

November 4, 2004

David Parrella
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Department of Social Services
25 Sigourney Street
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Re: **Proposed Changes to the Connecticut Medicaid Managed Care 1915(b)Waiver (HUSKY A) and SCHIP (HUSKY B) State Plan** published in the Connecticut Law Journal
October 26, 2004

Dear Mr. Parrella,

On behalf of the over 300,000 HUSKY A recipients who comprise a class certified by the United States District Court District of Connecticut in Carr v. Wilson-Coker, No. 3:00 CV1050 (AWT), we submit these comments concerning the Waiver Amendment (hereafter "carve-out") proposed by the Department of Social Services. Our detailed comments are below. In summary, although it is not possible to comment comprehensively in the absence of detailed financial information including the proposed fee schedule, plaintiffs believe that the proposed carve out will not have the desired beneficial effects-- because of the absence of adequate funding. Instead, the dental carve-out will perpetuate the inadequate access and low services utilization that characterize both the Medicaid managed care and fee-for-service systems, will consign Medicaid recipients to yet another defective program, with the same negative consequences for their health and daily lives, and will not comply with federal law.

Comments

1. Reimbursement Rates

DSS' September 17, 2004 presentation to the Medicaid Managed Care Council and the HUSKY A Waiver Amendment released October 26, 2004 propose that the new proposed dental fee (reimbursement rate) schedule be based on a weighted average of the HUSKY MCO reimbursement rates. The MCO rates were only slightly above or identical to DSS' fee for service rates. These rates have not been raised since 1993 for children (and since 1989 for adults). DSS has conceded for years that its low reimbursement rates are a fundamental impediment to achieving the participation of a sufficient number of dental providers. Clearly, changes fail if the need for adequate funding is ignored. In 1995, DSS switched most children and families to managed care, and simply folded into the MCOs' "per member per month" rate

the same amount DSS had been spending in the fee for service Medicaid program. The predictable result occurred. There was no improvement in children's dental care utilization rates in Medicaid managed care. In fact, as shown on the state's annual reports to the federal government, children's dental care utilization rates in Medicaid managed care declined. The children's preventive dental care utilization rate was 29.7% in 1997, and it subsequently fell to 25.5% in 2003.¹

Actuarial experts retained by the plaintiffs in Carr estimated in 2002 that, in order to increase the availability of dental providers so as to support significantly increased utilization levels and thus to comply with federal law, DSS would have to increase its funding for dental services by at least 300%. Robert Hoyer concluded that in order to attract sufficient dental providers and to allow for increased utilization approaching commercial utilization rates (which would require access to care equal to that of the general population with insurance, the legal standard for equal access under Medicaid law), a funding increase of over 350% would be required. (This result excluded the impact of pent-up demand.)

Since 1995 DSS has allocated approximately \$7-8 per member per month (pmpm) of the capitation payments made to the MCOs for dental services under the Medicaid managed care program. The proposed Waiver Amendment indicates that the dental carve-out will be budget/cost neutral, i.e., DSS does not intend to allocate any additional funds beyond \$7-8 pmpm. Sandra Hunt, creator of the "Milbank Model"², concluded that the adjusted per member per month costs for **appropriate** levels of dental care utilization, using reasonably market-based fee levels, range from \$14.99 to \$18.42 pmpm without considering pent-up demand, and from \$24.48 to \$30.19 pmpm with pent-up demand. Her study indicated that increasing provider payment rates in the Connecticut Medicaid dental program, combined with an increase in dental care utilization to levels recommended by the American Academy of Pediatric Dentists, would require an estimated increase in funding ranging from approximately 309% to 623% of current costs depending on the level of pent-up demand. Dr. James Crall and Dr. Burton Edelstein, both of whom have had extensive experience as providers within the CT Medicaid program and conduct oral health policy and program analysis nationally, have provided sworn expert testimony to the effect that the inability of the HUSKY A fee schedules to cover the costs of providing care inhibited providers' willingness to participate. In fact Dr. Crall's analysis showed that the CT HUSKY A reimbursement rates are considerably less than the 20th percentile of prevailing fees, and generally less than the 10th percentile of regional commercial reimbursement rates. Since the Medicaid program requires providers to accept the program's payments as payment in full, HUSKY A patients, unlike most other patients, must rely exclusively upon the adequacy of Medicaid payments to ensure that dentists are available to them. The inadequacy of payments means that dentists either will not participate in the program or will provide care to only token numbers of beneficiaries.

