

Meeting Summary December 18, 1998

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, Commissioner Starkowski and David Parrella (DSS), Arthur Evans for Paul DiLeo (DMHAS), Marie Roberto (DPH), Dr. Kamens for Sen. Gunther, Robert Gribbons (Office of Comptroller), Cynthia Matthews, Ellen Andrews, Dr. Wilfred Reguero, Lisa Sementill-Dann, Peter Johnson and Dorian Long for Gary Blau (DCF), Janice Perkins, Dr. Helen Smits, Dr. L. Banco, Judith Solomon, Laraine Milazzo.

Also present: Katey Eyestone (CPRO), Mary Alice Lee, Rose Ciarcio, David Dearborn and Adele Kusnitz (DSS), Paula Armbruster, Chet Brodnicki and Mariette McCourt (Council staff).

DSS Report

HUSKY Outreach Grants

Commissioner Starkowski reported that letters would be sent today to the 10 entities that have been awarded the outreach grants. The Commissioner is aware of concern regarding the delayed granting of the contracts as well as the HUSKY enrollment numbers. The Department's initial efforts were aimed at disseminating statewide information about HUSKY B. The community-based organization (CBO) involvement in outreach, through the grants, will facilitate a more focused approach to enrollment, according to the Commissioner.

The outreach grants vary in amounts, with:

- Five given at \$20,000 amount

- Three at \$50,000 amount

- Two at \$100,000 that provide statewide outreach

Since the Northwestern part of the state was not represented by a CBO in the grants, the Department will reserve \$50,000 of the grant monies to apply to this geographic area. The Children's Health Council will provide grant coordination, with Judy Solomon acting as the coordinator, to ensure the entities know the goals and objectives of the project and are familiar with the grant process.

Council comments addressed the following concerns:

- Extent of overall school involvement in the outreach process. Rep. Nardello observed that the GAO report on outreach recommended the school systems as one of the more important venues for outreach activities. The Department reported that joint efforts between the Department of Education and DSS have been implemented, that include beginning work with school nurses in the NE part of the state, and superintendents dispensing HUSKY information to parents. The Commissioner stated that while these efforts should have occurred earlier in the school year, they are now proceeding on target and believe that the information has filtered down to the individual schools.

- It was suggested that school-based health clinics (SBHC) and Child Guidance clinics would be another valuable outreach resource. While not specifically targeting SBHC, the Department reportedly is working closely with them and the Commissioner stated there are dollars in the DPH budget to enable the SBHC to work with DSS in HUSKY outreach.

Dr. Banco suggested the Department speak with the leadership in the CT chapters of the American Academy of Pediatrics and Family Medicine as they have worked with other State agencies in the past to present programs to pediatrician offices. The Commissioner stated that DSS has discussed HUSKY outreach with Academy members and is considering proposals to involve the medical community in outreach.

David Dearborn reported that the Department has initiated collaboration with federal agencies such as the IRS and HUD to include HUSKY information in their mailings. Outreach through various community and civic organizations have also been initiated. The Commissioner stated that DSS will provide the Council with a list of outreach efforts for the next Council meeting. The projected uninsured numbers (90,000) were probably unrealistically high, according to the Commissioner and the Department is discussing a future survey that would more realistically define CT's uninsured population with the Office of Health Care Access (OHCA). (In an earlier meeting with Sen. Harp and the Commissioner, HUSKY Plus projected numbers were discussed. The Department had projected that each PLUS program enrollment would be 3% of the HUSKY B population. Both the Behavioral Health and Title V center programs, funded at \$2.5 million, are in the DSS budget and services are paid in a FFS arrangement. The centers incur no financial risk in that the Department has committed to providing additional funding if needed).

Outreach efforts to the Hispanic community, one of the larger uninsured populations, through Hispanic radio, newspaper and community leaders have been initiated. Two of outreach grantees have targeted the Hispanic population in their proposals. The Department will continue to work toward engaging the Hispanic community in outreach efforts.

Senator Harp thanked the Commissioner for his report and the Department's positive partnership with the Consumer Access subcommittee in addressing HUSKY access issues. The Department has clearly put a great deal of effort into outreach and the Council looks forward to a steady increase in enrollment numbers.

HUSKY Enrollment: Benova

Sheila Bell, Regional Director of Benova, the HUSKY enrollment contractor, presented the recent Husky enrollment data for the period 7/1/98 to 12/15/98. The numbers have been validated in order to reflect the actual net enrollment and may vary from previously released numbers. While the HUSKY B enrollment remains modest, HUSKY A enrollments have increased by 3% (5790, from 219782 to 225557).

