



## Connecticut Medicaid Managed Care Council

Legislative Office Building Room 3000, Hartford CT 06106  
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-5306

[www.cga.ct.gov/ph/medicaid](http://www.cga.ct.gov/ph/medicaid)

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### Medicaid Council Quarterly Report: 1<sup>st</sup> & 2<sup>nd</sup> Quarters 2007

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*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 January through June 2007. 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 (HUSKY A) and in 1998, the State Children's Health Insurance Program (CHIP), which is HUSKY B. The law also charges the Council with monitoring such planning and implementation and advising DSS 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 and Quality Assurance Subcommittee*

The Medicaid Managed Care Council and Subcommittees met monthly during the 1<sup>st</sup> and 2<sup>nd</sup> quarters of 2007. A summary of the topics/themes during the first half of 2007 includes:

- Administrative/program issues for the HUSKY A and B programs included expansion of Easy Breathing asthma program, Medicaid disease management, managed care corrective action plans related to "Mystery Shopper" study, Husky outreach contracts, managed care pharmacy and HUSKY appeals reports and Medicaid outlier costs, report one.
- Policy issues included the State General Assistance (SAGA) non-emergency transportation changes, impact of the federal Citizenship/identity documentation on Medicaid enrollment, CMS policy revision for newborn 'deemed eligible' categories and proposed budget items for Medicaid for SFY 2008-2009.
- Quality and Access reports included Mercer managed care audit, service utilization, managed care contract status with urgent care centers, Ct Voices 2005 reports on emergency use, asthma services and birth data and managed care descriptions of outreach initiatives.
- HUSKY enrollment
- Special reports included Medicaid interpretation service reimbursement, development of an

annual HUSKY managed care “report card”, HUSKY InfoLine call content report and Office of Health Care Access (OHCA) household survey and uninsured hospitalizations.

### **Program Administration**

Over the six meetings in the first half of 2007 key administrative and policy issues were at times addressed within the context of Medicaid funding that impacts beneficiary access. Inadequate Medicaid reimbursement reportedly limits provider participation in Medicaid. Managed care plans asserted that increasing outlier Medicaid HUSKY expenditures limited their ability to pass on plan rate increases to their provider network. Increases in Medicaid reimbursement were proposed in the legislative Appropriations budget. (*Passed by the General Assembly June 25*).

Summary of program administration topics:

- ***Medicaid Disease Management and asthma programs (Jan):***
  - The Governor funded at \$1.5M Disease Management programs in Medicaid fee-for-service and HUSKY that will focus on childhood obesity, diabetes and cardiac conditions. The RFP was to be released mid-2007 but has not been released to date.
  - The Governor funded a statewide expansion of the Easy Breathing asthma program with \$500,000. The program is a provider-directed evidenced-based asthma management program that has reduced asthma-related emergency department visits and hospitalizations. The Medicaid Council had recommended in 2006 that the program be further expanded in the HUSKY program. There is no indication from DSS how these program quality initiatives will interface with MCO disease/quality activities.
  - DSS has received 3 technical assistance grant for (*May*):
    - Provider pay-for-performance: stakeholder groups are working on this.
    - Return on Investment (ROI) model will be applied to chronic disease management in Medicaid fee-for-service and HUSKY.
    - ABCD grant: provider screens of patients for specific problems. The focus is on childhood developmental screens. Maternal perinatal depression may also be included.
- DSS reported the agency was in the process of hiring a Medicaid Medical Director (April).
- WellCare was the only MCO that agreed in contract to report their provider rates to DSS. The company has, as have other MCOs, purchased a proprietary medical evidenced-based management system and reportedly cannot by contract with the vendor disclose information about the program upon which they base their authorization decision. There was a court hearing in May 2007 regarding disclosure of the information in response to Freedom of Information (FOI) request.
- DSS will be contracting with a new entity for ongoing review of MCO medical necessity decisions beyond what is measured in Mercer audits. This should be in place during CY 2007.
- ***Managed Care (MCO) corrective action plans*** related to the DSS “Mystery Shopper” results were reviewed. The survey showed that only about 26% of new members were able to secure

appointments. The four plans' core corrective actions were similar:

- Network capacity: Periodically check network provider participation status, delete non-participating providers from their network listing and continue provider recruitment.
- Provider adherence to timely appointment scheduling: remind providers and do periodic surveys.
- Revised member services training to focus on staff responsibility in member appointment assistance.

