

Connecticut Medicaid Managed Care Council

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Medicaid Council Quarterly Report: 1st & 2nd Quarters 2008

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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 2008**. 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 (SCHIP), 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 two working subcommittees: Consumer Access and Quality Assurance Subcommittee*

Both the Medicaid Council and Subcommittees met monthly during the first two quarters of 2008. The main focus of the meetings was the HUSKY transition process, program delivery changes, the future plan for HUSKY service delivery system and DSS policy changes. Special reports were CT Voices CY 2006 children's preventive care and Emergency Department utilization and assessment of Medicaid provider fee changes.

HUSKY Transition from risk-based to non-risk managed care & FFS

History:

November 2007 Governor Rell directed the Commissioner of DSS to terminate the HUSKY managed care at-risk contracts when three of the MCOs (Anthem, Health Net and CHNCT, the latter plan later agreed to this contract language as did WellCare from the start) had not agreed to contract language of the Freedom of Information (FOIA) that addressed public program transparency and accountability. The four MCOs – Anthem, Health Net, Community Health Network of CT (CHNCT) and WellCare – were transitioned to a DSS non-risk contract with medical necessity decisions and rate determinations responsibilities assumed by DSS. The member transition to the remaining non-risk plans was to be completed by Feb. 29, 2008. The Governor allowed DSS to extend the transition period to 3 months, through March 31, 2008. During this time there were several changes in health plan participation:

- In **December 2007** DSS reported to the Council that CHNCT and WellCare would remain as Pre-paid Inpatient Health Plans (PIHPs) maintaining responsibility for administrative activities.
- At the **January 2008** Council meeting DSS reported that only CHNCT remained in the HUSKY A & B programs. HUSKY A member choice was now limited to CHNCT or Medicaid fee-for-service (FFS).
- In **February 2008** DSS reported that Anthem had made system changes that would allow the plan to participate as a non-risk pre-paid inpatient health plan (PIHP) along with CHNCT.

Current HUSKY Program Delivery System

- *Health Plan Participation April 1, 2008:* Anthem continues as a pre-paid inpatient health plan (PIHP) and the plan is willing to continue in the HUSKY program as long as needed during the phase-in of the new MCOs after July 1, 2008. Anthem and CHNCT contracts, in compliance with FOIA, were extended through *June 30, 2008*. The contracts could be extended beyond June 30 if the HUSKY/Charter Oak health plan re-procurement process hadn't been completed. Member choice during the transition phase until the 'new' structure is in place included:
 - Under the 1915 (b) "choice waiver", HUSKY A member choice during the transition was Anthem, CHNCT or Medicaid FFS. Beneficiaries and new members that had not chosen a plan/FFS within a specified time period (30 days from receipt of member notice to change) were defaulted into Medicaid FFS.
 - HUSKY B member choice included Anthem and CHNCT and non-plan choosers were defaulted on a rotating basis to one of these two plans. HUSKY B band 3 (full premium) members who did not choose a plan and/or did not submit the first month payment were dis-enrolled. ACS, the DSS enrollment contractor made numerous outreach calls to these members in an attempt to prevent dis-enrollment.
- By *March 12, 2008* DSS reported that of the total 116,365 Health Net & WellCare members that had to choose a new plan, 59% (51,942) chose one of the two plans and 36,239 were defaulted to FFS: 28,184 members were still enrolled in Health Net & WellCare in March. (See DSS communication with providers and members about the program changes at www.HUSKYHealth.com)
- Three *HUSKY parents* from Parent Power, a statewide program, described the difficulties experienced in this program transition. Common issues were communication problems that included not receiving the DSS letter announcing the changes and required member action, lack of consistent information about the changes and difficult to understand language in the notices. The families described difficulty in finding general and specialty providers in HUSKY FFS and expressed strong concern that HUSKY members will again experience a program change in SFY 09 and urged a delay in implementing another program change in such a short time period.
- Sen. Harp had requested DSS consider a plan during this transitional period for ***basic member supports for HUSKY FFS*** members with chronic health conditions or pregnancy. DSS outlined in the March meeting current and planned "member support services" for HUSKY A FFS members including CTBHP co-management with the Medicaid medical unit, added DSS staff for care management of medically complex members, review of Healthy Start contracts for this entity's care coordination of pregnant FFS members' care and DSS plans to mail EPSDT reminders to HUSKY families.
- ***Provider Network capacity*** changed during the transition period, with each of the remaining plans recruiting and adding primary care and sub-specialty providers, in particular in counties that had a high penetration of the two plans that no longer participate in HUSKY as of April 1, 2008. The enrollment broker, ACS, received twice weekly reports on provider networks from Anthem and CHNCT; Medicaid provider network changes are on the DSS EDS web site: www.ctdssmap.com
- Beginning Jan. 1, 2008, health plans were required to submit denied requests for prior authorization (PA) to DSS Medical Director for review and final decision. Dr. Zavoski, DSS Medical Director, provided a summary of these full/partial denials and DSS action. The PIHPs submitted 589 denied requests, 303 for members under age 21 years and 279 for adults. DSS

actions:

- 68% of children's denied/partially denied requests were fully or partially approved by DSS and 32% of PIHP denials were upheld by DSS.
- 80% of all adult denied/partially denied services were either fully or partially approved by DSS and 20% of the denials were upheld.
- The majority of the types of services involved in this process were for physical, speech and occupational therapy that often were partially denied with DSS partial approval (i.e. number of visits/week for 6-8 weeks).

Dr. Zavoski commended the PIHP medical directors and staff for their work with DSS in this process. The Council suggested that a similar process and/or close monitoring be included in the at-risk MCO system going forward.

Enrollment

As of June 1, 2008 total HUSKY A enrollment increased to 321,996 members, a 3% increase (9,321 since January 1, 2008). HUSKY B enrollment showed a 1.7% (268) increase to 16,400 members over these 6 months. HUSKY A members can change their plan/FFS at any time. Enrollment by health plan or Medicaid FFS (HUSKY A only) as of June 1, 2008:

- Anthem: 189,917 HUSKY A members (59% of total HUSKY A membership) and 11,856 (72%) HUSKY B members
- CHNCT 94,261 (29%) HUSKY A members and 4,544 HUSKY B members
- Medicaid HUSKY A FFS 37,818 (12% of total HUSKY A enrollment)

SFY09 HUSKY and Charter Oak Health Plan (COHP)

Health Plan Participation

Anthem has chosen not to participate as a bidder for the HUSKY/Charter Oak programs. CHNCT, Aetna Better Living and AmeriChoice (United Health Care parent company) all are in the process of contract negotiations with DSS: contracts had not been finalized by the June 13 Council meeting. The three Medicaid –only plans will comply with the FOI provisions. The plans will all participate in HUSKY A, B and COHP.

SFY 09 Member Transition Plan & Charter Oak Health Plan (COHP)

Given the assumption that the three managed care organizations (MCOs) sign contracts with the State, DSS plans to phase-in the enrollment in the plans by county, starting in August for enrollment in September in one county, 3 counties the following month and 4 counties in November. DSS has agreed to conduct random provider calls in a county prior to HUSKY transition to the new plans to ascertain the nature of their participation as a Medicaid provider (i.e. taking new Medicaid patients vs. only providing services to their existing Medicaid patients). Anthem enrollment of new members is expected to end as the county phase-in begins. DSS expects Anthem participation and HUSKY FFS to end when all counties have transitioned into the new at- risk managed care delivery system.

Council member response to COHP raised several issues including:

- Member affordability: the maximum out-of-pocket cost share seemed high and there were questions about the premium/deductibles and service caps by dollar amounts. DSS will present scenarios to illustrate member cost share at the July council meeting.
- State financial risk: concerns were raised about state risk if COHP costs exceed the budget and that currently COHP is fully State subsidized with no federal match. DSS stated:

- The three plans are at full risk for COHP; if enrollment or health expenditures exceed the appropriation, DSS would go to the legislature for deficiency appropriation, authorization for an enrollment cap or both.
- DSS will be applying for a federal waiver for COHP, SAGA and Family Planning.
- DSS was asked to provide actuary data on the program cost projections and cost share pool.

