

**MEETING SUMMARY  
FEBRUARY 19, 1999**

**Present:** Rep. Vickie Nardello (Acting Chair), Rep. Boucher, David Parrella and James Gaito (DSS), Dr. Edward Kamen, Laraine Millazo, Judith Solomon, Jeffery Walters, Marilyn Cormack, Lisa Sementill-Dann, Marie Roberto (DPH), Ellen Andrews, Eva Bunnell, Steve Netkin (OPM), Catherine Jackson for Janice Perkins (PHS).

**Also present:** James Linnane and Rose Ciarcia (DSS), Karen Fritzinger (AAG), Lynn LaPenta and Greg Vitiello (Benova), Barbara Casey, Dr. Van Hoof (Qualidigm), Paula Milone-Nuzzo (Yale School of Nursing), Donna Campbell (Employment Success Program) and M. McCourt (Council staff).

**Department of Social Services Report**

Contract Status

The new contract was signed by all plans (5), officially authorized by the Attorneys General Office and implemented February 1, 1999. The contract will be in effect through June 2001. The waiver renewal has been sent to the CT Law Journal and expected to be published for public review and comment March 2, 1999. The Department has sent letters to the Chairs and Ranking Members of the legislative committees of cognizance informing them that the waiver will be presented for legislative approval on or near April 5, 1999. This will allow time for the 15-day public comment period and DSS response. The waiver will be sent to HCFA after legislative approval. David Parrella stated that he does not anticipate significant issues with the HCFA approval process.

HealthRight Transition Process

The transition agreement signed by HRI and DSS governs the operations of HRI for the transition period through April 30, 1999 (copies are available in LOB RM 3000). The agreement pertains to both HUSKY A and B HealthRight plans. The following key points were reviewed:

DSS will withhold the final month capitated payment to HRI to ensure HRI compliance with outstanding obligations, including provider reimbursement and the provision of the last quarter encounter data (Sec. E). The withhold amount will depend on the remaining membership in the plan at that time. The Department expects 20-30% of the December HRI membership to be in the plan during that last month, which would make the withhold equal to approximately \$1 million. HRI can report they have met a percentage of their obligation and request that percentage of the withhold be returned to the plan or request part of the withhold for provider reimbursement. The Department is very concerned about the fulfillment of plan obligations after April 30, at which time HRI as a company will no longer exist; hence the implementation of the withhold. Mr. Parrella stated that the Department does not expect the withhold to interfere with provider reimbursement.

HRI is responsible for making available their health provider lists to other plans to allow members to continue with their providers whenever possible as they transition to the remaining plans (Sec. L).

The monitor role is defined in Sec. O. The monitor will have sole decision making authority for all medical necessity decisions related to both physical and behavioral health, as would have been referred to the Medical Director of HRI.

HRI will make reasonable efforts to ensure the subcontractors, including Pro Behavioral Health, remain in place to provide services for the duration of the transition agreement (Sec. R).

HRI is obligated to process claims and encounter data for services provided on or before April 30, 1999 (Sec. U).

HRI is responsible for the provision of all services authorized by HRI or the monitors prior to May 1, 1999, including inpatient admissions that occur prior to May 1 but extend beyond April 30, 1999. The Department will pay clean claims from the withhold (Sec. V).

Mr. Parrella stated that those community health clinics that had contracts with HRI are in the process of contracting with other plans. The Hartford CHS previously had contracts with other plans; CHC of Middletown has a signed contract with CHNCT and PHS is actively contracting with providers at CHC. Legal issues may delay conclusion of the CHC/MCO contracts until the whole HRI situation is resolved.

#### Uninsured Adults Expansion Plan

David Parrella summarized the projected uninsured adult parents numbers and coverage options (copies are in LOB 3000) available to states. Mr. Parrella observed that there are a number of proposed bills for parent health coverage expansion that involve HUSKY A and B. The present budget has not included funds to expand coverage. The Department is working on adding coverage for those <100%FPL, using the 1931 provision of the Social Security Act. This is not a waiver, rather a State Plan Amendment that allows states' greater flexibility in determining income disregards and asset ceilings to make these individuals eligible for Medicaid. Mr. Parrella stated that expanding adult coverage beyond the 100%FPL is a State policy decision regarding funding such an expansion. The actual implementation of changing the eligibility system within DSS would cost \$2-3 million; it can be done, but the policy decision has to be made first.

