

Connecticut Medicaid Managed Care Council

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Medicaid Council Quarterly Report: 3rd & 4th Quarters 2008

*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 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), in 1998, the State Children's Health Insurance Program (SCHIP), which is HUSKY B and in 2006 the managed care portion of the State General Assistance (SAGA) program. The law also charges the Council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation, eligibility standards, benefits, health care access and quality measures. The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans and state agencies. The Council has three working subcommittees: Consumer Access, Quality Assurance and Women's Health Subcommittees.*

Both the Medicaid Council and Subcommittees met monthly during the last two quarters of 2008.

The primary focus of the meetings in the last half of 2008 was on the HUSKY transition back to a mandatory at-risk managed care model under a 1915(b) HUSKY program waiver extension thru June 30, 2009 if CT accepted the CMS terms and conditions for the waiver extension, which the State did. The transition was complicated by the linkage of three programs within managed care organization contracts with DSS for HUSKY A/B and the new Charter Oak Health Plan (COHP).

Background on HUSKY Delivery System Changes and Charter Oak Health Plan

COHP, begun August 1, 2008 was proposed by the Governor and approved by the Legislature in the 2007 biennial budget session as a state funded health program that offers health coverage to uninsured CT adult, ages 19-64 years. DSS expects to apply for a Federal waiver for COHP that would provide the State with federal matching dollars for the program's expenditures. The benefit package was designed as a "commercial like" benefit with the increased Medicaid fee-for-service (FFS) rates creating the floor for MCO-negotiated provider reimbursement. COHP has no income eligibility limits rather eligibility is based on lack of credible health insurance for 6 months, with certain exceptions. Applicant income levels are required to determine member cost share in one of five bands. Services for COHP members outside the managed care organizations include:

- Affiliated Computer Systems (ACS), the DSS enrollment broker, became the single point of entry for HUSKY and COHP applications. ACS reviewed all new and renewal applications for an applicant's potential eligibility for a Medicaid, HUSKY A or B or State General Assistance (SAGA) program before offering them COHP enrollment. ACS now also manages the premiums for COHP and HUSKY B.

- Behavioral Health services are administratively managed by the Behavioral Health Partnership (BHP) contracted Administrative Service Organization, ValueOptions and provider reimbursement is through DSS. The provider network is the established Partnership's providers – the BHP providers do not have an 'opt-out' provision for participating in COHP. There was no rate adjustment to the established HUSKY BHP rates to offset potential unpaid member cost share.
- COHP pharmacy services are provided through the DSS Preferred Drug List and EDS system.
- COHP dental services are not included in the benefit package but can be purchased by the member.

The HUSKY delivery system model changed from an at-risk managed care model to a non-risk Prepaid Inpatient Hospital Plan (PIHP) after the Governor had DSS assume the management of the HUSKY program. Two MCOs (WellCare and Health Net) withdrew from the program, WellCare in December 2007 and Health Net in April 1, 2008. Anthem chose not to respond to the RFP for the procurement of HUSKY managed care plans. Anthem agreed to remain as a PIHP and reiterated this. Of the four MCOs that DSS had delegated HUSKY program management to, Community Health Network of CT-a Medicaid only plan (CHNCT) and Anthem Blue Care Family Plan (Anthem) remained as PIHPs and DSS created a HUSKY FFS option to accommodate the increasing numbers of HUSKY members.

Program Changes in the last half of 2008

HUSKY Transition & COHP

The at-risk managed care program resumed September 1, 2008. Anthem's contract with DSS as a PIHP was extended monthly until DSS ends their contract by Jan. 31, 2009 after the Centers for Medicare and Medicaid Services (CMS) approved the 1915(b) waiver extension when DSS demonstrated provider network adequacy in each county. The long, complicated HUSKY transition process included:

- Completion of the three DSS/MCO contracts for HUSKY A/B and COHP after July 1, 2008. The three plans are Aetna Better Health, United Health Care's AmeriChoice and CHNCT. The plans began recruiting providers for HUSKY A/B and COHP in July; providers were required to sign contracts for participation in all three programs.
- DSS implementation of member *voluntary* plan changes from Anthem and FFS by county occurred from Sept through December 2008 beginning with Middlesex County in September. Anthem member enrollment stopped in September 2008.
 - *New members* in the identified 'roll-out' county had to choose one of the three plans or be defaulted into FFS; *new members* in the *non-rolled out counties* were initially enrolled in HUSKY FFS until their county roll-out when they could voluntarily change to one of the health plans.
 - Current beneficiaries were encouraged to voluntarily change to one of the three plans when they received the county "roll-out" letter. There were strong concerns about health care access during voluntary enrollment when the new health plan's networks developed so slowly. DSS stated the MCOs have a contractual obligation to pay for out-of-network services that include primary care and specialty services and DSS will monitor this during the transition period.
- Implementation of HUSKY *mandatory enrollment in an at-risk MCO*, initially planned to

begin Dec. 1, 2008 was moved to Feb. 1, 2009 after final CMS approval of Medicaid network adequacy/ 1915(b) waiver extension late in December 2008. Anthem and FFS member notices for the required plan changes were mailed Dec. 30, 2008. Members had 30 days to choose a plan or be defaulted into one of the two new plans – Aetna or AmeriChoice by Jan. 30, 2009.

