



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

27 March 1998

Estelle Chisholm
Department of Health & Human Services
Health Care Financing Administration
Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Chisholm:

Enclosed herewith are our responses to the questions posed in your letter of March 18, 1998. Thank you for arranging the conference call on Monday, March 23, 1998. We found the interactions between our two agencies to be helpful in preparing these responses. If you have any further questions, please do not hesitate to contact me at (860) 424-5995.

Sincerely,

Linda J. Mead
HUSKY Plan Project Manager

3.1 How was the Yale Child Study Center chosen for coordination of the HUSKY Plus Behavioral Health Needs? Was a competitive RFP process used? Please describe the process used for awarding this contract?

We based the delivery system on the Title V model which, in Connecticut, contracts with two centers of excellence, the Yale University School of Medicine's Children with Special Health Care Needs Program and the Connecticut Children's Medical Center. Since the Title V program in Connecticut does not currently provide behavioral health services we thought it would be better to pursue a separate contract with a center for the behavioral health part of the program. We looked for an entity similar to the two Title V centers of excellence which focused on behavioral health. We wanted a university-related center which was not an insurance product. Based on our conversations with the Connecticut Department of Children and Families, the Office of Policy and Management and the Department of Mental Health and Addiction Services, we decided that the Yale Child Study Center could best fulfill our need.

The Yale Child Study Center is renowned in the state and has a national reputation for innovative service delivery. Its network will be based on the child guidance clinics around the state, which are supported by the Department of Children and Families and the Department of Social Services. We believe that going with a one year contract with the Yale Child Study Center was crucial to getting our HUSKY Plus program operational.

Please clarify how the care will be coordinated for children covered under HUSKY, Part B, and HUSKY Plus for intensive behavioral health services and/or intensive physical health.

The care coordination between HUSKY Part B and HUSKY Plus is modeled on care coordination in our existing Title V program.

To be eligible for services under HUSKY Plus, the child must be eligible for and enrolled in HUSKY, Part B. If, upon application to HUSKY Plus, the child is found to be eligible to receive services from HUSKY Plus, a care management team will be established for that child. This care management team will consist of HUSKY, Part B, and HUSKY Plus, and the child's parent(s). This will maximize the coordination of benefits under both plans. The care management team will coordinate the development of the treatment plan on an individual basis.

In the event that the child is eligible for HUSKY, Part B and both HUSKY Plus for Behavioral Health and HUSKY Plus for Children with Special Physical Needs, the care management team will include case managers from all three plans and will develop a treatment plan that integrates services from all three benefit packages. All children must be eligible for HUSKY, Part B in order to receive

services from HUSKY Plus. However, these children will be dually eligible. That is, they will be eligible to receive the services provide under both programs simultaneously. They will not need to exhaust their benefits under HUSKY, Part B in order to receive HUSKY Plus services.

Financial risk lies with the plan that is responsible for the services provided. For example, HUSKY, Part B will have final decision making authority for those services for which they are at risk and HUSKY Plus will have the decision making authority for services in which they are at risk. If discrepancies arise the final decision on coverage and liability will rest with the Department.

- 4.3** We understand that you extended your current enrollment broker contract for one year to serve as the single point of entry servicer (SPES). What are the requirements of the contract amendment for the SPES, i.e. geographic locations across State; linguistic capability, training for ethnic/racial and cultural characteristics of potential clients? Will the State use “out-stationed” eligibility workers, access to local community organizations, etc? What are the State’s plans to provide SPES services beyond this one-year period?

The customer service representatives of our SPES will have multiple linguistic capabilities. All materials the SPES uses will be done in both English and Spanish language versions, with the availability of other languages as requested. The SPES will have out-stationed staff at the Department of Social Service regional offices to accept and screen HUSKY applications. The SPES will be required to receive applications for HUSKY by mail, by phone, or in person. All applications will be screened for Medicaid eligibility. The same application form will be used for Medicaid (HUSKY, Part A) and Title XXI (HUSKY, Part B). The SPES will refer all applications that appear to be eligible for HUSKY, Part A to the DSS regional offices. The SPES is also required to perform approximately 100-120 community presentations with the community action agencies throughout the State each month regarding both parts of the HUSKY Plan. During these presentations, applications will be made available and assistance with completing those applications will be given, if needed. The SPES contract will be amended for the period of July 1, 1998 through June 30, 1999. Prior to the expiration of the amended contract period, a competitive procurement will be conducted for future years.

Please provide assurance that the Title XXI State Plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.

The Title XXI State Plan will be conducted in compliance with all civil rights requirements.

