

Meeting Summary November 6, 1998

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella and James Gaito (DSS), Paul DiLeo (DMHAS), Dr. Kamens for Sen. Gunther, Robert Gribbons (Office of Comptroller), Marilyn Cormack, Cynthia Matthews. Dr. Raye, Eva Bunnell, Dr. Wilfred Reguero, Lisa Sementill-Dann, Jeffery Walters, Dorian Long for Gary Blau (DCF), Janice Perkins, Dr. Helen Smits. Also present: Dr. Thomas Van Hoof (CPRO), Mary Alice Lee (CHC), James Linnane and Rose Ciarcio (DSS), health plan representatives from Anthem Blue Care, CHNCT, HRI, PHS/MD, Pro BH, Magellen, Preferred One, and Mariette McCourt (Council staff).

Department of Social Services Report

Contract Process

A series of meetings with managed care organizations (MCO) and the Department have been held dealing with issues raised by the MCO response to the draft contract submitted to the plans in September 1998. The plans submitted 300 comments on a wide range of topics, which DSS organized into three main categories:

Applicability of the Balanced Budget Act (BBA) requirements placed on state Medicaid programs to enforce federal language that address emergency services, sanctions and incentives, etc. has been clarified. While the HCFA provisions raise concerns for states and MCO in relation to the potential for increased program administrative costs, the contract draft incorporated provisions that have the most impact on the program. The HCFA provisions will not be accepted as regulations until the Spring of 1999, when states will then have one year to bring programs into compliance with the regulations. Mr. Parrella stated that the discussions regarding the BBA have led to a resolution of major areas of concern.

Grievance/Fair Hearing processes are being streamlined to make parallel time lines of internal (MCO) and external (DSS) processes consistent with federal regulations. The Department observed that over the past three years, the internal and external processes had different time clocks and had not served the best interest of the client. Within this contract, there has been an attempt to maintain common Notice of Action and continuity of service provision for both MCO and Department complaint processes. David Parrella stated that this is a complex process, with many time line requirements, but the resolution of which will provide better protection for patients and plans. A working group was formed to ensure that the contract language is clear and understandable by both parties.

Performance measures that involve sanctions and incentives have been included in the contract. The current contract has few performance measures in relation to MCO accountability for acute care and behavioral health services. The new contract includes quantifiable standards for health care delivery. Both parties have spent considerable time working on the process of the applicability of the performance measures, sanctions and incentives.

There were miscellaneous issues, some of which were semantic and some substantive that will

be addressed at the next meeting between DSS and the MCOs.

The draft contract is being rewritten to reflect the negotiated agreements reached to date. This will be shared with all the MCOs next week. The Department hopes to complete the contract process in December, stating that all plans will need to sign on to the contract; there is no individual plan negotiation in this contract process as there was in the first contract process three years ago.

Council concerns following this update were:

*Dr. Reguero observed that the language of the initial draft contract was punitive whereas the Department has usually preferred a more collaborative approach. Mr. Parrella stated that it was not the intention of the Department to be punitive; however the experience over the past three years of managed care demonstrated a need to develop intermediary actions that address problems with meaningful dollar amounts. This is preferable to dealing with problems through the only sanction allowed in the current contract, that of plan contract termination. The Department described the need for a balance, in the contracts, that involves developing a partnership with the MCO yet maintaining control over services by a process that does not compromise clients. The contracts provide a more formal process that allows a focus on performance standards, rather than 'damage control'.

Rep. Nardello reiterated Council support, expressed in previous meetings, for inclusion of clear performance measures in this contract that will enhance the HUSKY program. The Department was requested to inform the Council liaison, Judith Solomon, of any substantive contract changes prior to the completion of the contract process. Ms. Solomon would report significant contract changes to the Council Chair. While the Department reportedly does not anticipate significant substantive changes to be forthcoming, DSS will inform Ms. Solomon of the contract process.

