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

Quarterly Report: 2nd Quarter 2009

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 April through June 2009. 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 now has four working subcommittees: Consumer Access, Quality Assurance, Primary Care Case Management and Women’s Health Subcommittees.

Both the Medicaid Council and Subcommittees met monthly during this 2009 quarter. The meetings focused on:

- **Program administration** that included SAGA CY08 report, status 1915(b) HUSKY waiver, Primary Care Case Management (PCCM), federal stimulus bill enhanced federal match to CT, provider network development for HUSKY & Charter Oak Health Plan with out-of-network access reports, Dental network development, Prepaid Inpatient Hospital Plan (PIHP) expenditure report for HUSKY A & B, Anthem data submission status and HUSKY/Charter Oak enrollment, application process and HUSKY member default assignments.

- **DSS policy changes** in proposed budgets.

- **Special reports** included CT Health Foundation report on the impact of proposed HUSKY cost share and premiums and two Yale graduate student Council projects on Medicaid “Report Cards” and Chlamydia media project targeting young men.
**Program Administration**

**SAGA CY08 Report (June)**

DSS provided information on the State Administered General Assistance (SAGA) program medical expenditures. SAGA, a state only funded program, has had increasing expenditures since SFY 2007, with an 11.9% increase in SFY08 compared to 2007 and projected increase of 13.5% in SFY09 compared to 2008. Key factors that attributed to the increasing expenditures included:

- Enrollments increased with the most rapid growth (16.5%) seen from May 2008-May 2009 that was thought to reflect the recession.

- Improved access through expanded provider networks contributed to Medical provider expenditure 35% increase from SFY08 to SFY09.

- Added sites and DSS restoration of the full Federally Qualified Health Center (FQHC) rates in SAGA also improved health service access.

- Improvement in dental access related to fee increases, though small for adult dental, and an expanded dental network. Dental services had been one of the top 3 unmet health needs for this population.

While dental expenditures represent 4.8% (projected SFY09) of SAGA expenditures, there was a 174% increase in dental SFY08 to SFY09 that probably represents a pent up demand for such services. Pharmacy expenditures represent the highest service category, with 4.8% decrease projected in SFY09 followed by hospital expenditures (capped at ~50% Medicaid FFS rates) that were 33.4% in SFY08 down to 31.2% projected for SFY09. Council requested the following SAGA information:

- DSS provide a timeline for shared data for hospitalizations with CHNCT, manager of SAGA ambulatory services.

- SAGA per member per month expenditures.

- ED utilization and costs.

**1915(b) Waiver Status (May & June)**

DSS applied for a new 1915(b) {choice} waiver for HUSKY A given major program changes. The waiver, amended by the Legislative Committees of Cognizance, was submitted to CMS April 1, 2009. CMS questions to DSS related to an explanation of:
• The FQHC ‘carve-out’ payments: while FQHCs will remain part of the managed care organizations’ (MCO) network, DSS will, beginning Sept 1, 2009, directly pay the FQHCs the full federally required service payments. Previously DSS had paid the ‘wrap around’ costs and the MCOs paid the clinics the Medicaid fee schedule rate. The DSS financial unit will negotiate with the MCOs the reduction in MCO capitation dollars, similar to the process undertaken with other service ‘carve-outs’ in HUSKY.

• PCCM access standards and grievance process implementation.

DSS has responded to CMS questions and will send the Council the waiver Q&A. DSS stated the waiver process would be completed by July 1, 2009.

**Primary Care Case Management**

The Legislative Committees amendment to the 1915(b) waiver addressed PCCM implementation;

• By Jan. 1, 2010 PCCM will be operational in the greater New Haven and Hartford areas.

• DSS will commission an independent evaluation of the cost, quality and access impact in the first two areas (Windham & Waterbury) by July 1, 2010.

• DSS will offer PCCM in additional geographic areas after July 15, 2010 pending the evaluation findings.

• DSS will report to the Legislative Human Services and Appropriations Committees on the status of PCCM roll-out Jan. 1, 2010.

Council members suggested DSS consider an entity outside DSS to do the evaluation. DSS saw the value of this but noted this is a funding issue. *Sen. Harp recommended and the Council agreed to establish a Council PCCM Subcommittee to work with DSS* on the various public notices, implementation of expansion as outlined in the waiver amendment, monitor progress and report back to the Council. Robert Zavoski, MD, Medicaid Medical Director and Riva Weiser, DSS PCCM Coordinator will participate in the Subcommittee. DSS has during this quarter and will continue to provide the Council with progress updates.