DSS will report to the Council any MCO applied sanctions for failure to implement corrective action plans.

- ***HUSKY A outlier costs (June)***

At the request of Sen. Harp, Council Chair, DSS provided the first of two reports on HUSKY A “outlier” expenditures with expenditures for 2% of the highest cost HUSKY A children by age and diagnosis in CY 2006. The report showed that of the total expenditures of \$74,530,070:

- Children under the age of one year incurred the highest average cost/child at \$83,950 compared to \$16,111 for children ages 1-5, \$ 10, 535 for ages 6-14 and \$14,087 for HUSKY A members 15-20 years.
- Childbirth-related costs and teen pregnancy represented a significant percentage of the costs/age group:
  - 81% (\$19,175,920) of the total expenditures for children under age one was for birth, perinatal period conditions and congenital anomalies.
  - 51% (\$5,948,833) of the total expenditures for 2% of the highest cost members ages 15-20 were for childbirth and pregnancy.
  - Birth and pregnancy-related costs for the 2% highest cost HUSKY A members represented 34% (\$25,124,753) of the total expenditures for the 2% highest cost members ages 0-20 years in CY 2006.

HUSKY A birth data reported annually by CT Voices shows that since 2001 there has been minimal change in teen birth rates (20% of all HUSKY A births) and 16% of HUSKY A teens had a second or more birth in 2005. Low birth weight newborns (9.5% compared to 7% general population) and preterm deliveries (10.6%) have remained the same over the past 5 years. In 2005 the percentage of members enrolled in HUSKY managed care that received 1<sup>st</sup> trimester prenatal care (PNC) fell to 76.4% from 79.3% in 2001 and adequate care was 73% compared to 74.5% in 2001.

Sen. Harp requested the Charter Oak Group consultants that are working with the legislature and the executive branch on applying the Results Based Accountability (RBA) model to key areas to look at the potential application of this model to maternal care. The Early Childhood Cabinet that has used this model agreed to support the maternal care application. A Quality Assurance subcommittee workgroup was formed in May 2007 with a report due to the Medicaid Council and Early Childhood Cabinet in the fall of 2007.

- ***HUSKY Appeals (May)***

An appeal is defined as a member/representative request to the MCO for a formal review of

MCO action on request for services. DSS administrative hearing is directly connected to the fair hearing process. The member has 60 days after receiving the MCO notice to file an appeal. Both the MCO and DSS process have an expedited appeal process: MCO-3 days, DSS-5 days.

- ✓ In 2006 Pharmacy represented 38% of the appeals, dental 30% and transportation 8%.
- ✓ At the MCO appeal review level, the 66% of client appeals were upheld whereas at the DSS administrative hearing level client appeal was upheld 3%. Client withdrawal (66%) from the process was attributed to resolution of the appeal at the MCO level.

### **Pharmacy Report (May)**

There were over 2 million prescriptions (Rx) filled in CY 2006 for HUSKY A members ranging from 700 – 500 Rx per 1000 member months (MM) among the plans. Prior authorizations (PA) Rx *requests* per 1000 MM ranged by plan from over 20 (WellCare, Health Net) to under 5 (Anthem, CHNCT) per 1000 MM. Denied requests for Anthem and Health Net was about 5 Rx per 1000 MM. Primary denial reasons were “equally effective alternative on formulary” (48%) and “medical necessity not established” (39%). In spring 2007 both Anthem and Health Net revised their temporary medication supply process at the pharmacy level when required PA was not requested. The pharmacist screen messages still need to be revised to clearly reflect the Medicaid policy of dispensing temporary medication supply when required PA was not requested.