Based on the 1995 Health Care Access survey data, the number of uninsured parents (not the global CT uninsured numbers) totals 35,427 with about equal numbers in the <185% FPL range and >185%FPL range. Since 1995 the improving economy may have decreased these numbers; however the private sector has increasingly reduced employee insurance availability. The 1995 numbers may actually represent the current reality of the numbers of uninsured parents.

States have several coverage options for expanding insurance to families (access [familiesusa.org/famcov5.htm](http://familiesusa.org/famcov5.htm) or [nga.org/CBP](http://nga.org/CBP){ Issues Brief 1999} for a summary of coverage options and states' implementation of expanded coverage):

Section 1931 of the SSA allows states to use more liberal financial eligibility rules to provide Medicaid to families who would not have qualified under current state guidelines. The advantage of using this provision is that it requires no waiver, rather is a State Plan amendment with no cost-effectiveness test. The disadvantages of using this are the application of Medicaid provisions to this Medicaid expansion program and a 50/50 match of State/federal funds.

1115 Waiver under Title XXI, the Title XXI variance: This health insurance waiver variance offers new flexibility in program design, provides the same health care package with access to the same providers to both parents and children and states receive the enhanced federal SCHIP rate (65/35) for both children and their parents. States have had difficulty receiving HCFA approval for this waiver variance, initially because HCFA was not prepared to accept waivers at the start of the Title XXI program. Demonstration of the cost-effectiveness has also been a

barrier to states in that HCFA had not issued guidelines on this. Wisconsin has recently received approval for this waiver, using the combined SCHIPS and 1115 Medicaid waiver to expand insurance coverage to parents at the lower 50/50 match.

Structural obstacles of Title XXI lock out many underinsured children, in that insured children are ineligible for Title XXI, even though the insurance may cover only 'catastrophic' care. Massachusetts developed a modified 1115 waiver that wraps Medicaid benefits around children that have insurance coverage but don't have access to the full XXI benefit. Another barrier to enrollment in both the 1915(b) and Title XXI is the inclusion of children but not the parents. Families might become more active in the enrollment process if insurance coverage was provided to the household as a unit rather than certain members of the household.

The Department has been rethinking the outreach approach in that if one conceptualizes the process as marketing an insurance policy to individuals rather than a group policy, different marketing strategies may be required. The Community-based outreach grants and current DSS outreach efforts will continue through the biennium. The Department will also work with the Office of Health Care Access, recently awarded a \$664,000 grant by the Robert Wood Johnson Foundation, for studying the uninsured, building on the 1995 survey. DSS would consider study coordination of uninsured parent and children and outreach efforts.

The Department of Social Services present position is that the HUSKY program needs time to consolidate and perfect the reforms already enacted, including guaranteed and continuous eligibility implemented with the July start of HUSKY B, lock-in, to be implemented upon waiver approval from HCFA, and presumptive eligibility, not yet implemented. Contracts for HUSKY A are completed; however HUSKY B is operating on letters of intent because contract negotiations have not yet begun.

#### Outstanding Behavioral Health Claims

James Gaito (DSS) had facilitated a lengthy but successful process to resolve the majority of the substance abuse unpaid claims, working with the health plans, providers and Linda Tatarczuch of Ct Community Providers Association (CCPA). It was unclear what type of mediation would be done to resolve the remaining claims. At the December Council meeting, DSS had declined to take an active role in the resolution of subsequent recently submitted behavioral health unpaid claims because of concerns of legal issues related to the precise nature of DSS authority in these matters. Senator Harp had requested the Department rethink the Department's position regarding further mediation.

The Department has "decided to make an exception in this instance and will help bring the parties together", facilitating the meetings between the plans and providers with clear goals/timetables established. The Department will obligate health plans to participate and assume providers will welcome this opportunity to come together with the MCOs to resolve these claims that occurred under the old contract. The meetings, to begin in March, will address two sets of claims issues: closure of the substance abuse claims through DSS mediation and resolution of the new set of Behavioral Health unpaid claims (under the old contract). Rep. Nardello thanked DSS for reconsidering their position and agreeing to facilitate the process. The Council appreciates the efforts of all involved, in particular Mr. Gaito and CCPA, in bringing this difficult yet important process to closure.