HUSKY B enrollments were identified by county, age and income band, at Senator Harp's request. To date **2595** applications have been approved and **2382** children have been enrolled in HUSKY B. The following summarizes HUSKY B enrollment by age, income band and county:

Age: <1 years 1 to 5 6-10 11-15 16-18

Total 75 666 720 664 257

Income Band Premium Band 1 Premium Band 2 Premium Band 3

(>185 -235% FPL) (>235-300% FPL) (>300% FPL)

Total 1565 730 87

County Enrollment:

Fairfield Hartford Litchfield Middlesex New Haven New London Tolland Windham

495 507 211 131 648 209 94 87

Council discussion identified the following issues:

Enrollment projections: the projections were based on overall projections of uninsured children (90,000) not by income category. Dr. Banco stated it might be a worthwhile exercise, noting that only 87 are enrolled in Band 3. The Department replied that one might expect this band (>300% FPL, paying full premiums) to be smaller as individuals in this band would more apt to be insured through their employer.

Children enrolled in HUSKY B have **continuous enrollment for 12 months**, unless they leave the state or are institutionalized. Failure to pay the premiums (Band 2 and 3) would result in disenrollment from the health plan, however the child keeps the continuous eligibility status and may avail themselves of services once the family reinstates the premium payments.

Ms. Bell reported that there have been 1000 HUSKY A denials, based on the DSS eligibility/application assessment (see 'reasons for denials' in the November Council summary). The DSS eligibility policy division will continue to assess the A denials. Approximately **60% of HUSKY A denials thus far have been associated with lack of the applicant's follow up with additional information or income verification for eligibility determination**. Clients who apply for HUSKY are referred to DSS by Benova, who in turn may refer the client back to Benova for HUSKY B. The same completed application is used. A DSS courier collects all applications from regional DSS offices and brings them to Benova on a daily basis. Procedural changes have reduced some of the movement back and forth between the HUSKY A and B application process.

Ongoing monitoring of HUSKY B enrollment by age/county and income band would allow the Department to target specific groups/areas for future outreach.

Senator Harp thanked Ms. Bell for her presentation and requested that HUSKY B enrollment data and the numbers for HUSKY A referrals back to Benova be sent to Council staff along with the HUSKY A enrollment information that is currently sent. The Department agreed to do this.

Managed Care Contract Status

David Parrella stated that the lengthy contract process has been positive, with resolution of outstanding issues among DSS, MCOs and the Attorneys General staff. The Department has attempted to listen and respond to the issues brought to their attention during the negotiations. At this time the negotiations, on the Department's part, have been completed. Contract changes originating from the previous week negotiations have been written into the contract and mailed to the managed care plans today, along with an amendment to extend the current contracts through January 1999. The Department expects the contract process to be concluded February 1, 1999. This time frame is necessary for MCO legal review and contract signing and AG office review. The 1915b Waiver will be extended one more time for 90 days beyond December 24, 1998. The waiver application, including the cost-effectiveness information, will be published in the Connecticut Law Journal for public comment prior to submission to the committees of cognizance.

The following text from the DSS contract update presentation reflects the major contract issues. Council comments related to each issue are included in italics.

Sanctions

MCOs requested a clear process for the imposition of sanctions, hence a notice period will be implemented prior to the imposition of a sanction.

General provisions

1. Plans will receive thirty days notice prior to the imposition of a sanction.
2. Sanctions will be deducted from the monthly capitation payments and added to the funds reserved for incentive payments.

3. No sanctions on dental performance. Concerned with further disruptions in a very fragile network. Incentives for dental access will be paid, in combination with other measures to improve dental access.

This was a contentious issue and it was felt that sanctions would create more harm than good, hence dental incentives rather than sanctions were included.

Class A

1. Class A sanctions imposed after the third strike for failure to achieve performance measures identified in the contract (geographic coverage, PCP scheduling, linguistic access, data reporting, etc.).
2. Class A sanctions will be assessed at \$2,500 for the first incident, \$5,000 for the second, and \$10,000 for the third.
3. Class A sanctions assessed based on complaints or spot checks where no time frame is specified will be assessed over the life of the contract.

Class A sanctions will be imposed on the third strike, not the fourth incidence. The Department believes that the strikes may be as significant as sanctions for some issues and that the intent of the overall sanction system includes a means of monitoring performance as well as encouraging 'best practices'. The sanction time period will be over the course of the contract, applicable to those sanctions with or without an identified specific time period.

The Department recognizes limitations for monitoring aspects of the contract provisions and expects violations to come to the attention of DSS through complaints.

