement in preventive screens in HUSKY A. There has also been a modest increase in preventive services for the hard-to-reach 10-14 and 15-18 year group. Each MCO has developed a project to improve adolescent preventive care.
- ✓ Differences in HUSKY A & B dental access is due to differences in reporting. The department was requested to provide similar reports on HUSKY A & B in the future.
- ✓ HUSKY A ED use is double that of HUSKY B. The differences in use are puzzling in that both programs share the same provider network with the same HUSKY A & B MCOs; however there is a co pay for ED non-emergent use in HUSKY B.
- ✓ The percent of HUSKY members that received follow-up care within 30 days of discharge from psychiatric hospitalization for SFY 05:

<i>AGE</i>	<i>% Follow-up 7/1/02-6/30/03*</i>	<i>% Follow up 7/1/04-6/30/05</i>
<i>0-12 years</i>	<i>72%</i>	<i>65%</i>
<i>13-17 years</i>	<i>64.5%</i>	<i>60.5%</i>
<i>18-64 years</i>	<i>66.7%</i>	<i>61%</i>
<i>Total percent</i>	<i>67.4%</i>	<i>62%</i>

*\*Data presented by DSS at 4/16/04 Council meeting*

It was noted that while 60% follow up post psychiatric hospital discharge may seem reasonable, it means that **35-40 of 100** children were discharged from inpatient psychiatric care back into the community and schools without identifiable ongoing community Behavioral Health services. The impact of this is significant on families and schools.

CT Voices: Mary Alice Lee

Dr. Lee presented several descriptive reports on HUSKY A births and children's ambulatory and dental service utilization:

- The **2002** birth data match takes selected data from DPH birth certificates and links this with HUSKY enrollment data to describe HUSKY A prenatal (PNC) health and birth outcomes.
  - The number of births increased slightly to 9,775 (24% of all CT births). Teen births (ages 15-19), which represent 21% of the births, remained unchanged.
  - Since 2000 there has been a slight increase in 1<sup>st</sup> trimester care in HUSKY (79% -the woman may have been receiving care prior to enrollment in HUSKY); however this remains under the national average of 84%.
  - Late or no PNC remains unchanged at 3% (4% national rate).
  - Low birth weight rates showed a slight increase to 9.7% (compared to 7.8% nationally).
  - Preterm (37 weeks) births have steadily decreased since 2000 from 13.2% to 10.9%.

Two changes may reduce administrative reporting burdens for providers /MCO and provide better information on HUSKY birth data: 1) DPH & DSS will complete a birth data match every 6 months and 2) the CT HMO Association has developed a standardized obstetric notification/risk assessment form that will be accepted by all CT commercial and Medicaid insurers from providers.

- **CY 2004: Dental Services** for continuously enrolled HUSKY A children ages 3-20.
  - The percentage of children that receive any dental service remains unchanged from 2001 (47%) as does the treatment percentages (21%). The number of children receiving services has increased yearly as the enrollment increases.
  - The Council requested routine reports on dental services for HUSKY A adults.
- **CY 2004: Ambulatory services** use for continuously enrolled HUSKY A children remains unchanged since 2002 with the exception of an increase in the percentage of well child visits in 2004 from 51% to 65%. The percentage of children with no ambulatory care remains at the 3 year level of 15%. This is approximately 894 more children compare to CY 2003, given the increased enrollment.

### Special Reports

- **Access to Adult Specialty Care in New Haven:** Dr. Kari Hartwig. A study of New Haven area safety net providers revealed increasing difficulty since 2002 in obtaining timely referrals for adult (uninsured, Medicaid and SAGA) specialty services, in particular cardiology and gastroenterology service. Provider interviews revealed that recent state budget cuts, unchanged Medicaid provider rates for more than a decade and policy changes have exacerbated barriers to primary and specialty services for these populations. The report had specific recommendations (October MMCC meeting) and the Rep. Nardello further suggested that DSS work with the Council to develop work groups with appropriate representation to identify improvement strategies for transportation and

subspecialty service access.

- Mecer, the Medicaid Quality Review subcontractor, presented two reports based on the HUSKY encounter data (November Council meeting):
  - Children with Special Health Care Needs (CSHCN) study assessed differences in health care access and utilization between DCF CSHCN and non-DCF CSHCN. Dissimilarities between the groups were more frequent ED use, higher average inpatient admissions, longer average length of stay per admission and significantly more behavioral health admissions for DCF CSHCN.
  - Prevalence of child Obesity and type II diabetes was studied using SFY 2004 encounter data including diagnoses and utilization. Rates of obesity (1%), with Type II diabetes (0.5%) or diabetes alone (0.1%) were extremely low compared to national and CT rates. Secondary diagnoses were not in the database. Of those identified with the above diagnoses, few received recommended clinical screens such as lipid tests, or glycosylated hemoglobin (A1C). There were few claims for nutritional services. The Quality Subcommittee will look further at this along with continued focus on obesity in HUSKY A/B.

## **Subcommittee Reports**

### Quality Assurance subcommittee-Chair Paula Armbruster SC highlights:

- Initiated discussions in the SC about the lead data match between DSS & DPH, the LAMPP lead abatement program and the connection of this program with managed care plans now that they are receiving timely lead data on their members. Dr. Balaski (DSS) has taken the lead in effectively bringing the data, MCOs and LAMPP program together.
- Women's Forum has been planned for February 28, 2006 with focus on the two generational impact of maternal perinatal depression and oral health status. Amy Gagliardi, CHC, Inc is the Forum Chair.
- ED use in HUSKY: MCO will present plan initiatives to address ED rates and provide information on how each plan evaluates the ED use.

### Consumer Access-Co-Chairs Christine Bianchi & Irene Liu

- Worked with DSS & CHNCT to develop a pilot program to identify member address changes and a process to get changes into the DSS system and MCO system. DSS will report back to Subcommittee early in 2006 on plans to address this.
- A recommendation was finalized for Council consideration for DSS/ MCO report on prior authorization denials, reasons for denials, and impact on member.
- The SC reviewed the DSS implementation plans for children's presumptive eligibility and pregnant women's expedited eligibility. The Subcommittee strongly urged DSS to better coordinate the site(s) that receive pregnant women's applications to ensure timely eligibility determinations based on the 5-day determination policy. The DSS agreed to look at this and decided that all applications from pregnant women would go to one of 3 regional processing units.
- Early in 2005 the SC worked with DSS and ACS on identifying more specific HUSKY members reasons for plan changes and if the change resolved the problem that led to the MCO change. Preliminary data from 246 households showed that more than half cited reasons for changes due to access issues to providers. CTVoices profile of HUSKY A

children that changed plans showed that there is an increase in changes since 2000, children < 1 year have the most frequent changes and New Haven, Hartford and Bridgeport have the highest percentage of plan changers. The SC will continue to review the on-going survey results to inform subcommittee/Medicaid Council recommendations on future HUSKY A plan lock-in policies.

- Sen. Prague discussed the increasing immigrant pregnant women's barriers to prenatal care and diagnostic tests. Children born in the US become citizens and may be eligible for Medicaid. It would seem prudent to ensure a healthy pregnancy and birth outcome through access to prenatal services. Sen. Prague requested DSS staff bring her concerns back to the DSS Commissioner for comment and a meeting on this. The SC will continue to address this.