

MEETING SUMMARY
NOVEMBER 5, 1999

Present: Sen. Toni Harp (Chair), Sen. Edith Prague (Vice-Chair), Rep. Nardello, David Parrella and James Gaito (DSS), Robert Gribbon (Comptroller Office), Paul DeLio (DMHAS), Dorian Long (DCF), Ellen Andrews, Patrick Carolyn (BeneCare), Janice Perkins (PHS), Eva Bunnell, Jeffery Walter, Dr. Edward Kamen, Judith Solomon, Lisa Sementilli-Dann.

Also Present: Debra Russo (Qualidigm), James Linnane, Rose Ciarcia and Zena Kovak (DSS), Mary Alice Lee and Mariette McCourt (Council staff).

Department of Social Services Report

Kaiser Exit

The Kaiser transition has been completed and the plan has ceased Medicaid managed care operations as of October 31, 1999. The transition agreement has been written and Mr. Parrella expects this to be signed by Kaiser. The transition of Kaiser members to the remaining plans was summarized by DSS:

HUSKY B

*Eleven members' eligibility was closed at redetermination prior to the Kaiser termination.

*One hundred members were transitioned to the remaining three plans through the choice process. **HUSKY A**

*3030 members were transitioned to the remaining four plans through the normal choice process and 571 Kaiser members were defaulted by rotation to the remaining plans.

*Kaiser members with special needs (59) were transitioned to plans that had their health providers in the network. Kaiser had no children with special needs. Benova, Kaiser and the four health plans worked together to ensure continuity of care for these members.

Safety Net Program First Year Report

Zena Kovak from the DSS Family Division presented highlights of data from the first year of the WorkSteps program, a component of the CT welfare reform initiative. The program was designed to assist the State's most vulnerable families who are experiencing the most difficulty in transitioning from welfare to work (WtW). The report establishes a baseline of information to further the understanding of those welfare recipients who have lost cash assistance due to failure to comply with the transitional welfare to work rules. The program is two years old as of November 1, 1999 and data is continuing to be analyzed.

The goal of the WorkSteps program is to minimize the likelihood of harm to children in families who are in danger of losing or have lost their TFA cash assistance. There are two components to the program:

Prevention services for those in their initial 21 months of cash assistance who will not be eligible for a six month extension(s) because of a lack of good faith effort to find and retain a job.

Successful completion of an Individual Performance Contract (IPC) designed to secure

employment restores a family's extension eligibility.

Safety Net services provide those families that have exhausted cash assistance and are ineligible for an extension, although their income is lower than the TFA standard, with support through counseling, referrals to community resources and job training and financial assistance through food, clothing, rent and utilities vouchers. Families voluntarily enter the program, referred by DSS or community organizations. The total TFA population is now at 29,000; 5% of these individuals are in the Safety Net program. Almost half of the program referrals were families that had been unable to comply with the WtW employment rules during their extension period (44%).

These adults received a sanction because of job loss through voluntary quits or willful firing. Although families receiving a sanction lose cash assistance and food stamps, they remain eligible for medical coverage in the HUSKY A program, based on their income level. There had been instances of adults losing HUSKY coverage due to computer glitches. Regional DSS workers have been instructed to reinstate these families in HUSKY. The WorkSteps advisory group continues to monitor the loss of medical coverage and update will be available after 11/16/99. During January through August 1999 there has been an increase in referrals to the program, averaging 122 per month, compared to 69 per month during the first year. There has been a sharp continuous increase in referrals since April 1999. From July 1998 through June 1999 553 new cases were added to the 346 carried over from the previous year. Approximately 768 cases were closed at the end of the first year. Of those families referred, slightly less than 50% refused services or were unable to be located. About 15% of the closed cases were families earning above the payment standard; however they can re-enter the program at a later time if their income changed. Eleven percent of the closed cases were reinstated with benefits upon further review.