Class B

1. Class B sanctions will be imposed for certain performance based on a single incident (failure to provide 24-hour access, credentialing, EPSDT, financial reporting).
2. Class B sanctions will be assessed at \$10,000 per incident.
3. For EPSDT, the performance period will be SFY 2000. Performance will be based on the data reported by the Children's Health Council.
4. No sanction will apply if the MCO's participation or screening ratio, although less than 80%, is more than one standard deviation above the mean for all plans.

Prior to the SFY 2000 performance period, "shadow sanctions" will be applied quarterly, with formal notification to those plans that do not achieve the performance goal.

Although the time period for the application of the EPSDT sanction is beyond the new contract period (after 6/2000), the withhold of a portion of the last month capitation payment (not to exceed \$100,000) for six months, as a surety bond, will be used for outstanding obligations, including sanction payments. There is also an expectation that the contracts may be extended beyond the 6/2000 period.

Class C

1. Class C sanctions will be imposed for actions which could potentially result in harm to an individual member (failure to provide medically necessary services covered under the contract, imposing a premium on a member, marketing, misrepresenting information, etc.).
2. Sanctions could include: withholding a monthly capitation payment, in full or in part; assessment of damages of up to \$25,000 per incident for failure to provide medically necessary services or PIP violations; damages of up to \$100,000 for discrimination against a member or falsifying information; freeze on enrollment; contract termination; appointment of temporary management.

Grievances and Fair Hearings

This was a major issue relative to the Balance Budget Act provision and forthcoming regulations in 1999, and Connecticut's state statute that has a brief time frame for fair hearings. These contract provisions sought to achieve resolution of issues of Notice of Action and continuity of care and distinction of the enrollee internal and external appeal process.

1. The process for grievances and fair hearings will be unified.
2. If the grievance pertains to a denial, reduction, suspension or termination of services, the MCO will treat the filing of a grievance as a simultaneous request for a fair hearing.
3. Department will approve all forms and procedures used by the MCOs for filing a grievance.
4. All requests for a grievance/fair hearing will be filed with the department, which will date, stamp and forward the request to the MCO within two business days.
5. All procedures must include provisions for expedited review.
6. MCO must mail a written decision on all grievances to the recipient and the department no later than the date of the department's fair hearing or thirty days from the date that the department received the grievance.
7. If the MCO fails to render a decision of the grievance within thirty days, the fair hearing will be held as scheduled.
8. If the MCO cannot show good cause why the decision was not rendered within the thirty-day timeframe, the hearing officer may uphold the grievance on that basis alone.
9. All the existing protections for continuity of service based on an appeal following a Notice of Action continue to apply.

Members will be notified of these new processes through the plan member handbook as well as by independent notice from DSS. Since grievances must be written, the Department will take under advisement the Council suggestion to provide enrollees with literacy limitations assistance in filing written grievances. The QA subcommittee had suggested a client advocate provision to facilitate the grievance process. The Children's Health Infoline has provided assistance to enrollees and CHC stated it would be agreeable to formalize this process to assist clients with limited literacy.

While the grievance/fair hearing process pertains to denial, reduction, suspension or termination of services, other issues may be dealt with through the plan complaint process. Plan lock-in 'good cause' disenrollment includes the enrollee use of the grievance process but does not include the complaint process as a disenrollment reason. The Department acknowledged a need to revisit the lock-in criteria to include the complaint process in the 'good cause' disenrollment process.

Surveys

1. MCOs will participate in two member satisfaction surveys.
2. One survey will be an NCQA Consumer Assessment of Health Plans (CAHPS) of HUSKY members using a vendor certified by NCQA and funded by the MCOs.
3. The other survey will be developed jointly by the department, the Children's Health Council, the EQRO, and the MCOs and will focus on Children with Special Health Care Needs. The department will fund this survey.

The Special Health Care needs survey was included because the Department thought that special issues for children with high volume utilization may not be reflected in the general survey.

Behavioral Health

1. The MCOs will be required to employ a full-time, credentialed professional responsible for

the oversight of the delivery of behavioral health services.

2. Vulnerable members with mental health and substance abuse disorders will not be refused treatment by the MCO at the point that they seek treatment because they did not abide by the MCOs rules.

Contract Termination

Part one originates from the Attorneys General delineation of general State contracts.

1. Part one was changed to require 90 days as opposed to 60 days notice for either party to withdraw from the contract.

2. In the event of a termination, the department will be responsible for notifying the members and making arrangements for them to receive services. The MCO will be responsible for notifying providers.