- 4.4.1 How does the State’s Medicaid screening meet the minimum screening guidelines described in the outreach letter to State Medicaid Directors of

January 23, 1998? Section 4.3, first paragraph, indicates that “Income will be calculated in the same manner as for poverty level children under Medicaid with the income disregards provided in section 15 of Public Act 97.1. . . Public Act 97.1 only references income disregards for incomes between 235 and 300% of the FPL. Please verify that a test will be used to see who is eligible for Medicaid when income disregards are applied for poverty-level related groups.

Please provide more details on the State’s efforts to ensure that only eligible targeted children are covered.

The State will screen HUSKY applications through the SPES. Staff at the SPES will be trained in the Medicaid (HUSKY A) gross income limits, and applied income limits considering concepts such as, but not limited to, income disregards, and excluded income to ensure that Medicaid eligible children who apply for HUSKY are properly identified and referred to DSS to be granted Medicaid. HUSKY applicants will also be screened by the SPES for potential Medicaid eligibility under spenddown if family income exceeds 185% of the Federal Poverty Level and there exist unpaid medical bills for the family sufficient to meet the spenddown. If the family chooses to be eligible for Medicaid under spenddown, the SPES will refer the application to DSS for Medicaid processing. The SPES will retain all other HUSKY applications and process eligibility for HUSKY B (Title XXI). Conversely, if a family contacts DSS first to apply for HUSKY, DSS staff will screen for Medicaid eligibility as they currently do. If the child is not Medicaid eligible, including being eligible for Medicaid as a spenddown, DSS staff will refer the application to the SPES for potential processing for HUSKY B (Title XXI). DSS staff will be trained in the HUSKY B (Title XXI) requirements so they can properly identify such applications.

Please describe how the State will ensure that children who are determined to be Medicaid eligible will be enrolled in the Medicaid program (rather than simply referred to the Department of Social Services) and the timing involved in this process. If, after the child is referred to the Department of Social Services, she/he is found to be ineligible for Medicaid, how will the child be enrolled in HUSKY? How much time is involved in this entire process?

DSS through its Organizational and Skill Development Unit and its Family Support Team will train both DSS and SPES staff in the requirements for both HUSKY A (Medicaid) and HUSKY B (Title XXI) so children are correctly granted HUSKY.

A simplified, two page double sided, application form has been developed for use for all HUSKY applicants, both HUSKY A (Medicaid) and HUSKY B (Title XXI). When the SPES receives a HUSKY application and it becomes clear that eligibility only exists for Medicaid, the SPES will refer the application to the

appropriate DSS office for Medicaid processing. Benova will send the application electronically to their outstationed worker at the DSS regional office, who will forward it to a DSS worker for a determination of HUSKY, Part A eligibility.

The HUSKY application process is being designed so that it will be seamless to the applicant. The referral of the application from the SPES to DSS will be the responsibility of the SPES so that the family receives the program they are eligible for. The family will not be responsible for making a second application at the local DSS office if they have already filed a request for HUSKY at the SPES. Conversely, DSS will also be responsible for referring applications it receives to the SPES when a family has been screened for HUSKY A (Medicaid) and it appears that eligibility only exists for HUSKY B (Title XXI).

A standard of promptness (SOP) will be followed by the SPES to act on all HUSKY applications it receives. For applications received by the SPES that are identified as being HUSKY A (Medicaid) applications, all SOP and other processing rules for the Medicaid program will apply to the that case.

Please clarify how the State's presumptive eligibility process will work and who will be enrolling children in Medicaid under a presumptive eligibility determination. The first paragraph on page 8 indicates that "The SPES will be responsible for making a preliminary determination of eligibility under Part A...and enrolling eligible children under Part a and B into an MCP." Please be aware that a private contractor (such as the SPES) is not allowed to enroll children into Medicaid under a presumptive eligibility determination.

Presumptive eligibility is targeted to begin for only HUSKY A (Medicaid) cases effective 7/1/98. The SPES will not be making presumptive eligibility determinations. Initially, only DSS will be making presumptive eligibility determinations for HUSKY A (Medicaid). As the SPES refers a HUSKY application to DSS to process for HUSKY A (Medicaid), DSS will immediately review the case for potential eligibility under presumptive eligibility. The SPES will do an initial screen for HUSKY A (Medicaid) on all HUSKY applications, but this does not include the granting of HUSKY A or the granting of presumptive eligibility.

As staff are trained on presumptive eligibility and DSS gains experience and knowledge, the Department will develop a plan to allow qualified entities to do presumptive eligibility for HUSKY Part A.