Compared to families in the IPC and TFA program, families in the Safety Net program tended to be single parent households headed by women with lower education, more apt to have experienced domestic violence and have a history with DCF. In addition they reported a higher rate of physical health and mental health and/or substance abuse problems. Approximately 40% of the families in the program were at risk for housing eviction and reported greater unmet childcare needs.

Council discussion following the report highlighted concerns:

Limits on the number of benefit extensions and determination of the legitimacy of the extension: There are no limits on the number of extensions granted if the family has not incurred a sanction. The Dept. of Labor has partnered with the program to determine the employment plan and evidence of work.

Voucher amounts for housing, utilities and food are based on individual family need determined by a home visit by program staff.

The increasing number of referrals suggests that the WtW program has system problems and is not accomplishing the goal of family self-sufficiency as hoped. Ms. Kovak stated that the program is still relatively new, yet it is becoming clear that families in the Safety Net program require more time to stabilize before they can be helped to get employment.

Are referrals made for mental health/substance abuse treatment and does treatment participation allow the family to continue with benefits? DSS reported that treatment can be part of the employment plan and the Department is working to improve the identification of families that require intervention.

The Council requested further information about:

The assessment of MH/SA needs beyond self-report, the numbers of Safety Net clients who

have been referred for treatment, participated in these services and the outcome for these families. .

Assess the cumulative data of active cases over more than one FY, determining the duration of time spent in the program and the profile of those who require the greater length of time in the program.

Ms. Kovak agreed to report this information to the Council Chair.

Medicaid Managed Care program Network Capacity

James Linnane reviewed the Medicaid program network capacity status as of November 1999. Enrollment capacity is based on the principle that access must be better than or equal to historic FFS access (1994 data). A county enrollment cap for individual plan enrollment of new members is based on multiplying providers by specialty in that county by the historic FFS ratio of clients to providers. The established provider- member ratio by specialty is:

Children’s primary care: 1provider/301 members

Women’s health providers: 1/835

Dental providers: 1/486

Adult primary care: 1/387

Behavioral health: 1/459

DSS monitors MCO capacity through information provided by EDS as MCO’s enroll providers in their Medicaid panel through EDS. Benova provides DSS with MCO monthly member enrollment numbers by county. Benova also receives updated files from the MCO’s that includes an indicator as to whether the PCP in the plan panel is accepting new clients. While this information is available to DSS, it is not reported to the Department but is used by Benova in helping enrollees choose a PCP and plan. The monitoring of the enrollment cap involves;

Monthly monitoring of the MCO if the membership is 90% of the enrollment cap.

If a plan’s membership exceeds the enrollment cap in a county, the MCO is given 30 days notice to correct the provider deficit. Failure to correct the provider deficit results in an enrollment freeze.

The recent quarterly network capacity report shows areas of frozen enrollment or plans near the 100% capacity:

<i>PLAN</i>	<i>COUNTY</i>	<i>ENROLLMENT %</i>	<i>SERVICE</i>
Frozen enrollments			
Anthem BC	Hartford	114.23%	Dentistry
CHNCT	Middlesex	102.98%	Dentistry
CHNCT	New London	106.04%	Dentistry
PHS	Windham	109.21%	Children & dentistry

> 90% cap			
PHS*	Fairfield	94.99%	Dentistry
PHS	New London	98.11%	Children
PHS	Tolland	95.84%	Dentistry

*Mr. Linnane stated that PHS has enrolled new pediatricians into their panel since this report was developed.

Council discussion raised the following issues:

The current network capacity report does not truly reflect capacity in that the provider ‘slots’ for Medicaid are not defined, nor is the clinical site of the provider defined by private/public service setting. **Rep. Nardello requested the Department consider future data reports that include:**

Individual provider capacity for Medicaid clients (i.e. percentage of office/clinic appointments designated for Medicaid clients) and capacity to accept new Medicaid Managed Care clients.

Practice site of providers (i.e. community services versus private practice) in order to provide the legislature with information as to where to put resources for health care access. Mr. Linnane stated that the Department of Social Services does work with DPH in looking at the number of health professionals in shortage areas.