**Medicaid Federal Stimulus Package (May & June)**

States that meet certain conditions to maintain Medicaid eligibility standards or procedures would receive a 6.2 percentage point federal medical assistance percentage (FMAP) increase during the adjustment period from 10/1/08 through 12/31/10. The budget proposals to require Medicaid premiums and eliminate self declaration of income
were withdrawn by the Governor when CMS guidance was provided on the maintenance of effort, as these two policies would change State Medicaid eligibility.

CT FMAP would be ~ 60% instead of 50% totaling $1.3 billion over the designated adjustment period. In May DSS reported that for SFY09, CT expects to draw down $400M in federal match from Oct. 1, 2008 through June 30, 2009 (end of SFY09).

- Actual amount received to date is $232.6M
- Projected additional $157.6M would be received by the end of June 2009

**HUSKY & COHP Provider Network and Out of Network (OON) Services 2Q09 (April, May, June)**

- Provider networks for the two new MCOs have grown. DSS reported that:
  - Over past 7 months HUSKY primary care provider network has increased by 3,130 (49%) for all MCOs and the number of specialists increased by 3,452 (35%).
  - The projected HUSKY PCP capacity, based on PCP methodology (number of members/PCP/county) ranges from 42% to 19%, allowing capacity for new enrollees based on the current networks for 3 plans.
  - DSS expects to soon be able to identify unduplicated providers in order to clarify the ‘capacity’ dialogue.

- Authorization for OON services, required in the MCO/DSS contract, was seen as an initial ‘safety’ mechanism for health service access while the two new health plans built provider networks for HUSKY A, B & COHP and CHNCT developed a network for that program. Compared to Jan/Feb 2009, which had a total of 9,489 OON HUSKY A requests, Mar/April total requests in HUSKY A (primary care and specialty services) was 13,301 for 2 months. CHNCT had ~ 10% of the total 2-month OON requests for the 3 plans/program. DSS noted that PCP OON requests generally are from new members whose regular PCP is not in their chosen/default plan. There was an increase of 6015 HUSKY A members between January and April 2009. Early in the managed care program members were ‘locked-in’ with a PCP in order to encourage continuity of care but this restriction was removed when access problems were identified.

**HUSKY Dental Network (April)**

Dental services were ‘carved-out’ from HUSKY A & B managed care September 1, 2008 and BeneCare is the Administrative Organization for the **CT Dental Health Partnership**
(CTDHP) that also includes SAGA and Medicaid fee-for-service populations. From 12/31/08 through April 2009 there has been a 9.2% provider network growth. BeneCare’s mystery shopper survey done between 2/15 & 3/6/09 showed that:

- Of the 341 dentists surveyed, <10% had reached capacity to accept new patients.
- 351 members received routine appointments for all service types within the 8 week contract range.
- BeneCare did targeted outreach to dental practitioners in Windham and Tolland counties; however the overall number of dentists in those counties is low compared to other counties.

Many individuals participated in the Mission of Mercy (free dental care through donated dental services) in New Haven; HUSKY applications and assistants were available on site and a small number of families signed up for HUSKY. Council members emphasized the importance of oral health in maintaining overall health and the need to inform and change the public perception of oral health’s role in general health. CTDHP is working with DSS to identify special needs clients, including children in the Katie Becket waiver and with the MCOs to identify members that would benefit from medical/dental co-management.

Prepaid Inpatient Hospital Plan (PIHP) Report (May)

DSS actuary presented HUSKY A/B expenditures under the PIHP non-risk managed care system. Final reconciliation of claims should be completed by September, which will allow expenditure comparisons of the full risk managed care system and the non-risk PIHP system. The PIHPs’ administrative services were reimbursed at $18.18 PMPM. Medical/administrative costs in the report are based on plan enrollment numbers, length of time as a PIHP and 2007 budget Medicaid provider rate increases. For HUSKY A & B, Anthem administrative payment was $44,039,577 and total plan payment was $429,363,745, CHNCT received $15,822,245 in administrative payment and $174,418,259 in total plan payment. A total administrative payment for the 4 plans (as PIHP) was $65.6M with total payments of $676.1M. DSS stated a financial template for managed care will establish a fixed definition of common administrative expenditures across MCOs, allowing DSS to uniformly identify and monitor these activities in the revenue/expense reports.

Anthem Encounter Data Reports

During the last six months of 2007 through CY 2008, Anthem had difficulty having their encounter data accepted by Mercer within the edit parameters. Currently half of the 1.1M outstanding claims (due in part to vendor errors) have been resubmitted by Anthem and accepted. Sen. Harp stressed the importance of Anthem’s completion of data error corrections so that correct data will be in the DSS data warehouse for future rate setting, utilization trends and reports to CMS.
**HUSKY Enrollment**

- HUSKY A enrollment increased by 11,415 members (3.4%) since March 2009. The default enrollment, now assigned to the 3 plans by rotation, was 26.2% in May compared to 20% average default in CY07. Children’s enrollment increase was about 0.5% per month and parent/caregiver monthly increase was about 1%.