### **HUSKY/Medicaid Policy/Managed Care Contract**

*State Administered General Assistance (SAGA)* program changes based on the 2007 budget include a limited benefit for routine vision care (yearly exam) and eyeglasses (one pair/year). A limited transportation benefit was established, coordinated by Community Health Network of CT (CHNCT) transportation subcontractor CTS, that will provide transportation for SAGA members for certain specialty care and post operative care

### **Federal Medicaid Proof of Citizenship/Identity (Feb. & May)**

In July 2006 Connecticut implemented the provisions of the federal Deficit Reduction Act that requires states to obtain *original citizenship and identity documents* from current beneficiaries and new Medicaid enrollees. Current Medicaid enrollees remain enrolled while they show reasonable effort to obtain the required original documents; however new applicants otherwise eligible for Medicaid can NOT be enrolled without the documentation. The impact of the provisions on CT HUSKY:

- There were 17,227 pending renewals as of May 2007, of which most are beneficiaries in HUSKY managed care. This number has significantly increased since June 2006 prior to the implementation of federal law.
- Of the 4,753 new applications pending in May, approximately 1,960 that are overdue are HUSKY families (x 2.5 individuals/application = about 5000 individuals waiting for HUSKY enrollment determinations).

DSS has taken several steps to address the impact of the provision including:

- ✓ Creating and training 29 “Designated Outstation” entities that can certify they have

- viewed the required original documents and send copies with the application/renewal.
- ✓ DSS and Department of Public Health (DPH) have created an automated data match process that will confirm new applicants or beneficiaries' CT birth.
- ✓ DSS and the Dept of Motor Vehicles have signed a memorandum of understanding (MOU) to assist DSS in verifying a Medicaid client's identity.

United Way InfoLine was contracted by DSS to do a pilot whereby Info line contacts members who had renewals due after July 2006 by letter and then by phone (5 calls) to ascertain the reasons for non-renewal related to citizenship requirements and provide assistance and/or resource identification to the member for completion of the renewal process. DSS will provide the Council with a report of the pilot; preliminary lessons learned:

- ✓ Finding and then successfully contacting beneficiaries was labor intensive and only partly successful: **41%** of the 237 identified beneficiaries could not be reached through the listed phone number or other extraordinary Infoline efforts to find them.
- ✓ A reminder prompt, perhaps from a non-DSS entity may be effective; beneficiaries successfully contacted had submitted the required documents subsequent to receiving the InfoLine letter.
- ✓ The major confusion for beneficiaries that did not submit documents with renewal application was what is required for their children's identity documentation. School record or an affidavit can be used.

#### **Other Policy Issues:**

- ***Access to breast pumps:*** Medicaid policy will allow FSS billing under the newborn's name enrolled in Medicaid if the mother is *not* enrolled in Medicaid. The MCOs will cover the cost of the pump under the newborn member if the mother is *not* enrolled in HUSKY A.
- Quality Assurance Subcommittee Recommendation to DSS for 1) screening pregnant/postpartum women for ***perinatal depression*** and connecting the women to evaluation and treatment and 2) providing ***oral health services*** to women during pregnancy were accepted by the Medicaid Council. The health plans have begun to incorporate these two recommendations into their member pregnancy evaluation and will provide information on this to the QA subcommittee in September.
- CMS has recently announced a change in its policy so that the ***newborn children of mothers found eligible under Emergency Medicaid rules can now be deemed eligible for Medicaid*** for one year without having to file a separate application for such coverage. The hospital W-416 form for Medicaid newborns has been revised to reflect the CMS policy change. The W 416 forms for "deemed eligible" newborns of Medicaid eligible mothers, those granted emergency Medicaid and 'qualified aliens' will go to a new central processing unit in DSS.
- Council requested health plans, through DSS, to ***add urgent care centers to their Medicaid network***. This would offer some of their members an alternative to emergency department (ED) use. ED utilization has been steadily increasing in HUSKY. MCOs have sought Medicaid contracts with urgent care centers; however Medicaid-level reimbursement has been a primary barrier to successfully bringing most of these clinics into the network.

- The managed care organizations' contract with DSS has been extended to *October 1, 2007* in order for review and implementation of SFY 08-09 budget provisions.