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December 23, 2008

**By Fax and Regular Mail**

Diane Heffron, Acting Director  
Center for Medicaid and State Operations  
Family and Children's Health Programs Group  
Center for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850

**Re: Connecticut DSS's Request for Permission to Force Medicaid Recipients to Enroll in New Managed Care Organizations With Inadequate Provider Networks**

Dear Ms. Heffron:

On December 19, 2008, Michael Starkowski, the Connecticut Department of Social Services Commissioner, wrote to you accepting all of the conditions in your December 5, 2008 letter to him regarding a Medicaid managed care waiver extension. However, he argues in that letter that network capacity in the two new Medicaid Managed Care Organizations (MCOs) is sufficient to justify forcing approximately 138,000 vulnerable children and their parents to leave the well-functioning Anthem Blue Care Family Plan and to join one of the three capitated MCOs, including the two new MCOs you previously found to be inadequate, effective February 1, 2009. Because that letter leaves open major questions about the sufficiency of those networks, and because DSS has not met its burden to affirmatively demonstrate to CMS complete network sufficiency, **we urge you to deny DSS permission to issue letters to all of these 138,000 enrollees** right after Christmas (no later than December 29) advising them that they must choose a new plan in January.

A copy of our December 16, 2008 letter, addressed to Associate Regional Director Rich McGreal, and copied to you and Commissioner Starkowski, is attached. That letter raised a set of serious concerns with DSS's methodology used to reach its conclusion, presented at the December 12th meeting of the Medicaid Managed Care Council, that the individual provider networks of the two new MCOs were sufficient to force this major change on all Anthem enrollees, especially given the publicly-stated willingness of the Anthem plan to continue administering the HUSKY (Medicaid and SCHIP) program on the current non-risk basis indefinitely. The Commissioner's December 19<sup>th</sup> letter leaves most of these concerns completely unanswered while raising new ones.

**1. DSS provides no explanation justifying its use of antiquated cookbook ratios for primary care providers,** relative to the requirement of federal law that services must be available to Medicaid enrollees “at least to the extent that such care and services are available to the general population in the geographic area,” 42 U.S.C. § 1396a(a)(30)(A). These ratios used by DSS are not based on the actual needs of this population, nor on any comparison with the access for “the general population.”

**2. There are serious deficiencies in DSS’s analysis even under its inappropriate cookbook formulas.** Even if the application of these ratios were permissible under federal law, those cookbook standards have not yet been met for each MCO. Although the **totals** appear to exceed the number of HUSKY enrollees in each county, those totals are largely based on the capacity of Community Health Network of Connecticut (CHNCT), the already-established non-profit MCO that has been part of the HUSKY program for over 12 years. But DSS intends to move the Anthem enrollees into all three MCOs, including the very large percentage who “default” in response to the planned December 29<sup>th</sup> notices, disregarding the federal law requirement that **each** MCO have sufficient network capacity prior to enrollment.

First, DSS apparently counts the providers in either of the new MCOs (or CHNCT) who **also** participate in one or more of the other plans exactly the same as it counts providers who only participate in one such plan. For example, based on this methodology, DSS counts a provider participating only in the Aetna plan the same as a provider participating in Aetna plus both AmeriChoice and CHNCT. In this way, a provider can be double or even triple-counted in determining “capacity” for HUSKY enrollees in a given county.

Second, DSS’ cookbook formula is applied to every primary care provider listed by any of the MCOs, **even if they are not seeing any new patients under the plan in which they are listed.** DSS does not comply with 42 C.F.R. § 438.206(b)(1)(iv), which specifically requires consideration, in assessing adequacy of an MCO’s provider network, of “[t]he numbers of network providers who are **not accepting new Medicaid patients**” (emphasis added). Instead, DSS counts all primary care providers (PCPs) with closed panels the same as other PCPs who are actually taking new patients under a given plan.

