

MEETING SUMMARY

June 5, 1998

Present: Sen. Edith Prague (Vice Chair), Rep. Vicki Nardello, Dr. Wilfred Reguero, Dr. John Raye, Laraine Milazzo, Eva Bunnell, Robert Gribbons, Judith Solomon, David Parrella, James Gaito, Ellen Andrews, Steve Netkin, Dr. Helen Smits, Janice Perkins, Felix Cortez for Paul DiLeo, Dorian Long for Gary Blau, Peter Johnson, Dr. Edward Kamens, Jeffery Walters, Chris Love for Marilyn McCormack, Lisa Sementilli-Dann. Also present: Barbara Casey, Susan Simmat, Zena Kovack, James Linnane, Mary Alice Lee, Mariette McCourt (Council staff).

DSS Report

21 Month Cash Assistance Program

Susan Simmat from DSS reviewed the closed case assessment performed by the Department, in response to concerns about the children of Temporary Family Assistance (TFA) families who fail to appear for the 20 month Exit Interview. These families may lose Medicaid and Food Stamps if they do not contact the Department for an interview. The Department reviewed the January 1998 Exit Interviews and manually checked the earned income status of those who did not attend the interview. Of the 2,190 TFA families scheduled for an interview, 399 (18%) did not appear. The research on the 399 cases revealed that:

36% (145) of the discontinued cases had income above the payment standard.

65% (259) received the two-year Medicaid coverage extension, since there was an employed adult in the household when the TFA was discontinued.

Of those who did not receive a Medicaid extension (140), 38% reapplied for Medicaid and 34% (48) were granted.

58% (233) of the families reapplied for TFA and 64% (148) were granted an extension.

63% of the 399 families reapplied for Food Stamps and 59% were granted.

Approximately 92 families were not on Medicaid at the end of this review, but may be eligible. The Husky A program changes that include the 12-month continuous eligibility and six month guaranteed eligibility will allow additional time for families that do not appear for their Exit interview to remain insured beyond the recertification date. This may allow opportunity for DSS to contact the family to assist them in the extension process or refer them to the Safety Net Program.

Families that have complied with the TFA policy (IE show a good faith effort to find employment and whose earnings remain below the TFA standard) are eligible for unlimited 6 month extensions of coverage. Failure to follow the rules lead to sanctions: two sanctions or quitting a job during the 21 month of TFA makes the person ineligible for an extension.

Zena Kovack described a safety net program, WorkSteps, associated with the Cash

Assistance program. This relatively new program, begun 10/97, was established to minimize the likelihood of harm occurring to children of families who have or will lose TFA cash benefits. The program is for families ineligible for cash assistance extensions and is jointly managed by the United Way of CT/Infoline and CT Council of Family Service Agencies/Employment Success Program. Connecticut is the first state to provide such a program, which is funded by the Department of Social Services. The goal of the program is to support families through the welfare to work process by ensuring families receive appropriate resources that may include medical coverage, basic necessities such as food and housing, child care, job training and linkage to community agencies.

WorkSteps has two basic components:

Prevention services for families that are in danger of losing eligibility, targeting those who have violated the 21 month policy that makes them ineligible for an extension of benefits. A voluntary individual performance contract (IPC) is established to assist in employment through job training and support services. Successful completion of the IPC allows the adult to have their eligibility extension reinstated for 21 months; however there are no sanctions for non-completion of the IPC. At the end of March 1998, there were 623 cases in the Prevention program with an IPC, with a 69% contract completion success rate.

Safety Net services are available for families that are no longer eligible for the extension of the 21- month Cash Assistance program and have income below the TFA standards. The ultimate goal of this component is also employment. During this process there is no direct cash assistance, rather linkage to existing community resources, cash vouchers for emergency needs and six-month rent subsidies that will temporarily stabilize the family. Recognizing that these families generally have need for more services, a multitiered approach is used that includes:

Contact with the United Way Infoline 24-hour service through DSS referral or other outreach effort.

Infoline provides the information to Family Services who then do a home visit evaluation and assign the family to the appropriate program component, based on the intervention level determined from the evaluation.

Ms. Kovacks reported that the projected number of cases (411) for Safety Net services for 6/30/98, have not been realized. It was difficult to project numbers initially, as there had been no experience with families leaving welfare. The actual number of cases (at the end of March 1998) is 125, with the larger number of cases falling into the Safety Net program because of sanctions that prevented an extension. A significant increase in Safety Net participation was seen in March, at the 5-month extension re-certification period and this trend is expected to continue at the 5-month intervals.