The oversight Council concerns about the HUSKY transition and HUSKY/COHP linkage were considerable as the impact of COHP on the HUSKY program became apparent. Primary issues that impacted health care access were identified in Council meetings including:

- Development of adequate provider networks in both programs: Provider enrollment for HUSKY in the two new MCOs was slow and remained well below CHNCT and Anthem numbers. This sluggish growth in HUSKY networks was primarily attributed to provider reluctance to also participate in COHP for several reasons including:
 - The unknowns of COHP provider risk and case mix (healthy members versus the number of members with existing chronic health problems).
 - The economic impact of COHP on providers' practices; base rate structure was seen as inadequate given that member cost share could lower the base Medicaid fees. Unpaid member cost share would reduce provider service payments.
 - Want written agreement from DSS that the practice is not required to accept all Medicaid clients that seek their services. This is DSS policy – a 'Medicaid provider' can have an open or closed patient panel, but must inform the MCO if they stop taking new Medicaid patients (closed panel).
 - Providers, in particular specialists, do not want to be listed in a public Medicaid directory. This and/or could lead to a practice being inundated with referrals out side the practice geographic area.
 - Providers believe that if the State had worked with the broad provider community in designing COHP many of the issues could have been identified and resolved, avoiding the present state of confusion for the public and health providers.
- Application/eligibility determination delays: A somewhat unanticipated effect of COHP on HUSKY was the flood of phone calls and COHP applications that require complex processing in addition to the increasing number of HUSKY applications. Application processing delays became apparent toward the end of 2008. ACS added staff and restructured staff daily performance goals to manage the processing delays.
- State financial risk for:
 - COHP – costs could exceed the budgeted dollars with the state subsidizing services for individuals with incomes > 300% federal poverty level (FPL), which for an individual is income over \$31,200/year.
 - HUSKY- implementation of HUSKY mandatory enrollment that if not approved by CMS, would put Medicaid federal match at risk.

On August 20th the Medicaid Council met and agreed to send the following resolution to the Governor: Rep. Peter Villano made a motion, seconded by Rep. David McCluskey ***that the Medicaid Managed Care Council adopt a resolution addressed to Governor Rell making two recommendations:***

- 1. Freeze enrollment in the Charter Oak Plan until July 1, 2009 and***
- 2. To delay implementation of the HUSKY program as part of Charter Oak Health Plan implementation also to July 1, 2009.***

The objective (of this motion) is to provide time to develop adequate provider networks to service the

client populations

The Governor responded that the HUSKY and COHP programs would continue as planned.

At the **November 14, 2008** Council meeting a Council hospital participant's comments about their contracting process presented a scenario contrary to the MCO/provider contract requirements for participation in all 3 programs: this hospital system only contracted with MCOs for HUSKY A/B and would not have signed a contract for HUSKY without agreement that COHP would not be part of the contract. Late on the afternoon of Nov. 14th, the Governor directed DSS to ***separate the provider/MCO contracting process***, allowing health providers to contract for HUSKY A/B only and/or Charter Oak. Subsequent to this directive, Aetna and AmeriChoice networks expanded, including hospitals and Federally Qualified Health Centers (FQHCs).

Primary Care Case Management Pilot

Primary Care Case Management (PCCM) HUSKY A program, an alternative to managed care, was planned to start Jan. 1, 2009, one month after the expected MC mandatory enrollment 12/1/08. The Council expressed strong concern that adding another member choice after the mandatory deadline would be confusing to members. Given the delays in adequate network development, the final start date of mandatory enrollment in the managed care plans and PCCM will be the same – Feb. 1, 2009. There was further controversy about the DSS implementation plan for PCCM. DSS plans to start the program in three areas: Waterbury, Manchester & Willimantic. Advocates that participated in the PCCM planning meetings believed there was adequate provider representation for PCCM to allow statewide implementation. DSS stated their decision was to start the program within specific areas but expects the program to be available statewide by the end of the SFY 09.