HUSKY A Denials

Of the 1748 applications (which represented 3300 children) referred by Benova to the regional DSS offices, two-thirds were granted, 10% were pending at the end of October, 1% were placed in a spend down category, 135 were not acted upon and 20% were denied. Of the 3300 children, 2015 children have been enrolled in a HUSKY A health plan. During August to October 1998 there were 710 denials, of which DSS was able to research the reasons for 293 denials, which included:

Application incomplete to establish eligibility: **47%**

Missing verification (IE missing income, proof of address): **23%**

Miscellaneous denials (IE, voluntary withdrawal when applicant realized HUSKY A was Medicaid): **20%.**

Failure to contact DSS case worker: **10%**

Council discussion following this presentation raised the following concerns and suggestions:

Families may be concerned about asset tests; however children (<19 years) are not held to this standard (IE families can own their own homes).

Families may be concerned about citizenship status disclosure; however if a parent is applying to HUSKY for a child, only the child's citizenship status is required on the application.

It was suggested that information that is not necessary for completing the eligibility process could be included in the information packet. In addition, follow-up for denials based on asset limits would identify those families for whom the asset standard is inappropriate. The Department reportedly is following up on these.

The application is still cumbersome to complete. The Department is working with a team to revise the application further to address some of the above concerns. It was suggested that entities be available to help families complete the application, as HUSKY outreach is only one part of the process in successful enrollment in HUSKY A or B. Entities other than WIC, FQHC, the Benova line, may need to be identified to provide hands-on help with application completion. Follow-up for those applications denied for insufficient information is needed. DSS stated that the regional offices try to contact the client but the case is denied if the client does not respond. However if the family does respond within 30 days, the application will be re-opened rather than requiring a reapplication.

Children in the spend down category (10 children) were referred back to Benova for HUSKY B after DSS reviewed the application and eligibility status.

The stigma attached to the old AFDC Medicaid label often creates a barrier to enrollment for both the HUSKY A and B programs. While the Department markets the programs collectively as the HUSKY program, potential enrollees could identify HUSKY A as the CT Access program through benefit comparisons. The Department described situations in which families would not participate in HUSKY B because the program originates in DSS and the consumer equates this with Medicaid and welfare. It is a challenge for all involved with the HUSKY program to attempt to de-stigmatize this valuable health care access program.

Senator Harp inquired about the status of the HUSKY outreach contracts, observing that earlier marketing through the schools could have resulted in higher enrollments. The Department reported that the grant applications and recommendations have been compiled by the outreach team and will be sent to the Commissioner of Social Services November 9, 1998. Sen. Harp stated that the timely release of these grants is important in order for the program to live up to this year's funding levels and would appreciate Department efforts to move this forward by the next meeting in December.

Behavioral Health Spending

James Linnane reviewed the report on behavioral health spending that was compiled by the health plans. A corrected spending summary was distributed. While there is a 20% increase in spending for behavioral health services between 1996 and 1997, there was an 8% increase in member numbers, thus the per capita member month spending was actually increased by 11%. Most spending increases occurred in ambulatory services and decreased in inpatient services. Readmission rates, a basic Hedis measure thought to reflect the efficacy of treatment and service availability, remained stable through 1996 and 1997. Comparisons of this data is confounded by behavioral health population and service mix changes during this time that included:

August 1996 to March 1997, DCF children were not phased in to the managed care program.

March 1997, DCF children, high consumers of behavioral health services, were phased into managed care.

March 1997, children hospitalized at Riverview were disenrolled from managed care, primarily because plans were less apt to use this higher cost facility.

Council discussion raised the following issues:

Differences among plan readmission rates: DSS stated that the numbers are small and Dr. Smits (HRI) observed that DCF children are unevenly distributed across the state as well as plans.