The Department recognized the significant contributions of Michelle MacDonald, program supervisor of the DSS Medical Policy Unit. Ms MacDonald has provided significant expertise and effort in the DSS policy area, in particular, in the formation of the new MCO contracts. The Council applauded Ms Mac Donald in appreciation of her very important contributions to the

Medicaid program and wished her well in her journey to divinity school in California.

#### Authorization/denial Issues

Rep. Nardello reported that Sen. Harp had received written communication that identified two areas of concern in plan compliance with DSS policy:

Notice of Action (NOA), which is a written notice to be sent to clients whenever service is denied, terminated or reduced from what the health provider deems is medically necessary. This written notice is apparently not being sent in many cases.

According to the communication, MCOs are "denying, terminating, suspending or reducing medically necessary services to enrollees based on artificially-created distinctions among medical conditions and treatment types". Rep. Nardello asked DSS if the federal guidelines differentiate acute/chronic care?

Mr. Parrella stated that these two issues involve communication from Sheldon Toubman from New Haven Legal Assistance received by the Department, the last received two days ago. The Department responded:

NOA: DSS invited Attorney Toubman to participate in the design of the standardized forms that address grievance issues in the new contract. In addition, a strongly worded letter was sent to the MCOs regarding the failure to implement the NOA policy. The Department intends to pursue NOA violations that come to DSS attention through the application of sanctions identified in the new contract.

Acute/chronic care issues: There are no federal distinctions regarding services for acute or chronic conditions. Since the Department just received this communication February 17, there has been no time to respond to these issues; however internal meetings with DSS and the Attorneys General Office will be held. The Department cannot implement the suggested policy from Mr. Toubman but will consider his suggestions.

Rep. Nardello stated she appreciated the Department response and requested the Department address these issues at the March meeting. **Mr. Parrella will update the Council on the Department efforts to resolve these issues at the next meeting.**

#### **Benova Report**

##### HRI Transition

Thirty two percent of HRI enrollees have changed plans as of February 16: 23,391 of the 34,194 members remain in HRI. There were 1280 DCF kids in HRI in December, 705 remain enrolled as of January 15. Approximately 55% of the DCF children were reassigned to plans chosen by DCF and several hundred have chosen plans other than the assigned plan.

##### HUSKY A

An additional 8500 children have been enrolled since 7/98, due to the new application form and outreach efforts for the new HUSKY B program, continuous eligibility and Medicaid expansion for older children. The total HUSKY A number is 227, 516 as of February 1, 1999.

##### HUSKY B

The total number of children enrolled is 2906 since 7/98, (an average increase in enrollment of 300 members/month since November 1998). The greatest number of children enrolled (1928) are in premium income band 1 (185-235FPL%), with 917 in band 2 (235-300FPL%) and 61 in band 3 (>300%). Families that do not pay premiums are re-enrolled when the plan notifies Benova of receipt of the payment. There is a three-month lockout from the program if a family is disenrolled for non-payment of premiums.

##### Tracking incomplete applications

HUSKY A: 3272 applications were referred to DSS from Benova, representing 6381 children; of

these, 4426 children were approved, 1564 were denied. DSS is tracking the reasons for the denial, noting that lack of eligibility verification is the primary reason for denial. Rep. Nardello stated that a system is needed to contact parents, as the children are probably eligible for HUSKY A or B.

HUSKY B: Benova surveyed HUSKY B incomplete applications; all parents were asked if they wished to reapply or reopen their application. **Rep. Nardello requested Benova provide the Council with this survey at the March meeting.**

Greg Vitiello (Benova) described the system used to track those with incomplete HUSKY B applications, identifying repeated efforts to follow-up with families, using computer prompts for the staff to quickly identify the missing information needed by the family when they call. Prior to issuing a denial for B, the family is again contacted.

Judith Solomon recommended that because the more intense follow-up performed by Benova is impossible at the DSS Regional level, the CBO grants and two community pilots could provide the verification follow-ups as well as provide families with alternatives for proving income. Rep. Nardello supported this recommendation.

Rep. Nardello observed that the low HUSKY B numbers resulted in a large lapse in the budget.

Rep. Nardello asked what impact this unspent money will have on the new HUSKY budget.

Mr. Parrella replied that it is unclear what will happen with the lapsed money, observing that this is an administrative decision.