We do not know the details, or the results, of any surveys DSS has conducted of the new MCOs’ listed providers to confirm that they are accepting new patients. DSS does not address the provider survey we conducted and sent to DSS (and your agency), showing that significant percentages of listed pediatricians in New Haven and Hartford Counties are not seeing any new patients under the plan under which they are listed. Until DSS discloses the results of its own surveys, if any, and those surveys are found to be adequate for all categories of providers, with any providers with closed panels deleted when determining county network capacity, it is impossible for DSS to demonstrate compliance with 42 C.F.R. § 438.206(b)(1)(iv). As it stands today, the only surveys that have been provided to CMS (at least those made public) are our own, which clearly demonstrate the unwillingness of numerous pediatricians to accept new HUSKY patients

under one (or both) of the new plans, even though they appear in DSS's count under that plan.

Third, federal law provides that, in the context of Medicaid managed care, there must be "adequate assurances" of satisfaction of the equal access provider network standard of 42 U.S.C. §1396a(a)(30)(A) for **all** categories of providers, specifically including "a sufficient number, mix and geographic distribution of providers of services." 42 U.S.C. §1396u-2(b)(5)(B). 42 C.F.R. §§ 438.206(a) and (b)(1)(iii) require that there be an adequate network of **specialists**, as well as of primary care providers. Before forcing the Anthem enrollees out of their current plan, DSS must demonstrate to CMS that the specialists available in the new plans are at least as plentiful and geographically accessible as the specialists available under the current Anthem plan (the Anthem primary and specialty care provider numbers as of October, unrefuted by DSS, are attached).<sup>1</sup> But there is no mention in DSS's December 19<sup>th</sup> letter of the availability of specialists. This omission compromises the goals of Medicaid coverage for children under EPSDT, as well as the federal law requirements under EPSDT, 42 U.S.C. § 1396d(r)(5).

Given the absence of any need related to the Medicaid program (or SCHIP) to force the 138,000 vulnerable HUSKY enrollees in the Anthem plan out of that stable plan, we urge CMS to reject the provider network adequacy analysis DSS produced on December 19th and to deny it permission to send letters to all Anthem enrollees next week requiring them to change plans. CMS should decline such permission until DSS:

- Correctly analyzes network capacity based on the federal statutory standards, 42 U.S.C. §§ 1396a(a)(30)(A) and 1396u-2(b)(5), not on DSS' antiquated formulas, including for all categories of specialists
- Revises its network capacity reports by deleting unavailable listed providers, based on sufficient independent statewide provider surveys verified by CMS
- Analyzes network capacity for **each MCO separately**, avoiding double (or triple) counting of providers and any counting of providers accepting no new patients under a given plan
- Demonstrates sufficient capacity in the new MCOs based on real numbers counting only those providers who will actually see new patients, for primary care providers **and** for all categories of specialists

These concerns are not merely hypothetical. Of the approximately 28,000 HUSKY enrollees who already moved to Aetna and AmeriChoice as a result of DSS's ill-timed letters, many are being confronted with provider access problems already, with the

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<sup>1</sup> The potential availability of out-of-network payment for specialists is insufficient to meet this requirement. The federal regulations only allow this as a satisfactory response where a "particular enrollee" has specialized out-of-network needs, not as a cure for wholesale inadequacy of specialists. 42 C.F.R. § 438.206(b)(4). Apart from its legal impermissibility, the persistent lack of knowledge about the availability of this form of payment among enrollees renders this an impractical solution to the system-wide problem of lack of specialists.

new plans' listed providers, for both primary and specialty care, proving to be unavailable to them. Since the adequacy of the networks has not been established, the remedial conditions set forth in your December 5<sup>th</sup> letter, which DSS has accepted, should also now be implemented without delay.

On behalf of the many HUSKY enrollees we represent who are still in the Anthem health plan, as well as the Traditional Medicaid plan, both of which are stable and have reasonably adequate provider networks, we thank you for your immediate attention to this request and for acting to prevent this difficult situation from becoming far worse.

Respectfully yours,

Sheldon V. Toubman

Encs.

cc: Rich McGreal, Associate Regional Director, CMS  
Governor M. Jodi Rell  
Commissioner Michael Starkowski  
David Parrella, Director, DSS Medical Care Administration