Qualidigm (CPRO) will be following up on their Discharge study with an assessment of ambulatory care received by the 'Appendix K' children in their new contract period. The results

will identify if the children were discharged too early and the quality of the OP care they received. Dr. Van Hoof suggested that it would be useful to assess differences among those readmitted/ not readmitted in regard to inpatient/outpatient utilization patterns and pharmacy usage.

Use of utilization data in improving quality of care: DSS stated that plans are required to have internal quality improvement programs and the Qualidigm operational audits address this. The HCFA data tool, QUISMC may eventually be applicable to Medicaid providing more uniform data acquisition. It remained unclear how health plans use their data for QI; further dialogue on the BH subcommittee level regarding this would be helpful.

Behavioral health spending represents approximately 7% (\$25 million) of the total HUSKY expenditures (approximately \$400million). The PMPM rates are spread over the whole population while only 4% actually receive services.

Ambulatory BH care and psychotropic drugs may, at times, be provided by Primary Care Providers (PCP). Health plans can determine spending by provider type. Since it is difficult to obtain separate costs for pharmaceuticals (these costs are not in the BH spending report), the health plans could work with DSS to identify pharmacy utilization by standard aggregated drug types.

Compared to 1994 fee-for-service (FFS) outpatient spending for 1996 was lower as was inpatient spending. There was an increase in ambulatory spending for 1997 and continued decrease in inpatient spending, compared to FFS 1994. The question was raised as to whether we are reducing services in both inpatient and outpatient areas. The Department stated one would need to look at utilization trends and treatment outcomes in order to identify the effectiveness of the behavioral health component of the program.

Husky A Behavioral Health Expenditures

	'94 FFS Total \$	'96 MCO Total \$	'97 MCO Total \$	'94 FFS PMPM \$	'96 MCO PMPM \$	'97 MCO PMPM \$
Inpatient	35,777,577	9,707,971	9,915,408	13.90	4.87	4.61
Ambulatory	12,247,551	11,067,224	14,946,847	4.74	5.55	6.95
Grand total	56,803,469	20,775,195	24,862,255	22.08	10.42	11.56
Memb M # Months	2,573,016	1,993,765	2,149,794			

There is significant variation in the PMPM costs among plans (IE for 1997, the lowest MCO PMPM cost was \$2.13 and the highest was \$11.12). Janice Perkins (MDPHS) stated that there could be huge differences in provider contracts that may account for the differences in spending, hence it is difficult to conclude quality of care from PMPM costs. Other members argued that quality is affected by PMPM spending if provider reimbursement is such that length and level of intensity of treatment is influenced by rates. Council members questioned if it is possible to purchase the same services for approximately one-half the FFS PMPM rate. It was suggested that outcome measurement in addition to spending/utilization patterns would provide a better assessment of the quality and efficacy of care of the HUSKY A behavioral health program. Senator Harp questioned if the three agencies (DSS, DCF, OPM) have moved forward

to address the gaps in the BH continuum of care, in particular available subacute care for those children for whom transition from inpatient care to home is not possible. The Department of Social Services indicated that there are DCF-funded services that are not covered by Medicaid, in particular the residential treatment model. DCF is seeking consultation that focuses on expanding Medicaid coverage for this category of service and budget options for the next session would be put forward to address this. In response to Council questions regarding the role of health plans in authorization of subacute services, DSS stated that they could purchase such services. This is included in the current Special Services for Children contract with the health plans. Subacute care is a complicated issue that involves DCF licensure of the facilities and appropriate placement of the child. While a complex process, the inclusion of DCF-managed services currently outside the Medicaid reimbursement system into the Medicaid net through the budget process would ensure a continuum of care, adequately coordinated and financed, that would improve the outcomes for these children. DSS will continue to work with DCF and OPM regarding the integration of these services into the Medicaid system.