The Council appreciated the Department's efforts to assess the TFA case disposition as well as bring the WorkSteps program to the Council. An evaluation of WorkSteps participation at a future Council meeting would be helpful, as the Council remains concerned about the children of parents who miss the Exit Interview and lose medical and nutritional support.

Health Plans Quarterly Report

James Linnane reviewed the data that included the annual preventive report, based on service to members enrolled for a full year in a health plan.

Oxford Health Plans, which left the Ct Access program April 1, 1998 has not submitted all of their reports due April 1998. Since they enrolled 30,000 Medicaid members, the omission of their data is significant in that reports such as maternal/prenatal show a

decline in numbers that may actually reflect the loss of data rather a reduction in member participation.

*HealthTrack participation for all ages over 1 year old was decreased but increased above 1996 rates, as was dental services and exams.

*Behavioral Health service utilization, decreased last quarter, was slightly increased (4.58%); however plan variation was significant and rates were less than 1994 FFS (4.75%). The Behavioral Health subcommittee is in the process of obtaining consultation in the development of outcome measures that will provide a better assessment of the access to and the quality of services under managed care.

*Emergency Department utilization declined from 33.3 to 28.4 per thousand member months, with all but one plan reporting declines in utilization. Primary care visits showed a 3.5% increase compared to 1996. The QA subcommittee has reviewed the managed care ED data and will be inviting plans to share their internal tracking and management strategies with the committee in July.

*Annual preventive women's health data revealed an increase in women 18 years and over who received Pap smears, however the median percentage is below 50% (45.4%). It is notable that Preferred One showed a 47.5% increase to 82.7%. The report on uninsured, performed by the Office of Health Care Access, revealed those insured adult women 19 - 64 with NO Pap smear was 3.6%. Ct Access has a much lower rate of reported access to this preventive screen. The newly formed Women's health subcommittee has identified preventive health screens as an area to be further addressed.

Cost Proposal/Contract Process

As a preamble to the review of the cost proposal, the Department presented revenue reports of HMO's, published in the Hartford Courant that show similar patterns in the Medicaid revenue and expense self report from plans. While 12 of the 16 CT HMO's reported losses, Anthem BC and MD Plan reported gains both in total revenue (commercial and Medicaid) as well as Medicaid only {see enclosed data correction submitted by ABC that showed a transposition of 1996/1997 profit/loss numbers}. On the commercial side, PHS losses were attributed to "merger-related consolidation and restructuring charges" and Kaiser Permanent's \$5.9 million loss was reportedly reflective of information systems expenses, merger costs and new program start-up costs.

The 1997 Medicaid revenue and profit/loss table presented by the Department revealed that ABC and MD, whose Medicaid business is 66% and 12%, respectively, of their total book of business, reported profits. ABC has the largest Medicaid membership, which suggests that economies of scale contribute to a positive business outcome. The January 1 through March 31, 1998 revenue self-report shows a net income PMPM loss of \$1.65 for ABC, while MD, PHS and HRI all report a PMPM gain ranging from \$1.12 to \$4.17. Of the plans that are solely Medicaid (Preferred One, CHN-CT, HRI), all reported losses in 1997 but only HRI showed a PMPM gain in the first five months of 1998. A yearly audited revenue/expense will establish financial trends and perhaps allow a closer look at reasons for why plans sustain losses or gains in the Medicaid program. The Department summarized the cost proposal structure and rates that have been described at previous Council meetings. The rates/structure have been formally submitted to the plans. Health plans are to report their decision regarding remaining in the Medicaid program, to DSS by Thursday, June 11. DSS will review plan deficiencies,

and proceed forward with negotiations on the final cost plan and contract content. The Department stated that they expect to have the contracts in place by July 1, 1998. The basic underpinnings of the cost proposal includes:

Upper Payment Limits are based in part on the 1995 base year data that includes expenditures and member months, rate year trended analysis, a percentage (92.5%) of the UPL and reinsurance and risk sharing.

Removal of a county adjustment, creating a state rate.

Repeal of the premium tax for Medicaid HMO's.

Maternity and Delivery "kick" payments, with a reduction in PMPM amounts.