Mr. Parrella stated that DSS would report at a future Council meeting a breakdown of providers accepting Medicaid clients within plans and counties; however the capacity problem really involves dental services rather than primary care services, based on the network capacity report.

Since dental capacity is a major reason for plan frozen enrollment, does the Department of Social Services collect the same information on dentists as they have on PCP’s? Mr. Parrella stated that there is not the detailed information regarding dentists concerning the number of plans they participate in or the dental providers’ capacity to accept new patients. Since the same dental carve-in subcontractor serves the two largest Medicaid plans, there was concern that the same dentists may participate in the two network panels, thus both MCO’s members would be receiving care from the same pool of providers. This would impact further on dental access as the dental cap per plan that is set at 1 provider/486 members may in fact be applied to the same dental provider who belongs to more than one network panel. Mr. Parrella stated that the provider networks are not identical even though they use the same dental subcontractor; however we do not have a way to measure this at this time.

Mr. Linnane stated that the Department is planning to refine the whole methodology of assessing network capacity. The current methodology does not take into account the number of plans a provider is in nor the provider’s willingness to take new Medicaid patients. Sen. Harp commented that we have know all along that dentistry would be a huge problem and the Council, dentists and other have worked to resolve the access issues. It remains unclear what strategies are successful in expanding the dental network.

School-based HUSKY Outreach

David Dearborn, Director of Communications at DSS, reported on these outreach efforts. Mr. Dearborn stated that school-based outreach is a critical component of HUSKY outreach and in

CT these efforts have been focused on:

HUSKY fliers accompanying the school lunch programs

Onsite HUSKY training of school nurses, social workers and teachers

State collaboration with subcontractors such as the Children's Health Project and granting of community based organizations.

Other endeavors that the Department of Social Services have undertaken include:

HUSKY fliers will be included with income tax booklets

Dissemination of HUSKY information to 20,000 special needs families in 14 school districts.

Enlistment of 75 teens as peer ambassadors to promote HUSKY and the concept of health insurance to teens in the community.

SBHC have received a grant to identify uninsured families who use the clinics. The clinics began HUSKY outreach last year and have referred 600 families to HUSKY. A database is being established that will identify uninsured families.

The Council made the following recommendations to DSS regarding HUSKY outreach:

The HUSKY parent expansion is a start in insuring the 300,000 CT residents that are uninsured.

Sen. Prague urged DSS to have a plan for outreach to the HUSKY A parents in place soon, as the program starts in July 2000.

Rep. Nardello stated that there had been discussion with DSS regarding the need to meet with the Commissioner of Education and DSS to develop a uniform identification of uninsured students throughout CT. This may require a new mandate as all schools are not requiring this information now. Rep. Nardello assumed that the collection of this information was being done.

It is more effective for HUSKY outreach staff to meet with the regional Boards of Education, as they are in the decision-making role for information dissemination in their region. Mr. Dearborn will follow-up on this.

While education staff training is important, further establishment of one-on-one HUSKY outreach in schools by parents or other community members is most effective. Rep. Nardello recommended DSS continue to implement this process.

Sen. Harp described Ohio's strategy of 15 second AM prime time TV spots for their CHIPS program. The Senator recommended DSS consider using outreach money to do this.

Rep. Nardello stated that the State needs to decide whether to do things (outreach) that feel good or to undertake activities that work. School outreach has been in place for two years; the results have been disappointing, especially for HUSKY B. Mr. Dearborn stated that 20,000 children have been insured, most of whom have been HUSKY A. DSS is aware that there needs to be stronger efforts targeting potential HUSKY B enrollees.

Dental rates in the global capitation rates

James Gaito stated that the global capitation rate for covered benefits is based on the last year of FFS claims (1995). There was no allocation for subcapitation rates for specific services such as dental. In 1995, DSS spent \$13.2 million on dental services, with a \$5.51 PMPM rate. Using certain assumptions in the rate setting, trending forward using the base 1995 data, the PMPM rate would be \$6.23. Mr. Gaito stated he thought the MCO's were paying in excess of this to dental contractors and individual providers. MCO dental spending for 1998 will be presented at the December Council meeting. A discussion ensued, raising the following issues:

The current capitation rates were derived from a 'snap-shot' in time (1995) when the program was different. For example, some of the SBHC's provided dental services but were not billing DSS in 1995.

