

# Connecticut Medicaid Managed Care Council

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## Quarterly Report: 3<sup>rd</sup> 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 **July through September 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 ( 17b-28b). 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.*

The Council met twice in the 3<sup>rd</sup> Quarter of 2009: in July and September 2009. The meetings focus on utilization data, programmatic items and HUSKY & Charter Oak Health Plan (COHP) enrollment.

### Utilization Reports

#### Dental Utilization Sept – Dec. 2008 (July MMCC meeting)

BeneCare assumed management for Medicaid and SAGA program dental services as a non-risk Administrative Service Organization on September 1, 2008. What this means:

- The HUSKY A & B managed care organizations (MCOs) no longer have responsibility for member dental care/expenditures.
- The CT Dental Health Partnership (**CTDHP**) now manages SAGA dental services and for the first time Medicaid Fee-for-service dental care is being managed.
- Dental services are not a covered benefit in Charter Oak Health Plan.

Dental expenditures over **four months** from Sept. to Dec 2008 were:

- \$25M for children under 21 years: 93% of the dollars (\$23M) was for HUSKY A. Over the 4 months 25% of enrolled HUSKY A children received 'any' dental service, 15% preventive 'services and 7.6 treatment interventions.
- Adult dental care totaled \$14.5M: 49% for HUSKY A adults, 17% for SAGA and 34%

for FFS adults.

- CTDHP dental provider rates range from 89 -93% of commercial payer rates.
- Safety Net (I.E. federally qualified health centers, hospital clinics & school based health centers) expenditures in CTDHP decreased from \$6M in Sept to \$2M in Dec. 08. DSS attributed this change to growth of independent dental practitioners in the network. From May to June 09 dental network participation increased 4.4%. There is now a total 924 practitioners enrolled in the CTDHP.

DSS, CTDHP and MCOs have begun a prenatal dental outreach program to women in their 1<sup>st</sup>/2<sup>nd</sup> trimester that have not had dental services in the last 6 months. Aetna is the first MCO to work with CTDHP in the project.

### SAGA Service Utilization (July meeting)

DSS reported State Administered General Assistance (SAGA) annual utilization at the May Council meeting and in July responded to Council requests that included:

- 11% SAGA expenditure increase over the past 3 years; this increase is attributed to increase SAGA enrollment (12% increase in 2009 compared to 2008) and increased Medicaid provider rates implemented in the 2007 biennial budget. While the over all program costs increased, the per member per month (PMPM) expenditures actually showed a slight decrease (0.6%) in 2009 compared to 2008.
- DSS reported that SAGA dental expenditures increased significantly from 2007 (\$2.9M) to \$9M in 2009; however SAGA dental expenditures in SFY09 represent about 4.7% of the total SAGA expenditures.
- SAGA ED use decreased from 73% in 2005 to 71.7% in 2008. The Council commended the work of CHNCT (MCO manages ambulatory services) and DSS in overall reduction of ED use in this program. Sen. Harp asked DSS to look at the ED 'high utilizer' data in order to identify structural changes needed to reduce this sub-population's frequent ED use.

### **Program Reports**

#### HUSKY

- *Revenue/Expense report 2008(Sept. meeting)*

During CY 2008 the HUSKY A & B program delivery model was a non-risk Prepaid Inpatient Hospital Plan (PIHP) January thru August 2008 with ~ 40,000 HUSKY fee-for-service members. Beginning in September 2008 three managed care organizations (MCOs), Aetna Better Health, AmeriChoice (new to HUSKY) and CHNCT signed contracts with DSS as risk-based organizations. Discussion points included:

- DSS would need to do an in depth analysis to determine the cost difference of the two models.
- DSS did not have a comparison of HUSKY fee-for-service (default system for new members/county during the roll out and non-plan choosers throughout the PIHP era) costs nor details of the HUSKY FFS PMPM expenditures.
- Combined total expenses for both delivery models was \$717,923,322, total

revenue was \$719,108,800 with 3,468,885 member months. The report showed PMPM expenditures as:

- PIHP PMPM - \$209.30
  - Capitated (4 months) PMPM - \$185.89
  - Combined CY PMPM - \$206.96
- The biennial budget for 2010 – 2011 reduces the MCO capitated rate by \$50M. DSS does not plan to re-bid the HUSKY contract, but will negotiate a contract with the MCOs within the context of lower capitation rates in the budget.
  - Beginning SFY 2010 DSS has brought external contracted actuarial and data collection/editing functions into the internal agency units. DSS stated this will provide more complete, reliable claims data that will be used for future rate setting, create program transparency and allow comparisons of HUSKY and Medicaid FFS expenditures.

- *HUSKY A Primary Care Case Management (PCCM) (July & Sept)*

HUSKY Primary Care (HPC) began in the Waterbury area and Windham County in Feb. 2009. There were 165 members enrolled in PCCM July 2009 and 211 in Sept. 2009. A provider RFP was issued for the expansion of the program in Hartford and New Haven areas. The Council's PCCM subcommittee is addressing barriers to low provider and member enrollment in this 4<sup>th</sup> HUSKY A option with DSS.

- *Denials/appeals 2007-2008\_(July meeting)*

The report, requested by Rep. Walker, provides benchmark data for comparison of the impact of changes in the HUSKY 'medical necessity' definition. The report compared 2007 with 2008 member appeals and found:

- A 48% decrease in the number of appeals from 2007 (MCO system) to 2008 non-risk PIHP system. Dental appeals accounted for 1/3 of all denials in 2008.
- 60% of member appeals were upheld at the MCO and DSS hearing level. MCOs may overturn their denial when providers give MCO more information. While providers experience the Medicaid appeal process as more timely than that of private carriers, the Council suggested the MCO should reserve their service authorization decision until adequate medical information is given.
- Overall the number of appeals is small given the HUSKY enrollment numbers; DSS was encouraged to seek other sources of complaint (informal) information from HUSKY Infoline and MCO member Services.

### HUSKY & Charter Oak

- *MCO Provider Network changes*

DSS provides monthly network development reports to the Council. At the Sept meeting DSS summarized the network improvement to date:

- Since 12/08 there has been a 50% increase in provider networks in every County.
- The COHP network is now 66% of the provider network for HUSKY.
- A preliminary total unduplicated provider count is 10,022 with about 2,500

- primary care providers.
- While all CT hospitals (32) have signed HUSKY contracts with MCO, 16 have signed COHP contracts. Some hospitals that do not have medical COHP contracts do accept COHP members for behavioral health services. DSS stated the COHP medical networks are separate from the CTBHP program's network.
- *HUSKY and Charter Oak Health Plan Enrollment July – Sept 1, 2009*
  - HUSKY A total enrollment increased by 5407 members since July; 3018 (57%) are enrollees < 19 years and 2389 are HUSKY A adults.
  - HUSKY B enrollment increased by 268 enrollees.
  - COHP enrollment increased by 1207 members.
  - August had the highest percentage (35.3%) since June 08 of new/renewal HUSKY applications to DSS for Medicaid eligibility determination.
  - HUSKY A default enrollment percentage of new members (failure to choose a plan) increased from 19.45% in July to 21.5% in Sept.

### Charter Oak

- *Annual/lifetime benefits*

At the request of Sen. Prague DSS is looking at COHP options that would allow a member with a serious life-threatening medical condition to have continued access to medical services beyond the point when their annual benefit of \$100,000 is used. COHP members have a \$1M lifetime cap that they currently cannot access when their medical benefit has been used for the remainder of the CY. DSS will request an underwriting analysis of use of a portion of the life time cap and exclusion of specialty drugs from the pharmacy cap (\$7500/CY) for members that are close to exceeding the annual caps. Program changes such as these would increase the monthly premium amount and exceed the budgeted state subsidy for lower income COHP members. Among the current COHP enrollees, one member has exceeded the \$100,000 annual cap and 5 members have expended \$50-60,000 of their annual benefit prior to the close of their CY, based on their enrollment date in COHP.