

MEETING SUMMARY DECEMBER 5, 1997

Present: Sen. Toni Harp (Chair), Sen. Edith Prague (Vice chair), Rep. Vicki Nardello, Marie Roberto (DPH), David Parella and Jim Gaito (DSS), Paul DiLeo (DMHAS), Judith Solomon (CHC), Gary Blau and Dr. Marie Casalino (DCF), Jeff Walters, Eva Bunnell, Pat Baker, Bob Gribbons(OSC), Cynthia Matthews, Dr. Leonard Banco, Laraine Milazzo, Lisa Sementilli-Dann, Marilyn McMellon-Cormack. Also present: Barbara Casey (CPRO), Paula Armbruster, Gary Steck, Stewart Greenbaum and Ann Bonney (CAMHCC) Mariette McCourt (Council staff).

DSS Report: Business Cost Proposal Progress

The intent to renew the 1915B waiver authority will be published in the CT Law Journal 12/9/97. This publication will highlight significant changes in the CT Access program; specifically the guaranteed eligibility and new lock-in period for children, retrospective estimates of savings and projected cost effectiveness with projected UPL and rate cell category changes (see Nov. Meeting summary). The current time table for the 1915 B renewal process is:

- * 12/9 - Law journal publication
- * fifteen day public comment period, followed by DSS response to this
- * present to legislature (Committees of Cognizance)
- * final waiver renewal to HICFA

DSS reported that following the November Council meeting in which retrospective and projected cost effectiveness proposals were reviewed, much discussion was generated and policy issues were raised regarding differential rates for specific categories. Given that the national trend is toward separating coverage of Medicaid eligibility from categorical eligibility and the State's goal to bring all children into Medicaid and Title XXI through a single point of entry, with income-based determinations, the question arises about the risks of continuing the rate setting based on historical differences. An example would be one category child's member month(MM) reimbursement at \$140 and another category child's MM at \$60. Would these significant differences promote an outreach selection bias in which the higher reimbursed child would be brought in; thus the dollar differential may send a selection bias message in spite of the state's attempt to eliminate distinctions with the single entry system proposed in the Husky plan. The state has proposed blending some rate categories(see handout) so as to not perpetuate cost differentials for members of the same population; however the risk in doing this may be creating disproportionately higher cost groups.

Another issue that is part of the renewal process is the state's options for guaranteed eligibility and lock-in periods with the challenge of interweaving different "continuous

eligibility" time periods for the Husky part A, B and special needs children (CSHCN). The new congressional Balanced Budget Act (BBA) provides for the new option of granting 'continuous eligibility' (guaranteed eligibility) to children aged 19 yrs or less for a one year period. Hence the Department is considering a one year eligibility and lock-in period. CSHCN would be excluded from the Title XXI state plan program requiring a waiver provision with the option of adopting a one year continuous eligibility, but providing a 30 day free look period and six month lock-in time (1915B designated lock-in). Adults in the program are not covered under the BBA, thus the 1915B six month eligibility and lock-in govern their enrollment. The Department noted that the actual lock-in period with a health plan may be the balance of the time left in the continuous eligibility period as a person may not immediately enroll in a plan at the time they become eligible for the program (either Husky part A or B).

DSS is seeking clarification from HICFA regarding the legal authority to determine options as they move through the waiver process. The present time line for the HUSKY Plus proposal is:

- *develop HUSKY Plus proposal by 12/1 (copies are in LOB RM 3000)

- *15 day review the plan upon receipt of the proposal

- *submission of state plan for actual implementation of Title XXI, which includes a narrative and HICFA forms as well as actuarial information by December 15.

Council Questions Regarding Husky Part A, B and Plus Plan

Council members raised questions related to the above DSS report and these are summarized by content.

financial concerns

- *DSS clarified the dollar amounts for the UPL, at Senator Prague's behest, indicating that the two tables provided in handouts allow one to calculate the total cost for those MM of eligibility for that category (IE in category 1(0-3 months) multiply 16,472 MM X \$1530.44 PM = total cost for this category).