3. The department will withhold a portion of the last month's capitation payment, not to exceed \$100,000, as a surety bond for six months to ensure compliance under the contract.

Incentives

Incentives represent approximately 1% of the total program expenditures (\$3.8 million); in addition, sanction payments will be added to the funds reserved for incentive payments.

General

1. Incentives will be awarded in four areas of the contract: EPSDT, Dental Access, Consumer Satisfaction, and Behavioral Health.

2. Incentive funds will be awarded in equal amounts for the four performance areas.

EPSDT

1. Baseline will be the participation and screening ratios for the period from October 1, 1998 through September 30, 1999.

2. Measurement will be based on the last twelve months of the contract.

Measurement will be based on encounter data.

Dental Access

1. Baseline will be the first twelve months of the contract.

2. Measures will be based on the HCFA 416:

Percent of members 4 to 21 years of age receiving any dental service.

- Percent of members 4 to 21 years of age receiving preventive dental services.

- Percent of members 4 to 21 years of age receiving dental treatment services.

3. Measurement will be based on encounter data.

The Department stated it has recognized the crisis of oral health care access in Medicaid and, in addition to focusing resources toward children's access to oral health care through the contract, DSS will be addressing the broader dental access issues through budget initiatives (see dental access report below).

Consumer Satisfaction

1. The department will base the incentive awards on the results of two surveys: CAHPS and Children with Special Health Care Needs.

The survey will apply to adults and children in the HUSKY A program. The Women's Health subcommittee offered assistance in formulating client satisfaction items that address adult Medicaid member satisfaction.

Behavioral Health

Incentives will be based on encounter data (follow-up treatment within 30 days of discharge) and data collected as part of behavioral health outcomes study.

Medical Records and Encounter Data Validation

This contract provision addresses the concern raised in Qualidigm studies in which outpatient medical records were difficult to find.

1. MCOs must maintain a centralized medical record, which complies with the department's regulations and NCQA standards. The record shall include all contacts with the member.
2. A sample of 50 records must be made available each quarter for the validation of encounter data.

The Department corrected this to 100 records per year per plan for validation.

Financial Reporting

The financial reporting of a separate Medicaid book of business was a significant issue in that it places additional administrative burdens and cost on the health plans and may provide a strong disincentive to plans to continue in the program. The Department stated that an audited annual statement is important for monitoring plan financial solvency and more realistic future rate setting. As has been discussed in previous Council meetings, the 1995 FFS fiscal data will become less applicable in establishing future Medicaid rates. The Department believes it is important to base future rate setting on actual recent experience in Medicaid managed care.

1. MCOs will be required to submit an audited statement of income and loss in April, 2000 for calendar year 1999.
2. If the variance between the audited annual statement and the unaudited quarterly reports for the same period is less than 10%, MCOs will not be required to submit another audited financial statement until April, 2002.
3. The department reserves the right to require an annual audited statement at any time if there is evidence of financial insolvency or fraud.

Schedule

1. New redlined version of the contract mailed to the MCOs today with amendment extending the current contracts through January, 1999.
2. Signed contracts will be sent to the Attorney General's office for review.
3. Signed contracts should be in place effective February 1, 1999.

Waiver Renewal

1. Actuaries have completed the retrospective and prospective analysis of cost-effectiveness.
2. Data is currently being reviewed internally at DSS.
3. Cost-effectiveness test includes the extension period.
4. Waiver will be extended one more time for 90 days beyond December 24, 1998.
5. Full waiver application including the cost-effectiveness material will be published in the Connecticut Law Journal for public comment prior to submission to the committees of cognizance. *HCFA will also receive copies.*

Senator Harp thanked the Department for their excellent work in the development, over this long contract process, of a strong document that ensures plan accountability and key performance measures. Rep. Nardello stated that the Department listened well to the Council concerns. Senator Harp stated that the Council took a firm stand on substantive contract issues and the Governor's office and DSS considered the Council recommendations in the contract process. This should confirm that Council participants' time is well spent each month at Council meetings.

Outstanding Claims Resolution

The Department is in the process of putting together a remediation process with the Attorneys

General office to resolve the remaining small number of unpaid claims for substance abuse services. The Department stated that the Attorneys General office would prefer that settlement of future outstanding claims be resolved among the plans and providers, rather than through DSS. The Attorneys General office has recommended the Commissioner of DSS urge the parties (MCO's and providers) to settle the latest group of outstanding claims (\$1.5 million) involving mental health services among themselves. The Council will continue to monitor the resolution of these outstanding claims.