Senator Harp asked the Department if they had reached a decision regarding their approach to resolution of the remaining Behavioral Health outstanding claims. James Gaito reported that there has been ongoing internal discussion about the Department's policy regarding unpaid reimbursements to health providers within Medicaid plan networks. The discussion has been further complicated by another group of BH organizations that have disputed unpaid claims. The Department is cognizant of the vulnerability of these organizations and is at present unclear where interventions should appropriately occur, either within the civil court process or within the Department, involving arbitration or mediation to resolve the claims dispute. Sen. Harp requested the Department inform the Council of the decision regarding the resolution process at the December meeting.

Linkage of Prenatal Care and Substance Abuse Services

At the September Council meeting, prenatal care access rates and low birth weight rates in the HUSKY program were noted to be significantly lower than general population rates. Barriers to timely prenatal care were discussed with substance abuse during pregnancy presenting a challenge to health plans and providers in providing timely care. Health plans were asked to inform the Council of their care plan development that address case management and the linkage of prenatal care and substance abuse treatment.

Anthem Blue Care, CHNCT, HRI, PHS/MD/Pro Behavioral Health and Preferred One presented information that included the following common strategies:

- Identification of pregnant women: through welcome calls when the client enrolls in the plan, and through providers that see patients in various settings, including the ED, Primary Care Provider, Healthy Start, and Behavioral Health providers.

- Pregnancy Risk stratification is done that includes substance abuse (SA) history.

- Follow-up of the pregnant woman through health plan and BH outreach workers and case management was reported by each plan.

- Prenatal care education was provided to enrollees.

- Health provider education regarding the identification of clients with SA and appropriate treatment referrals was provided by most plans.

- Postpartum follow-up to ensure care was done through outreach plan efforts.

The overview of case management was informative and demonstrated similar efforts by health plans and their BH subcontractors to engage enrollees in timely prenatal care and SA treatment. This presentation could provide the basis for further exploration, perhaps at the Women's Health and/or Behavioral Health subcommittee level that would address more specific aspects of the linkage of prenatal care and SA treatment that includes:

The numbers of pregnant clients, by plan, who require SA services and the number who actually access these services during pregnancy.

The level of treatment authorized by health plans, including inpatient and outpatient treatment.

The average length of treatment.

The availability of treatment centers/resources for pregnant women within plan networks and plan-identified gaps in treatment availability.

The health plan use of formal/informal community-based services that provide social support to the high-risk client and their families.

Children's Health Council Update

Mary Alice Lee reported that the CHC November meeting the following issues will be discussed:

Dental Access recommendations

Report on utilization tracking

Enrollment outreach efforts

Council Quarterly Report

The Quarterly report, distributed to Council members prior to the meeting for their review, for the period July 1 to September 30, 1998 was accepted by the Council with no abstentions or corrections.

Subcommittee Reports

The Women's Health subcommittee reported that the Department of Social Services and Benova presented an excellent eligibility forum in October that highlighted the complexity of the eligibility categories. This information will provide the basis for the Subcommittee recommendations regarding expanding health coverage, benefits and program administration for Women's Health in the Medicaid program.

The Quality Assurance report was included in the Council handouts as Paula Armbruster, chair of the subcommittee, was unable to attend the meeting. The subcommittee met with DSS and CPRO, in October, to discuss projects for the new contract period and recommended:

Building on the previous prenatal study, assess prenatal participation in risk assessment and risk behavior change.

Development of a definition and identification process for Children With Special Health Care Needs (CSHCN) and assess service utilization and care accessibility.

Assess the prevalence of behavioral risk factor screenings by PCP and the frequency of referrals to behavioral health services.

Assess the availability of transportation as an important determinant of access to care.

THE NEXT COUNCIL MEETING, INITIALLY SCHEDULED FOR Friday December 11 HAS BEEN RESCHEDULED FOR FRIDAY DECEMBER 18, STARTING AT 10 AM. THE SUBCOMMITTEE CHAIRS ARE ASKED TO MEET IN LOB RM 3000 WITH SEN. HARP AT 9 AM ON 12/18 TO DISCUSS LEGISLATIVE INITIATIVES FOR THE UPCOMING SESSION.