### **Survey of VNA Sponsored Well Child Clinics**

Dr. Marie Roberto (DPH) introduced this study, reminding the Council of the Safety Net Provider (SNP) report presented by DPH in the past. That report was based on a legislative report that included SNP entities such as community health centers, school based health clinics, public dental services, local health departments, Family Planning clinics and Visiting Nurse (VNA) Well Child Clinics (WCC). Based on Public Health subcommittee questions originating from the report, DPH agreed to begin looking at some of the entities. The WCC was the first entity that was assessed to determine who is being served in the centers and the utilization patterns of the WCC surveyed. Dr. Paula Milone-Nuzzo, faculty at the Yale School of Nursing and experienced with VNA services, performed the study.

There have been major changes in health delivery, major shifts in funding sources as well as a shifting client base for SNP services that suggest information gaps about the use of WCC and raise questions about the continued need for these services. The purpose of this study was to determine the population served and the clinics' utilization patterns from July 1, 1997 through June 30, 1998.

Twenty-six VNA WCC were surveyed, with 20 clinics completing the survey. During the study period, four WCC had closed because of the clinics' perceived lack of need in the community as evidenced by cancelled WCC sessions. The clinics all operated in suburban and rural towns, with only 25% receiving municipal funding and 37% reported generating revenue from their WCC. The number of children served by the clinics varied, from two to 197 children.; approximately 860 children were served by the 20 WCC during the study time.

The majority of the WCC (80%) had eligibility criteria that included a requirement that the child be a town resident (69%), be 4 years or younger (69%) and 69% included insurance status as a criterion, with all accepting uninsured and underinsured children and only 18% accepting insured children. None of the WCC were participating in Medicaid managed care, although the VNA that sponsored the clinic was a participant.

### Who is served by the WCC

The children served by the WCC tended to be white, less than six years of age and either uninsured or under insured. The average age of the children was 4-5 years, suggesting that children were seen prior to entering school.

#### Utilization pattern of the WCC

The two most common services provided were well child physical exams (98%) and 700 children received immunizations. Most agencies held one WCC per month and most planned sessions were held, suggesting there were few cancellations, a proxy for service need. Most WCC clinics did not serve as outreach sites for other programs such as the HUSKY program. Only 25% were able to generate client-based data and while 75% reported operating to fill a community need, most did not perform a needs assessment, perhaps because they have an intimate knowledge of the community that they serve.

#### Study Recommendations

DPH develop a uniform needs assessment model for the WCC, develop a uniform data tool and collection method and perform a follow-up survey in FY 99, a year after the HUSKY B program has been in effect.

WCC serve as screening sites for State and federal programs, refer families to HUSKY and inform families of their potential eligibility for State and federal health programs.

Municipalities consider innovative use of funds to facilitate the enrollment of children in the HUSKY program, perhaps providing funds for families who need assistance in paying premiums for HUSKY B.

WCC consider regionalization as a strategy for more efficient use of resources and service provision.

Council comments supported the study recommendations.

Rep. Nardello recommended that DSS consider as potential outreach sites those providers who have not been reached through HUSKY information mailings to Medicaid providers. These WCC represent non-Medicaid providers who serve potential HUSKY-eligible populations, yet do not refer families to the HUSKY program. The Department noted that the WCC can currently give clients the 1-877-CTHUSKY or the Benova number @ 1 800-656-6684 for application assistance.

DPH may consider asking WCC to identify financial eligibility criteria as part of the clinic licensing requirements. Dr. Roberto stated that the WCC care is for well children; these children need to be connected to a primary care provider for sick care. Enrollment in the HUSKY program would provide a better-coordinated care system that is probably already available to most of the families served by the WCC.

Uniform needs assessment and data collection tools that are uncomplicated is vital to the WCC ability to plan and evaluate their impact on community health, as they are a crucial safety net provider.

Rep. Nardello thanked Dr. Milone-Nuzzo and DPH for this very important study of a key participant in the SNP system. The study provided the Council with information about HUSKY outreach and SNP services that had not previously been available. The study also demonstrates that the work performed at the subcommittee level does indeed reflect the goals of the Council.

#### **21 Month Exit Interview, WorkSteps and the Employment Success Program**

James Gaito stated that Donna Campbell would present the Employment Success Program, a key program for outreach relative to the 21 Exit Interview re-determination process. At a subsequent Council meeting DSS will present data for the first year of the program.