- *In light of the previous Council meeting discussion (Nov.) of health plans' concern about the feasibility of providing services within the proposed UPL, given the perceived narrow inflation trend line rate, Senator Harp questioned if plans and/or actuarial consultants have suggested a different way to develop rates. DSS responded that plans are concerned about the lowering capitation rates in relation to the slowing of the trend line and the increased utilization rates. This may create difficulties in providing service within the cost constraints. DSS stated that actuarial projections are based on data and assumptions about utilization increases and will be outlined in the business proposal. Further, the Department noted that the plans will know that costs related to FQHC and children admitted to inpatient psychiatric care under the state have been removed from the capitation base and plans are not responsible for these.

- *DSS was asked about cost-sharing monitoring in the HUSKY part B and stated that health plans will monitor cost sharing for individual clients and a health care provider would be informed when a member reaches the cost sharing cap for the year. DSS identified need to develop an education system for consumers as part of the HUSKY Plan.

- *Time line for the business proposal was outlined by DSS in that the business proposal phase will be in January, followed by contract negotiations and program implementation by April 1, 1998.

Quality of Care Issues

Senator Harp and Rep. Nardello outlined two possible consequences of inadequate plan capitation rates in which some plans may drop out or plans may offset the lowered costs by reducing services identified by medical necessity or by paying providers less. Loss of plans begs the question of the state's ability to maintain adequate provider networks for service delivery and changes in intensity of service delivery or loss of health providers, secondary to lowered reimbursement rates, will lead to reduced access and quality of care. The legislators asked if DSS has developed any contingency plans to meet these potential problems. The Department indicated that there are no plans at present since the business proposal has not been released and that DSS expects that continued monitoring of access and compliance with meeting the requirements for medical necessity through CPRO will identify trends in changes in care. DSS noted that at a certain, as yet unidentified, level of capitation, quality and access may be adversely affected. It is notable that detection of this remains difficult as health plans, CPRO and DSS attempt to correct the data collection problems which will allow CPRO to move ahead with the data validation study.

In regard to the selection bias described in rate setting for specific categories, Marie Roberto suggested that identification of cost increases related to different levels of care would be helpful in developing cost containment strategies. DSS responded that the main concern is the totality of costs for categorical recipients. Indeed, improvement in data quality is needed in order to assess these issues.

Sen. Prague raised the question of continuity of care with the consumer lock-in time in a plan and what recourse does the consumer have if their health care provider leaves the plan. DSS observed that there is no legal way to keep providers in a plan, although they may have contracts with individual plans. DSS can terminate a health plan's contract or the plan may terminate, without cause, after giving 90 day notice. Termination with cause is subject to contract provisions. Dr. Banco noted that MD's scrutinize the plans they wish to join and patients may have to follow the MD through plan participation if they wish to have continuity of care.

Husky Outreach

Cynthia Matthews questioned how the state plans to reach the numbers of uninsured families. DSS responded that an outreach strategy needs to be developed that involves community involvement, funding and identification of local outreach entities.

Summary of Survey Studies on CT Children's Mental Health System

Ann Bonney, Executive Director of the CT Association of Mental Health Clinics for Children initially brought the CAMHCC survey to the attention of the Behavioral Subcommittee as another perspective on the impact of Medicaid Managed Care on mental health service delivery. This study and the survey of families and providers performed by Citizens for Connecticut's Children and Youth (CCCY) suggested significant access barriers to clinically appropriate, medically necessary mental health services, as determined by mental health providers. The subcommittee recommended the surveys be presented to the Council. Gary Steck, director of Children's Services, CMHA and Stewart Greenbaum, Exec. Director of Mid-Fairfield Child Guidance Center presented the CAMHCC survey and Ann Bonney summarized the CCCY study for Shelley Geballe. Both surveys identified access to care difficulties, especially for

uncommitted children who require DCF-funded services. Specific concerns identified were:

- * differing interpretations of "medical necessity" among plans and providers
- * denial of services that are designated as approved services in the RFP (IE partial hospitalization).
- * emphasis on crisis intervention and brief treatment sessions in a population that often requires longer term therapy secondary to the severity and chronicity of the illness.
- * growing national trend reflected in the HMO's approval for individual RX at the exclusion of the family or social unit the child has been living in and may return to.
- * pharmacological intervention preference by MCO's accompanied by shorter LOS in both inpatient and outpatient clinical sites.
- * lack of clarity of the financial and service responsibility boundaries for the agencies involved in children's care, in particular DCF and the Dept. of Education, which has led to cost-shifting or redundant payment for services to MCO's or agencies and reduced access to services.
- * access difficulties to the grievance process for both clients and providers.

The Council members comments reflected the multifaceted nature of behavioral health problems, some which were preexisting before the conversion to Medicaid Managed Care. The move to managed care has highlighted the need to 1) develop new service models that meet crisis mental health needs as well as those of the chronically ill child who experiences exacerbations of symptoms that require short term intensive therapy and the long term institutionalized client 2) address system level issues involving the statutory responsibility of state agencies in the provision of care, 3) the interface of agencies with MCO's as increasing numbers entitled to specific services are placed in MCO's and 4) the interaction of various state and community agencies with each other and the MCO's in the delivery of care.

Managed care issues also involve the level of expertise within the organization regarding mental health authorization of treatment issues, the reported variability of plan adherence to contract specifications and the quality of data currently providing an incomplete analysis of health plan accountability in service provision.

DSS plans to meet with Child Guidance clinics and DCF, initially, then bring this group together with the health plans to problem solve. A suggestion in the Behavioral Health Subcommittee that system issues be dealt with also merits consideration by the Department. The Behavioral Health subcommittee will continue to work with DSS, CPRO, health plans and providers in developing appropriate process outcomes that can monitor service provision. Senator Harp requested that DSS report back to the Council in January on the progress of addressing the mental health issues and the subcommittees continue to work on access and care delivery issues.

Subcommittee Reports

QA Subcommittee: the committee is in the process of developing a core group of members representative of child and adult health issues within the Medicaid Managed Care system. This group will meet January 22 to begin a collaborative effort with DSS, CPRO, plans and providers to identify target populations and treatment outcome indicators. Additionally, Behavioral Health, QA, DCF, DSS, CPRO and Sen. Harp have met with Professor Kazdin at Yale University to develop a study of "what really works in children's mental health".

Behavioral Health: the Methadone standardized form was completed at the last meeting

with primary help from Jill Benson(Pro Beh Health) and greater participation of health plans. The form will be presented to the subcommittee on Jan. 28, then the full Council. A subcommittee presentation of the effect of SSI reevaluations on children, especially those with behavioral health diagnoses, identified the need for a state agency to assume the responsibility of educating families about the appeal process and the Governor has agreed to identify an agency to follow up with families who are to be reevaluated for SSI benefits.

Access/EPSTD: plans to meet December 10, 1997.

Public Health: the committee has begun discussions of voluntary Community Benefits programs for HMO's to improve the health of the community. The January meeting will include this and an update of the Safety Net Provider Survey.

Other Items

Sen. Harp brought the Council's attention to the consequences of TFA families' failure to attend the 21 month Jobs First Cash Assistance program exit interview. Failure to attend or reschedule an interview results in cessation of food stamps and participation in the CT Access program if there is no DSS record of earned income. Families with identifiable earned income who fail to attend the interview will continue with a two-year Medicaid extension of health care coverage if they meet the income guidelines of the program. The Department will bring information about this to the January Council meeting.

The next Medicaid Managed Care meeting will be: **Friday, January 16, 1998, 9:30 AM in LOB RM 1D. Please note the date change from 1/9/98.**

Happy Holidays to all !