1 DSS' CMS 416 reports to CMS 1991 through 2003.

2 The Milbank model estimates the cost of comprehensive dental care to the Medicaid child population at market-based rates and at utilization levels recommended by the American Academy of Pediatric Dentistry (AAPD). The model combines historical dental utilization data broken down by dental service components (e.g., oral examination, amalgam, etc.) with projected utilization targets by age group and projected fee schedules to anticipate dental program costs for children.

Even safety net providers, upon which DSS relies as an answer to the shortage of dental care, report that the inadequate reimbursement rates have jeopardized their ability to continue to operate, and to meet client needs. Furthermore, the safety net providers cannot meet the comprehensive needs of their clients because there are an insufficient number of specialists to which to refer them. The proposed carve-out does nothing to address these serious issues.

DSS has stated it will use a weighted average of the MCOs' HUSKY A fee schedules to set fees for the dental carve-out; yet even DSS' own actuaries concluded that these rates are dramatically below market rates. A Mercer analysis in September 2002 found that compared to "commercial charge levels for dental services in the state", the weighted average of the payments to HUSKY providers under the HUSKY A MCO fee schedule is a small fraction of what only 25% of dentists in Connecticut would consider reasonable. Further, the Waiver Amendment includes a projection of only a 5% increase in services utilization, an increase which is highly improbable given the lack of funding investment and will not bring the program into compliance with federal law.

Thus, there is more than ample reason to conclude that the essentially static dental services fee schedule proposed by DSS for the carve-out means that the historically problematic access and poor utilization levels of the previous fee-for-service program and the HUSKY A program will be perpetuated. Once again the state is choosing short-sighted cost savings over the long term savings inherent in investing in adequate oral health care.

2. ASO Model

Simply carving out dental services from the existing managed care program will not solve the dental access crisis. Under the proposed ASO model, DSS will be paying providers within the ASOs' networks under essentially the same fee structure as that in the current HUSKY A program. Therefore the principal difference in the ASO model is simply that DSS will reimburse the ASOs for all services rendered, i.e. dental services are not at risk. This could be a significant advantage, but only if there are providers willing to provide the services.

The ASO model standing alone will not solve the crisis in dental access for Medicaid recipients because there will not be a sufficient number of providers. DSS has selected as the ASOs for the dental carve-out two of the same dental subcontractors, United Health Group-Dental Benefit Providers (DBP) and Doral, which have participated in the managed care program for several years. Both failed to ensure adequate provider networks under HUSKY A. As a result, utilization levels remained alarmingly low.. There is no reason to believe that these subcontractors could achieve significantly improved access and higher utilization when the only change to the delivery mechanism is the elimination of the at-risk arrangement. The experience with Doral, the current subcontractor for HealthNet of the Northeast (which currently operates its dental program under an ASO, non-risk arrangement) has already demonstrated this. Doral's preventive dental care utilization rates for children have never reached 25% in the three years it has participated in HUSKY A, far short of the federal goal of 80%.