Children's Health Council Report

Dental Access

A study of 87,000 children, continuously enrolled for 12 months in Medicaid managed care from 7/1/96 through 6/30/97, was undertaken by the CHC to determine dental access. Connecticut dental access issues are complex and generally pre-date Medicaid managed care; indeed dental access under EPSDT is problematic throughout the nation. In this descriptive CHC study, it was found that:

- Only 31% of children in the study received any preventive dental services.

- 18% received treatment services.

- Lowest utilization rates were among children aged 15-19 years (18%), Black children (27%), children in DCF custody (28%) and those residing in the counties of Fairfield (21%), New Haven (22%) and Tolland (22%) as compared to the highest county rate, Hartford (47%).

- 73% of the encounter data identified dental providers and revealed that the top 10 providers are responsible for 40% of the dental care provided the HUSKY enrollees.

- The children's Health Infoline revealed a disproportionate number of calls from Windham, New Haven and Fairfield compared to the enrollment proportions in those areas.

The Children's Health Council supports an integrated effort among DSS and DPH, Husky A health plans, the CT State Dental Association and the CT chapters of the American Academy of Pediatric Dentistry, Dental Hygienists and Pediatrics to develop strategies to improve dental access. The CHC has made recommendations that include increased Medicaid fees for children and adults, inclusion of dental utilization incentives and performance measures in the new MCO contract, direct reimbursement to dental hygienists for preventive dental care and the development of demonstration projects that increase comprehensive dental care for HUSKY children.

David Parrella stated that the Department of Social Services has long been aware and concerned about CT's oral health care crisis and the Department plans to take the following steps in meeting this crisis:

- Include a fee increase for adults in the DSS budget initiative

- Work with DPH to develop community projects for dental care

- Change the State Medicaid plan to provide direct reimbursement to dental hygienists for work within their scope of practice.

The Department of Public Health commented that as more people move into the HUSKY program, access efforts can be directed to traditional office-based practices as well as clinics. Improving oral health access requires a system change as well as reimbursement change. Ms Solomon (CHC) stated that the hygienist plays an important role as does the dentist who diagnoses oral problems. There is a need to build on the infrastructure and expand types of dental services. Rep. Nardello thanked Judy Solomon, Mary Alice Lee and David Parrella for working on this important issue. Connecticut will be a leader among states in this area as the recommendations are implemented to address this challenging problem. Sen. Harp stated that

Rep. Nardello brought this issue to the General Assembly and persevered in keeping this in the legislative agenda. Sen. Harp also recognized the Dental Society's work with the legislature, DSS, CHC, and advocates to improve the delivery of oral health care and the Senator looks forward to future positive changes within the system that ensures access and dental care delivery.

On-Time EPSDT Visit Rates

Screening rates have improved over time, however most children are still not receiving timely, comprehensive EPSDT screening examinations. The on-time visit rate (36.8%) is over 40% higher than the estimate from the first quarter 1997. Children aged four to 24 months had the highest rates (56%) with those 6 to 18 years old the lowest rate (13%). Preferred One had the highest on-time rate (44.5%) while CHNCT (33.1%), HRI (29.5%) and PHS (28.8%) were less than the overall rate for the quarter.

Adolescent Ambulatory Care Utilization

Adolescents (23,448) aged 12 to 19, continuously enrolled in Medicaid managed care who received ambulatory health visits, including well-child visits and other ambulatory care, ED care and counseling were identified from encounter data submitted by Medicaid plans. More than 9000 adolescents did not receive any ambulatory care in 1997. The average number of encounters per child of those that did receive care was 2.03.

The leading diagnoses associated with other ambulatory care encounters were normal pregnancy (6.6%), acute pharyngitis (5.6%), contraceptive management (5.5%), asthma (5.2%) and acute upper respiratory infection (4.6%).

Among the 47,675 encounter record, 18% were well-child care, 77% other ambulatory care, 3% emergency care and 1% counseling services. The study suggests that regularly scheduled well-child visits seem to be replaced in part with episodic care related to problems. These represent 'missed opportunities' for comprehensive screens. Health education and promotion activities should be offered in schools, other community sites and information regarding screens and health coverage should be conveyed to families. Since a third of the encounter data had no provider ID, it was difficult to identify the use of school-based health clinics in care provision. There is a need for improvement in the data that includes provider ID.

Sen. Harp thanked CHC for their work and participation in the Council. Since the health plans will be at the January meeting, the Senator requested that they come prepared to discuss what can be done to encourage adolescents to access well care visits.

The next Council meeting is January 22, 9:30 AM in LOB RM 1D.