- During this quarter HUSKY B (children only) enrollment peaked to 15,217 in May and decreased by 164 members in June.

- Charter Oak Health Plan enrollment increased by 2,459 members during this quarter compared to March 2009.

- Disenrollments for failure to pay premiums in HUSKY B band 2 and COHP increased in May compared to April. ACS noted that families said they could not afford the premiums. Sen. Harp commented this is instructive in light of the biennial budget proposals.

- Other points in the HUSKY/COHP data included:
  - Stabilization of HUSKY B/COHP pending applications since March 2009.
  - Stabilization of HUSKY B and COHP units denied or closed since the high number in the first quarter 2009.
  - HUSKY A plan changes (members are ‘locked’ into a plan only in HUSKY B after the 90-day look period) represent about 0.7% (2,265) of the total HUSKY population with the primary plan change reason of ‘PCP not in plan’ (60%).

**HUSKY Policy**

*Mathicaid “medical necessity” (June)*

Advocates expressed concerns about the proposed budget item that changes *Medicaid ‘medical necessity’ definition* from the standard of “maintaining optimal level of care” to that applied in the SAGA program and by commercial payers that include the principle of providing services which are “reasonable and necessary” or “appropriate” in light of clinical standards of practices. Associated saving are projected at $4.5M in SFY10 and $9M in SFY11. Discussion points included:
• Office of the health Care Advocate noted that this is a major issue in the private pay system and that medical necessity determinations are to be made on a case-by-case basis as defined in CT statute.

• Advocates stated that the source of the projected savings is unclear and reduction of medical service expenditures would primarily benefit the MCOs.

• Advocates were concerned about timely access to pediatric psychotropic medications, citing problems under the full-risk MC system when each MCO had their own formula.

• DSS summarized the intent of the proposed change that would balance the interest in the positive health outcomes, provide health services that are in the best interest of the patient and a transparent prior authorization system. DSS stated the definition change is not intended to interfere with practitioners’ decisions, but gives DSS a framework within which to manage the HUSKY program through a process that allows use of new clinical management strategies.

• DSS will seek ‘stakeholder’ input into the development of clinical management strategies that would improve the level of care and health outcomes.

• Council Legislators requested DSS capture authorization/appeal data under the current definition and new one (if adopted) and develop a plan for Agency response if a deleterious impact on clients is detected under the new definition.

_HUSKY Outreach (May)_

In response to Council questions, DSS stated that the HUSKY outreach contracts will end 5/30/09 with no financial provisions to continue these contracts. Community-based organizations continue to assist members with HUSKY applications, FQHCs receive dollars for general Medicaid outreach and HUSKY Infoline assists callers with HUSKY enrollment issues. While an evaluation plan was in place at the start of the DSS outreach contracts, financial resources for system support of the evaluation were not available.

_CHIP Reauthorization (CHIPRA) state eligibility bonus (June)_

States may receive a federal eligibility bonus under the recent CHIPRA act passed by Congress and signed by the President that reauthorizes the Children’s health Insurance program. States have to meet 5 criteria to be eligible for the grant; CT would need to add several criteria such as simplification of the eligibility process and reinstatement of children’s continuous eligibility for 12 months in order to qualify for the grant. Mary Alice Lee asked DSS if the administration was planning to implement such changes to qualify for the $5M grant. DSS stated it is not part of their work plan given that there is no final state budget and significant DSS staff losses due to retirement incentive. Dr. Lee suggested the legislature does need to look at this as part of the biennial budget.
Special Reports

CT Health Foundation: Impact of proposed budgetary HUSKY cost share on enrollment & elimination of legal emigrant state-funded health care. (May)

HUSKY Cost Share

Patricia Baker, President & CEO of the CT Health Foundation presented the findings of a research paper by Professor Jack Hoadley of Georgetown University that CTHF commissioned:

- HUSKY copayments proposed in the Governor’s budget could, as other states have found, lead to members foregoing needed services including pharmacy that could result in higher level of care costs. Copayments could reduce Medicaid provider payments if the Medicaid service rate deducts the copay from the base rate, creating a disincentive for practitioners to participate in Medicaid.

- Once CMS guidance regarding the stimulus bill enhanced FMAP was released, the Governor’s office rejected the budget proposal for Medicaid premiums.