3. Network Adequacy

Under the current managed care system, the MCOs' dental care subcontractors repeatedly claimed to have sufficient networks of dental providers. They cited, as the basis for this, having

providers credentialed within their networks, regardless of whether those providers were actually accepting Medicaid patients and providing care. In fact, because of financial constraints providers have either closed their Medicaid practices, instituted rationing mechanisms (limited hours, days, numbers of patients) or maintained lengthy waiting lists. In the proposed dental carve-out DSS has engaged in a flawed ASO selection process which will perpetuate the fundamental deficits of the current system. That is, providers will be “signed up”, but due to their inability to cover costs, will be unable to meet the need for services sought by Medicaid recipients. DSS’ selection process was flawed because the agency chose the lowest cost bid without any analysis of what it would take to attract providers willing and able to provide dental services. Here, DSS is again seeking to institute a system which at best can provide only *theoretical* access to dental care. Without actually determining whether or not a dental provider whose name is on a network provider list is actually providing appointments, the claim of DSS or an ASO that its networks are adequate is hollow.

Furthermore, for years DSS included provisions in its MCO contracts requiring that dental appointments be scheduled within 6 weeks. Not only has this provision been violated regularly, it has also never been enforced by DSS, thus undermining DSS’ credibility regarding ensuring appointment availability, which is the true measure of network adequacy.

4. Appointment Scheduling Assistance

DSS states that in the proposed carve-out the ASO will be responsible for assisting in appointment scheduling for EPSDT services. DSS also requires in its current MCO contracts that MCOs assist in appointment scheduling. Further, federal law requires that DSS provide this assistance to the approximately 200,000 children entitled to EPSDT services. Unfortunately, the MCOs and DSS have interpreted this requirement as merely requiring the provision of a list of ostensible providers within the network to recipients who ask for assistance. As a result of DSS’ and the MCOs’ failures adequately and regularly to monitor whether providers in the MCO networks are actually accepting appointments, this interpretation can not be considered meaningful, or legally sufficient, assistance. Further, DSS never required that the MCOs do more than provide this inadequate assistance. Therefore, the perpetual failure of DSS to comply with this provision of federal law makes insubstantial its claim that the ASO will be responsible for appointment scheduling assistance.

5. Transportation

Since, under the carve-out, non-emergency medical transportation will remain the responsibility of the MCOs, there is likely to be much confusion and difficulty for consumers required to navigate two or three disparate and inefficient management companies. For instance, where a recipient has finally been able to schedule a dental appointment, the recipient might understandably but incorrectly make a transportation request to the ASO, which refers the recipient to the MCO, which then bumps the caller to the transportation vendor. This is likely to result in confusion and delay, if not an outright inability to keep a hard-won dental appointment. At the very least, when a recipient requests medical transportation for a dental appointment, the ASO should be required to directly contact the transportation vendor to arrange for and ensure the transportation.

6. Lack of Consumer Involvement

Inexplicably, DSS allowed for no involvement of consumers or advocates in the design of the dental carve-out and the selection of the ASOs. Public participation could have resulted in identifying and trouble-shooting potential problems and solutions, and thus have increased the confidence of recipients, and the public, in the program. Instead of a constructive engagement with the countless members of the public, public health, oral health and Medicaid advocacy communities who are committed to improving this important program, which engagement might have resulted in a truly feasible program and an end to 4 years of litigation, DSS conducted a closed-door, narrowly-conceived process which ignored the many problems identified over the years by a multitude of legitimately concerned parties. This means that yet again DSS intends to embark upon a health program experiment, involving the most vulnerable citizens, which is doomed to fail, and which will unnecessarily prolong the litigation against the Department.

7. Lack of Detailed Information Regarding Fees

Since the waiver amendment does not include such critical information as the proposed dental provider fee schedule, it is impossible to comment comprehensively on the proposal. Therefore we request that the comment period be extended to allow a fair and reasonable opportunity to comment on such an important and far-reaching alteration of the state's major health insurance program for low-income people.

All of the above comments are consistent with and elaborated upon in the Carr v. Wilson-Coker Plaintiffs' Motion for Partial Summary Judgment and Statement of Facts filed with the court on June 19, 2003.

Plaintiffs' counsel in Carr remain willing to discuss these matters with the Department and counsel from the assistant attorney general's office. Thank you for your attention.

Sincerely,

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