Carve-out of Dental Services

While DSS initially planned to implement removing HUSKY A/B dental services from managed care organization responsibility in July 2008, the dental “carve – out” became operational September 1, 2008 with distribution of the \$4.5 million dental grants to school based health centers and non-FQHCs and additional dollars budgeted in the 2007 biennial budget for pediatric dental care based on the dental litigation settlement. BeneCare was awarded the dental benefits manager (DBM) contract for HUSKY A/B, Medicaid FFS aged, blind and disabled clients and State Administered General Assistance (SAGA) program. DSS will periodically report on dental network development and access. Dental network information in October and November showed that of the 300 unduplicated dental providers in managed care prior to the carve-out, more than half have enrolled in BeneCare and there were 109 newly enrolled dental providers. By Nov. 560 dentists, 83 dental hygienists were enrolled and there were 43 applications pending. A DSS/DBM dental provider survey revealed that 10.8% of dental providers are not taking new patients. The professional licensure system does not identify the number of licensed dental professionals that are practicing (versus retired) in CT so it is difficult to assess the percentage of practicing dentists that participate in Medicaid.

HUSKY and Charter Oak Financials

The Council had requested information on the financial basis for HUSKY and Charter Oak programs. In September 2008 this information was presented:

Charter Oak rate methodology was reviewed by the DSS contractor Schramm-Raleigh Health Strategy. The basis of the rate methodology was HUSKY A adult data with the final COHP premiums derived from the MCO bidding process. The Governor's target was a global rate that was based on the assumption that all services, managed care and non-managed care services (in carve-out) would be

included in the negotiated rate. Behavioral health and pharmacy account for a total of ~50% deduction from the MCO per member per month (PMPM) premiums. Each bidder was asked to submit an alternative design to meet the global target; while increased member cost share was considered, this adversely affected the program affordability. The negotiated base design with an annual \$100,000 maximum cost coverage brought the premium cost into the global range. DSS will monitor the COHP member risk profile (acuity, services) to identify adequacy of the state subsidized premium and will ask the Office of Health Care Access to monitor changes in the employer-based insurance participation and aggregate approved “crowd out” exceptions.

HUSKY A/B rate development that met the CMS actuarial soundness requirement was reviewed by Mercer. This process was reportedly completely separate from the COHP process. Base data was adjusted to reflect population expansion and service care-outs program trends. The aggregate increase of 24% from SFY 08 to SFY 09 in the HUSKY rate range development was broken down by trends (5.6%), programmatic changes including expanded populations and Medicaid rate increases approved in the 2007 biennial budget (13.1%), and change in MCO financial position (5.3%). The latter is derived from the historical perspective of average 4% MCO rate increases, program trend drivers and competitive DSS/MCO negotiations. The 5.3% reflects change in the MCO negotiations from SFY 08 – SFY 09. Council comments included:

- In response to a question, Mercer stated the MCO administrative loss ratio would be 10% with an additional profit margin of ~ 1%. It was noted that DSS should not reward a MCO with higher administrative costs.
- DSS expected the HUSKY B band 3 (full premium payment) payment is ~\$195/month.
- Sen. Harp questioned why HUSKY A DCF children’s PMPM rate is \$125, lower than HUSKY B children that have lower acuity rates. Mercer stated that historically DCF children’s pharmacy was a significant cost factor: pharmacy costs were “carved-out of managed care January 2008.
- Historically were MCO 4% rate increases passed on to all their providers? DSS stated provider rates ranged above, below or at Medicaid FFS rates, depending on the MCO network development needs. The current DSS/MCO contract establishes the Medicaid FFS rates as the ‘floor’ for all provider/MCO negotiated rates. Sen. Harp observed it was then incorrect for the legislature to assume MCO rates were higher than FFS rates and it would seem that the only way to increase HUSKY provider rates in the future is through the budgetary process. Ultimately a different actuarial process is needed to even the provider rates among those that negotiated higher than FFS rates and those that had no/few rate increases in MCO system.

Expenditure differences for at-risk MCOs and non-risk PIHPs (Oct. meeting)

The Council requested a report for CY 07 MCO R/E reports and comparison of HUSKY MCO expenditures with PIHPs.

- ✓ In October, DSS presented the HUSKY A/B Revenue & Expense report for CY 07. There was variability among the four plans related to PMPM administrative costs (Anthem the lowest at \$12.40 and Health Net the highest at \$28.99), and PMPM net medical expenses (WellCare had the lowest at \$139.74 and Health Net the highest at \$181.41). Anthem and Health Net PMPM margins showed losses for that calendar year.
- ✓ DSS compared Nov. 07 MCO capitation expenditures for HUSKY A & B with expenditures May 08 under the non-risk model. The ‘bottom line’ expenditures were higher in May 2008 compared to Nov. 07. DSS attributed the May 08 expenditure increase in part to pharmacy carve-

out, in that pharmacy was included in the capitation in Nov. 07. Presentation of per member per month expenditures would have made a clearer comparison. In addition, Council members noted that costs for the pharmacy carve-out were expected to increase and HUSKY enrollment increased in 2008. The Council would like DSS to present a clearer picture of cost differences between the two delivery system models in early 2009.