- 4.4.3** How will the SPES determine if an applicant or employer terminated dependent coverage due the availability of the HUSKY Plan? Do the crowd-out strategies discussed in this section apply only to Part B? The State should include a detailed description of its strategy to reduce the potential for

substitution for: 1) HUSKY, Part A if older children under Medicaid are covered as optional targeted low-income children; and 2) HUSKY, Part B. (See letter to State Health Officials dated February 13, 1998.)

Children will not be eligible for HUSKY Part B if they have medical insurance or were insured within the previous six months. The SPES will collect information about employers and will contact the benefits managers of employers in 20% of the cases to verify the lack of insurance coverage for children of the applicant. At the three-month point we will evaluate the results of the verification and will increase or decrease the size of our sample accordingly.

The crowd-out provision does not apply to HUSKY Part A (Medicaid).

5.1 Please describe in greater detail the State's outreach and education efforts, as well as coordination efforts, with the State's Native American tribes.

Connecticut has two federally recognized tribes. Another tribe is currently in the process of applying for federal recognition. Connecticut also has other state recognized tribes.

We are working directly with the two federally recognized tribes in coordinating outreach efforts. These federally recognized tribes have resources to help us reach out to and educate all the tribes in the state about the HUSKY Plan. We have a meeting scheduled with them on April 9, 1998 to discuss outreach plans and how we can work in coordination with each other.

In addition, Connecticut also has the State Indian Affairs Council, which includes representatives from the state tribes. We will schedule a meeting with the Council to discuss how they could be involved in the outreach effort.

7.1 Which agency is responsible for monitoring the quality of MCPs?

The Department of Social Services is responsible for monitoring the quality of the MCPs. We contract with an external entity, the Connecticut Peer Review Organization, to perform quality review and report back to the Department.

7.2 In Section 7.2, the State indicates that enrollment will be suspended if a plan's network capacity is exceeded. Please describe how the state will assure 1) that individuals will continue to have the freedom to choose plans (under HUSKY, Part A) if such a capacity problem arises; and 2) that, overall, there will be sufficient capacity to serve both the Title XXI and additional Medicaid populations, which the state is estimating to be more than 80,000 children.

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Based upon our intent to have multiple MCOs participating in HUSKY, all enrollees in the HUSKY Plan will have freedom of choice when choosing a health plan.

Our present procedure for monitoring capacity in our HUSKY A program is to require monthly reporting from the plans on certain categories of providers. We then use an algorithm to determine the number of clients the providers are serving. When a plan goes over 90% of capacity, they get a warning letter instructing them to increase their provider network or we will freeze their enrollment. If they stay above 90% or go higher their enrollment will be frozen and our enrollment broker will be told not to allow any further enrollment into that plan. Obviously, during the time the enrollment is frozen for a plan, clients are not allowed to choose that plan. With multiple plans participating, even if enrollment in one plan is closed, there are still choices for our clients.

When the plan signs on more providers, enrollment is once again open. In the past these situations where we have had to close enrollment have been resolved in a matter of weeks through the addition of more providers to their panel. This system has proven to be effective and we expect to continue this in HUSKY Part A, where we have seven plans available, and will use it for HUSKY Part B, where we expect to have three to four plans available. There is currently excess capacity for services for children in our HUSKY, Part A plans.

8.2 Please clarify how care delivered under both HUSKY, Part B and HUSKY Plus will affect cost sharing limits and describe how the copays will be monitored and tracked.

Cost sharing applies only to HUSKY, Part B. There is no cost sharing in HUSKY Plus. The copays will be monitored and tracked by the MCOs. The MCOs will report these payments to the SPES for tracking purposes on a monthly basis. Once a family has reached their cost-sharing maximum, the MCO will notify the family that premiums and copays are no longer required for the remainder of their enrollment period. The SPES, while tracking the cost sharing, will monitor to insure the MCOs discontinue the collection of premiums and copays once a family has reached their maximum

8.3 Section 8.4.2 indicates that no cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. Section 5(a)(1) on page 6 of the House Bill 8601 indicates that there will be no copayments for preventive care and services. However, Appendix 6.1, page 2, Preventive Care section indicates that “Periodic and well-child visits, immunizations, WIC evaluations, and prenatal care are covered in full with \$5 copay on other visits.” Please clarify what “other visits” are subject to the \$5 copay and that no copays will be assessed for preventive care for well-child care and age-appropriate immunizations.

No copays will apply to preventive care, including age-appropriate immunizations, well-child care, dental/sealants and exams, nor for inpatient physician and hospital, outpatient surgical, ambulance, skilled nursing, home health, hospice and short-term rehabilitation and physical therapy, occupational and speech therapies, lab and X-ray, preadmission testing, prosthetics, durable medical equipment, and dental exams.