Medicaid/HUSKY Program & Policy Changes

- Pharmacy services were ‘carved-out’ of managed care effective **Feb. 1, 2008**, whereby DSS assumed responsibility all pharmacy utilization for HUSKY A, B and State General Assistance (SAGA) programs under the Medicaid Preferred Drug List (PDL) and EDS payment of all pharmacy claims.
- HUSKY Dental services ‘carve out’ from HUSKY managed care is expected in **July 2008**. As of mid-June a successful Administrative Service Organization (ASO) bidder had not been named. DSS plans to phase in the ASO administrative responsibilities, similar to the process undertaken in the behavioral health partnership (BHP) program.
- interChange, a new Medicaid Management Information System, began Friday **January 26, 2008**. The system includes medical claims processing and payment, client eligibility information, pharmacy prior authorization service for pharmacy services to HUSKY A/B, SAGA and Medicaid FFS clients, provider and new client assistance call center and ConnPACE call center and application processing. The new system experienced startup problems that included claims payment issues that impacted HUSKY and CTBHP providers. Interim payments were issued to providers while processing issues were being resolved.
- A Primary Care Case Management (PCCM) program has been designed by DSS and a work group as a service delivery model in addition to managed care. **October 2008** is the anticipated start date.
- Uninsured Newborn initiative began in 1Q08. The intent of the program to enroll an uninsured newborn in HUSKY A or B before hospital discharge. The Medicaid enrollment broker ACS has been designated a “qualified entity” and will deem applicants presumptively eligible for HUSKY A or expedite HUSKY B enrollment within one day. Hospitals participation, critical to this program, has been solicited by DSS; to date 17/31 CT hospitals and one border hospital have contracted with DSS to facilitate the newborn initiative.
- Pregnant women’s Medicaid income eligibility increased from 185% FPL to 250% FPL effective January 1, 2008. Women over 185% FPL are covered under Medicaid during their pregnancy and 2 months postpartum period. DSS was asked to connect women over income for HUSKY A parent coverage and uninsured after the perinatal period to coverage options such as Charter Oak in order to maintain continuity of health coverage and health services. DSS agreed to put a process in place to respond to this request.
- Non-reimbursable prenatal care (PNC) services will be funded through a \$2M biennial budget provision to hospital PNC clinics and community health centers as a retrospective lump sum payment made after the delivery, which is paid for through Medicaid emergency services.
- Streamlined HUSKY Application process was the result of 2007 legislation that required the DSS to centralize the application process. DSS reorganized the application process from the individual DSS offices to the three existing regional processing units (RPU) that had previously been designated to process children’s presumptive eligibility cases and expedited eligibility process for pregnant women. New HUSKY A applications and interim changes received by ACS will proceed

from ACS to the RPU with the expectation that applications will be processed in one day.

- Enrollment Broker (ACS) contract has been expanded to managed the Charter Oak Health Plan(COHP) that includes:
 - Screening the ‘quick start’ application for potential eligibility for HUSKY A, Adult Medicaid or SAGA medical and send to the DSS office in the applicant’s geographic area.
 - Granting COHP eligibility.
 - Billing COHP members for premiums, tracking these payments and client deductible payment status.

- *Medicaid regulations and State Plan Amendment (SPA):* As of the June 13 Council meeting several regulations were awaiting approval that included MCO EPSDT appointment assistance, HUSKY B program and Medicaid Citizenship/Identity regulations. Notice of publication for SCHIP SPA changes related to newborn uninsured enrollment and pharmacy carve-out were placed on the DSS website: www.ct.gov/dss .

Medicaid Rates Biennial Budget

- The various rate structures are in the process of being reviewed by CMS. DSS stated state plan amendments (SPA) must have CMS approval before the State can claim federal match on those expenditures. The federal revenues will be in the SFY 09 budget, creating an artificial DSS agency deficiency that impacts the state balanced budget requirement. To date:
 - The Nursing home SPA has received CMS approval
 - Expect CMS to approve the SPA for hospital rates by the end of June 2008.
 - Other services require CMS approved methodology for arriving at Upper Payment Limit (Medicare): this is a complex process and DSS hopes to complete this by the end of June 2008.

- Dental grants (\$4.5M) for school based health centers and non-Federally Qualified Health Clinics: letters of approval were sent out June 14, 2008 and the checks will soon be released.

Special Reports: CT Voices

- **HUSKY A Children’s Preventive/ED Use CY 2006** (full report @ www.ctkidslink.org)
Discussion of the report focused on ED use, with over one-third of children seen in the ED having ambulatory care sensitive conditions (ACS) that could be treated in a primary care setting. Evidenced based professional telephonic evaluation and support, paid by practices, have been used successfully to limit ED use for ACSC and keep the patient connected to their PCP.
Senator Harp asked DSS to take the lead in developing a pilot for a practice-based telephonic evidenced-based system that includes outcome measurements.

- **Medicaid Provider Fee Changes** (full report @ www.ctkidslink.org) CTVoices analysis of \$27.3M for Medicaid fees, applied to Medicaid FFS, HUSKY, SAGA and BHP providers, showed that rate increase were applied to some pediatric services depending on the type of service whereas obstetric fees did not change. DSS stated that adult Medicaid and SAGA service rates have not been increased for over 20 years and there have been access difficulties for Medicaid specialty care/adult care.