End of Riverview exemption due to Appendix K reinsurance.

Consolidation of the rate cells into 6, with net rates per rate cell increased for DCF children aged 1 –14 years, reflecting higher costs for this group.

General reinsurance that establishes dollar thresholds for which the state will assume an increasing percentage of the cost, with decreasing MCO cost share.

Appendix K reinsurance, with increasing state assumption of costs for inpatient psychiatric care based on length of stay (inpatient days grouping rather than medical necessity LOS).

There was a lengthy Council discussion regarding the cost proposal and the formulation of the contracts. The following highlights concerns expressed by Council members.

The Appendix K reinsurance concerns reflected those raised at the May meeting. Specifically, those concerns addressed the lack of post-acute placement settings that has been a problem both in the FFS and the Medicaid program. Shifting cost responsibility does not solve this outstanding problem. Council members suggested that contracts contain clinical criteria, developed in concert with DCF, that ensure that child needs and resource availability be identified before movement to a different risk share LOS category be allowed. Further, the restructuring of the provider network, mandated in bill 1313, still requires more public process in the development of this network. DCF reported that they are requesting proposals from vendors to develop a system of care with global DCF funding that will keep children in the state and the community. Interested vendors are to respond to DCF RFP by August 31, 1998.

The health plans represented on the Council stated that they find the rate structure complex and requested a meeting with DSS and the actuarial consultant for clarification. DSS stated a preference not to respond to this request at this time. The Council stated that the rate issues are between DSS and the plans. The concern of the Council should be and remains on the impact of the UPL changes on the Medicaid participants and the program's viability. DSS stated that while the program has lost plans (a reduction from 11 to 7 participating plans), the network capacity has remained intact. There is a fail-safe point (not yet identified) in capacity, which when exceeded would cause the State to employ the ultimate strategy of placing 250,000 participants back into FFS. The Department does not expect to be at that point in this contract period; however DSS will know which plans expect to continue to participate in the program by next Thursday. The start date of Husky A under new contracts will depend on the plan response to the cost proposal.

While DSS has responded to MCO rate concerns through structural program changes, there was concern expressed by the Council that the substantive content of the RFP would change when the contracts are written, to make up for the plans reluctance to accept the proposed rate. DSS acknowledged that plan and DSS lawyers would negotiate the content of the contracts. The Department was reminded of the Council's agreement in March 1997, that a Council member be appointed to review the new model contract and be apprised of the changes that occur

throughout the negotiations. At the March 1997 Council meeting, Judith Solomon was appointed as the Council representative to work with DSS during the contracting process. The Department and OPM raised concerns about adding a third party to the negotiation process and requested the Council address this concern, in writing, to the Commissioner of social Services.

Questions were raised about the ability of the present automated eligibility system to identify Husky A/B participants and providers as well as give health providers the plan lock-in status of the patient in order for longer-term treatment planning and preventive health care.

The Council again asked if an audited Medicaid book of business could be provided on an annual basis rather than the current full book of business audit.

The Department requested that the Council address the concerns about the contract content, the automated eligibility system, Appendix K reinsurance replacement and the Medicaid financial report to Commissioner Thomas in a letter. Council staff will do this and DSS will report back to the Council in the July meeting.

Subcommittee Reports

Quality Assurance subcommittee reviewed the Medicaid Emergency Dept. data for 1996 and 1997, the comparison to FFS data. ED utilization may be both a Primary care access problem as well member education issue. The committee will invite plans to the July meeting to educate the committee on plan's internal quality process regarding ED use. CPRO will present a report on the patient focused studies at the June meeting.

Public Health reports that discussion with plans with outstanding SBHC contracts proved fruitful in that almost all contracts were signed by the June meeting. The subcommittee made recommendations based on the DPH Safety Net Provider survey, which will be presented to the Council in July. A representative from the Massachusetts Attorney General office will provide a forum on that state's voluntary Community Benefits program on July 15, 1PM in the LOB.

Access/EPSTD will schedule a future meeting to review information from the forum on EPSTD, organized by the Children's Health Council.

Behavioral Health described the important role of parents as care coordinators for children with special health needs. The committee is in the process of procuring funding for Dr. Mario Hernandez from the Florida Institute to provide technical assistance to the subcommittee for the development of outcome measures.

Women's Health subcommittee will meet June 10, 1998 for the first time.