The \$5 copay for “other visits” that is listed under Preventive Care in Appendix 6.1, does not refer to preventive care. It is for care during visits when a child is sick, i.e. a child has an earache and the mother brings the child in for an examination. Five dollar copays apply to outpatient physician visits, eye exams, hearing exams, nurse midwives, nurse practitioners, podiatrists, chiropractors, and naturopaths.

Appendix 6.1, page 4, Emergency Care section indicates that emergency care is covered “100% if determined to be an emergency in accordance with state law. **\$25** copay waived if the patient is admitted.” Please verify that the **\$25** copay for emergency room visits will be waived if the visit constitutes an emergency, in accordance with state law, regardless if it is treated through an inpatient or an outpatient visit. Please recognize that **\$10** maximum copayment for inappropriate use of the emergency room that can be charged for individuals where income is below 150% of FPL.

The \$25 copay will be waived if the visit constitutes an emergency, in accordance with state law, regardless if treatment provided results in an inpatient admission.

- 8.4 Annual aggregate cost sharing for families cannot exceed five percent of a family’s annual income. The State needs to provide assurances and describe how it will monitor the diligence of the MCPs efforts to track cost sharing and assure that cost-sharing charges will not exceed the five- percent maximum.

The maximums for annual aggregate cost sharing in the HUSKY Plan were computed by taking 5% of the lowest income in each of the two ranges: (1) over 185% FPL and up to 235% FPL and (2) over 235% FPL and up to 300 % FPL. For example, five percent of an annual income of \$20,072 for a family of two, which is at 185% FPL, is \$1003. Our plan stipulates that the maximum annual aggregate cost sharing for a family of two in this income range is \$650. Using the same calculation, five percent of an annual income of \$25,497 for a family of two, which is at 235% FPL, is \$1,275. Our plan limits the annual aggregate cost sharing for a family of two in this income range to \$1,250.

The annual aggregate cost sharing will be monitored and tracked by the MCOs. The MCOs will report these payments to the SPES for tracking purposes on a monthly basis.

Please describe the circumstances under which private organizations may subsidize premium payments and how will the State monitor this process.

Other states have been able to garner private foundation money to assist in the payment of premiums on behalf of enrolled clients. Connecticut is leaving the option open to have plans accept foundation money and apply it to the payment of premiums. Prior to the application of any foundation money, the MCO would have to receive approval from DSS in order to guarantee equity and equal access. The State will monitor the premium subsidies by requiring the MCOs to report monthly on the source of the subsidy, the clients and the amount paid.

- 9.3** What process will the State use to consistently measure the percentage of uninsured children in the future? To assess the “reduction in the percentage of uninsured children” (section **9.3.2**), which baseline will be used—10.6%, 5.7%, or something else?

For our original estimate for the number of uninsured children in Connecticut, we used CPAS data. In order to provide consistency, we will continue to rely on CPAS data interval census numbers used by Congress and measure against those interval census data on an annual basis. With regard to the reduction of the percentage of uninsured children, the consistent use of CPAS data will provide us with an overall annual percentage reduction.

- 9.10 The budget submitted appears to account for State funds only. What are the estimates of total spending including the federal share? Please include a complete budget (State and Federal) for the first three years of the program.

See attached.

The budget reflect total computable amounts at the enhanced FMAP with anticipated administrative charges which exceed the 10% limit as set forth in the December 8, 1997 All-State Financial Letter. We are concerned that the State may have miscalculated the amount or erroneously included certain expenditures in excess of the 10% limit, which are ineligible for Federal reimbursement. This situation would occur regardless of whether outreach function **3420** and **3430** are included as programmatic expenses or administrative charges. Please verify the budget to reflect administrative costs within the 10% statutory limit.

The Department has attached 3-year budgets for both state fiscal year and federal fiscal year starting with 1998.

We have acknowledged that the allowable administrative cost for FFP is limited to 10% as noted in the statute. Administrative costs over and above the 10% limit in Title XXI may be charged to Title XVIX (as applicable).

Please describe how the State can identify the clients with family incomes over 300% FPL who will buy-into the HUSKY coverage. This data must be extracted from the claims for FFP and enhanced match under Title XXI.

Clients above 300% FPL will be responsible for the entire premium payment, with no subsidy from the State. In turn those clients will not be included in the claims for FFP under Title XIX or Title XXI.