Donna Campbell, Executive Director of the Employment Success Program, presented a review

of this statewide program that is tied to welfare reform. The program provides outreach and intensive case management for clients transitioning from welfare to work or some other allowable activity. WorkSteps is a partnership of the United Way of CT/Infoline and the CT Council of Family Service Agencies/Employment Success Program. WorkSteps purpose is to minimize the likelihood of harm occurring to children in families that are at risk of or who have lost cash benefits as a result of sanctions for non-compliance with the 21 month limit guidelines and/or the 6 month unlimited extensions. The program seeks to stabilize families, assist with resource access to strengthen parenting skills and protect children and assist families to attain and maintain adequate employment through amelioration of barriers.

Connecticut is one of the few states to provide these DSS-funded services to sanctioned families. The program provides case management and clinical support, in particular for behavioral health and substance abuse. In addition assistance with basic needs, including food and rental vouchers and utilities payments are provided. The services are home-based and family focused.

Ms Campbell stated that poverty creates barriers to family stability. Welfare recipients rate access to health care as the most important service. Health status is a major determinant for families becoming gainfully employed. The current clients involved in the program may differ from the earlier welfare to work group that is now employed (approximately 30,000 families) in that they may be experiencing more barriers to attain economic levels that will allow them to leave cash assistance (24,000 families).

A comprehensive quantitative assessment of risk levels is used to predict the duration and intensity of program services. Preliminary data from this first year identified the prevalence of barriers in this WorkSteps population by quantifying data for a representative group of 300 clients. The following characteristics were described and compared to the general AFDC population:

80% had been on assistance for three years or longer, a higher rate than the AFDC population.

	WorkSteps	AFDC	General Pop.
>3 children	35%	20%	
HS/GED	30%	50%	
SA/month	17%	9.6%	5.1%
ETOH/>10/day	18%	8%	4%
Health rating:poor-fair	16 to 20%	12.6 to 17.5%	8 to 6%
DCF involve Hx	32%	20%	
Domestic violence Hx	31.4%	20 –40%	

Of those reporting drug (SA) use, 88% reported a willingness to seek help, perhaps related to the positive case management relationship established and availability of services.

58% of WorkSteps clients reported often feeling depressed compared to 16-39% of other welfare to work participants. Those in the WorkSteps program have significant stressors by the very nature of their participation in that they have been sanctioned, lost cash assistance, tend to have more children, lower education levels and higher risk factors.

The program is estimated to have prevented 54% of DCF referrals through intensive case management of high-risk families, based on the risk assessment data. DSS is credited with establishing the program that protects children and families and reduces stress on the DCF system.

Issues with children impact on day to day function and contribute to employment barriers. These concerns included children with developmental delays (9%), behavioral health problems (19%),

academic problems (22%), health problems (38%), adolescent legal problems (59%).

Program outcomes include:

12% employed in part time work in service occupations, earning <\$6/HR.

37% are employed earning \$7-8/HR, one-half of whom work full time.

13% of the cases were closed because the family was over the payment standard once they worked.

30% were exempted because of health problems or were reinstated on cash assistance.

17% refused services

20% moved

20% unable to locate

Ms Campbell noted that there has been an increase in referrals to the Safety Net program as over one-half have failed the extension process.

Rep. Nardello thanked Ms.Campbell for this report; it was most helpful to address differences in the WorkStep population compared to the general AFDC population, identifying the higher acuity of need and the success of intense case management for clients.

### **Quarterly Report**

The Council accepted the report without correction.

### **Subcommittee Reports**

Behavioral Health: Lynne Noyes (DPH) provided information, at the request of the chair, regarding the school-based health clinics' mental health contract status. Both DPH and DSS have agreed to bring the SBHC and MCOs together to address contract barriers.

Consumer/Access: working with DSS regarding focus groups to identify barriers to HUSKY enrollment.

Women's Health: obtained information from the Dept. of Corrections and linked HUSKY enrollment issues to the Consumer Access group, developed three priority areas to focus discussions with health plans regarding nutritional services and education, smoking cessation and linkage of prenatal care/SA services, pregnancy, lactation services.

Public Health: addressed two legislative proposals: voluntary community benefits, and DPH monitoring of the Safety Net Provider system. The two bills will be reviewed in public hearings this month. Rep. Nardello requested Council support for inclusion of the SNP financing in the budget, observing that the WCC study demonstrated the importance of adequate SNP information before health policy decisions are made.

**THE NEXT COUNCIL MEETING IS FRIDAY MARCH 12, AT 10 AM IN LOB RM 2D.**