Council members cautioned that co-pays for pediatric services (copays for well visits are excluded) will create a significant barrier for child/youth access to health care including school based health centers.

Lawfully residing immigrant health care is state-only funded for 6000 individuals. The CHIPRA now provides federal match (FMAP @ 65%) for immigrant children and pregnant women (CT numbers - 2,500). The Governor’s proposed budget eliminates all but emergency care for the children/adults in this population while the Legislative Appropriations Committees recommends covering the CHIPRA subpopulation. The research paper estimated that:

- $1 cut from prenatal care results in $3.33 more in postnatal costs and $4.63 more for other childhood services. While the legal immigrant woman is not eligible for Medicaid during the time period, their newborn, as a US citizen, will be eligible for HUSKY.
• Elimination of basic health care for this population that is legally present in the CT would reduce their primary care and prenatal care use, resulting in higher levels of care emergency costs.

Resolution of issues raised in the report will reside in the final biennial budget.

Yale University Graduate Projects

Two graduate schools at Yale University agreed to work with the Medicaid Council and Subcommittees on two projects, the outcomes of which were reported to the Council in April & June.

Chlamydia Screen Media project (APRIL) was done by four graduate students at the Yale School of Management School ((Megan Gagnon, Rebecca Lehrer, Adam Stone, Catherine Swick) with the Quality SC team (Susan Lane (PPCT), Heidi Jenkins (DPH, Deb Poerio (SBHC), Deb Crane (FQHC). The media project developed a ‘doable’ social marketing framework that targets young males 15-25 years, the goal of which is to increase awareness of Chlamydia as an STD, the relative ease of testing (urine test) and treatment (oral antibiotics). The Yale team tested public message ideas with representative groups, included their reactions in the final marketing report along with cost projections from low to high for marketing activities. The Quality Subcommittee and DPH will work to further address Chlamydia screens, treatment and follow up in HUSKY managed care with a practitioner clinical advisory, HUSKY MCO base line data reports and DPH media campaign based on the graduate student recommendations.

Medicaid Managed “Care Report Card” project (MAY) was presented by Yale School of Public Health MPH candidates Tina Edgerly Cheatwood and Michelle Salob, N.D. This project was phase two of a 2007 project that indicated a Medicaid “report card” was feasible in CT. This project creates a template for a single source of managed care performance reports to inform beneficiaries and policy makers about the HUSKY program. Three types of reports with identified data collection methods, data limitations and statistical significance of trends can provide MCO performance information. Posting this information on the DSS website would allow interested stakeholders to obtain more detailed information on a particular indicator of interest. The Yale Team suggested a three-step approach toward achieving an end goal of creating a comparative Medicaid ‘report card’. The first step would be ‘dashboard’ reports that have panels of key performance indicators and consider statistical significance of performance differences and data trends. Council members were very interested in this approach that displays performance data on-line and provides an opportunity to standardize and integrate a data process with other state agencies such as Dept of Public Health. Pat Rehmer (DMHAS) described such an effort through the SAMHSA Transformation grant that focuses on developing a pilot multi-agency data interoperability process. Tina Edgerly Cheatwood will be available to work with the Quality Subcommittee in June/July to complete the project.
Council Subcommittee Reports

**Quality Assurance:** Paula Armbruster, Chair, Deb Poerio, Vice-Chair

Focus areas include: DSS/MCO 2009 Quality Strategic plan indicators, baseline data and percentage improvements over 2-3 years, STDs - media campaign, provider clinical advisory for screening, treatment and follow up, & developing baseline data for Chlamydia & gonorrhea screens in HUSKY, creating HUSKY data dashboard & annual Medicaid MCO performance report card.

**Women’s Health:** Amy Gagliardi, Chair; Abby Watrous, Co-Chair

Women’s Health May 2009 forum focused on perinatal depression screening, referral, treatment. The Subcommittee will present recommendations to the Medicaid Council based on the forum.

**PCCM:** Rep. Toni Walker & Ellen Andrews, Co-Chairs

The Subcommittee developed a draft Subcommittee “purpose” statement and reviewed PCCM materials from DSS.

**Consumer Access:** Christine Bianchi & Marjorie Eichler, Co-Chairs

Focus areas include future access to HUSKY including on-line applications, presumptive eligibility for pregnant women, citizenship documentation under the CHIPRA, family planning waiver status and provider pharmacy survey (ease of use of Medicaid preferred drug list system) and ad hoc report on members that do not receive a temporary drug supply when a refill script is made without the required prior authorization secured by the provider. DSS EDS does not follow up with the provider; the local pharmacy has to contact the prescribing provider.