The SPES will be responsible for enrolling all clients into the MCOs participating in the HUSKY A and B programs. The SPES will track and report, through information on their system and information provided by the MCOs, the individuals enrolled on a monthly basis, those clients in HUSKY Part A, HUSKY Part B (over 185% FPL and up to 235 % FPL), HUSKY Part B (over 235% FPL and up to 300% FPL), and HUSKY Part B (over 300% FPL).

SUMMARY OF HUSKY INITIATIVE BUDGET - FFY 1998-2000

	Account	Function	FFY 1998	FFY 1999	FFY 2000
HUSKY Program, Part B					
Primary Medical Services	040	3280	528,020	9,690,867	16,201,180
HUSKY Plus Special Services	040	3410	1,887,500	5,000,000	5,000,000
Subtotal - HUSKY Program Svcs.			2,415,520	14,690,867	21,201,180
Administrative Expenses					
Personal Services	040	3400	203,586	353,061	366,137
Other Expenses	040	3400	604,838	555,000	555,000
Quality Assurance	040	3400	50,000	200,000	200,000
Enrollment Broker (OE)	040	3440	1,249,176	1,640,000	1,640,000
Outreach	040	3420	331,250	793,750	1,000,000
School Based Child Health-Outreach	040	3430	150,000		-
Equipment	040	3400	13,125	-	-
Subtotal - HUSKY Administrative			2,601,974	3,541,811	3,761,137
Total - HUSKY Part B			5,017,494	18,232,678	24,962,317
Medicaid Expansion, Part A					
Primary Medical Services	602	3280	1,929,638	3,799,840	3,262,225
Administrative Expenses					
Personal Services	001	5900	362,759	842,012	873,198
Other Expenses	002	3400	112,500	360,000	360,000
OE-Outreach	002	3420	212,500	550,000	550,000
OE-Enrollment Broker	002	3440	548,080	850,000	1,000,000
Equipment	005	3400	85,488	10,000	10,000
Subtotal-Administrative			1,321,327	2,612,012	2,793,198
Total-Medicaid HUSKY Part A			3,250,965	6,411,852	6,055,423
Total-All			8,268,459	24,644,530	31,017,740

Based upon the above expenses, our estimated Title XXI 10% administrative share would be \$482,795 in **FFY 98**, \$2,054,523 in **FFY 99** and \$2,718,156 in **FFY 2000**. The balance of these administrative expenses would be reimbursable at 50% in Title **XIX**.

*Does not include additional Medicaid expenditures anticipated to result due to HUSKY outreach activities which will draw in currently Title **XIX** eligible clients who are not yet enrolled.

SUMMARY OF HUSKY INITIATIVE BUDGET - SFY 1998-2000

	Account	Function	SFY 1998	SFY 1999	SFY 2000
<u>HUSKY Program, Part B</u>					
Primary Medical Services	040	3280	-	6,864,261	15,097,063
HUSKY Plus Special Services	040	3410	850,000	5,000,000	5,000,000
Subtotal - HUSKY Program Svcs.			850,000	11,864,261	20,097,063
Administrative Expenses					
Personal Services	040	3400	155,214	348,702	366,137
Other Expenses	040	3400	621,450	555,000	555,000
Quality Assurance	040	3400	-	200,000	200,000
Enrollment Broker (OE)	040	3440	1,118,901	1,640,000	1,640,000
Outreach	040	3420	200,000	725,000	1,000,000
School Based Child Health-Outreach	040	3430	200,000	-	-
Equipment	040	3400	17,500	-	-
Subtotal - HUSKY Administrative			2,313,065	3,468,702	3,761,137
Total - HUSKY			3,163,065	15,332,963	23,858,200
<u>Medicaid Expansion, Part A</u>					
Primary Medical Services*	602	3280	1,069,930	3,301,837	3,092,012
Administrative Expenses					
Personal Services	001	5900	206,473	831,617	873,198
Other Expenses	002	3400	30,000	360,000	360,000
OE-Outreach	002	3420	100,000	550,000	550,000
OE-Enrollment Broker	002	3440	464,107	800,000	1,000,000
Equipment	005	3400	110,650	10,000	10,000
Subtotal-Administrative			911,230	2,551,617	2,793,198
Total-Medicaid			1,981,160	5,853,454	5,885,210
Total-All			5,144,225	21,186,417	29,743,410

Based upon the above expenses, our estimated Title XXI 10% administrative share would be \$213,326 in SFY 98, \$1,685,120 in SFY 99 and \$2,576,564 in SFY 2000. The balance of these administrative expenses would be reimbursable at 50% under Title XIX.

*Does not include additional Medicaid expenditures anticipated to result due to HUSKY outreach activities which will draw in currently Title XIX eligible clients who are not yet enrolled.