In the medical model there are examples of cost reduction through a shift to primary care and

prevention; this offset is not as apparent in dental. Mr. Parrella stated that in dental people are more apt to not be served rather than dollars saved through shifting care to primary care settings. Dentistry built costly services into their practices, although some shared infrastructure with hospitals. Massachusetts is looking at cost savings through dental preventive services, however capturing the dental cost offset remains difficult. Rep. Nardello stated that dental care is primarily prevention if one considers that 80% of the decay is found in 25% of a population that is often low income. This suggests that dental care can be preventive, saving costs in restorative services through early screenings, preventive interventions such as sealants and family education.

Since the capitation rates are global, dental prevention is but one of many preventive services included in the rates. Perhaps the dental subcontractors need to look at the distribution of money with the main MCO.

In order to meet the goal of 80% EPSDT dental visits, the cost, without fee adjustments, would be approximately double or triple the current PMPM rates. Commercial rates in the State Employee program are about 60% utilization, well under the 80% EPSDT goals. Rep. Nardello reminded the Council that in the Medicaid population the disease rates are higher, so it is inappropriate to compare utilization patterns in this population with the commercial population. Clearly, different strategies are needed to engage the Medicaid population that has a higher rate of disease in accessing dental care.

Dental overhead is greater than that of primary care, thus providers need to see more patients to offset this cost, which may compromise the quality of care. Mr. Parrella disagreed that there is a linear relation with utilization management (UM) and quality stating there is no evidence in FFS that better access is achieved in a system that does not have UM.

Special Account for TANF Medicaid Matching Funds

Robert Gribbon from the Office of Comptroller reported that there was some confusion regarding the feasibility of establishing a special account within DSS for the federal matching dollars of the TANF Medicaid outreach funds. Mr. Gribbon worked with DSS and stated it is feasible to do this with the approval of OPM. Sen. Harp stated she had received communication from DSS that confirmed OPM approval to allow DSS to establish this special account. This would allow the matching funds to remain in the Department for WtW medical coverage outreach efforts, thus not adding expenditures to the Department's budget that would exceed the State spending cap. The Senator thanked the Comptrollers Office and DSS for moving forward on this Council recommendation in a timely manner.

Focus Group Report

Ellen Andrews, Chair of the Medicaid Council Consumer Access subcommittee and Executive Director of the CT Health Policy Project, presented a report on four focus groups of uninsured parents. This was a collaborative project of the subcommittee and DSS that sought to identify parent's attitudes about HUSKY and solicit suggestions to improve outreach to uninsured families. Enrollment in HUSKY is a complex process that involves more than the dispersion of brochures. It involves information dissemination, advocacy, application assistance, follow-up and persuasion. Many group participants knew little about HUSKY, not understanding if they were eligible or how it would benefit their family. Once they understood the program the parents were enthusiastic about HUSKY and some offered to spread the word in their communities. Parents care a great deal about their children's health care and report feeling stigmatized when

trying to access care without insurance. Enrollment barriers were identified as :

Lack of accurate information about HUSKY, particularly that working families may be eligible for the insurance coverage and that families can choose a health plan once they are enrolled. The stigma and suspicion of participating in a government program crossed cultural lines, related in part to fears about immigration status and the INS, and possible effects of enrollment in a government program affecting child custody proceedings.

Non-availability of diverse linguistic HUSKY information and cultural sensitivity about the marketing efforts that are not from within the community, rather provided by entities outside their ethnic groups.

Enrollment delays or problems were overcome with assistance; however failure to obtain this assistance often deterred parents from completing the process.

Limited access to providers, both dental and primary care providers, particularly in Williamatic, resulted in long waiting lists for appointments. This experience, spread word-of-mouth, may discourage other uninsured families from applying.

Recommendations for improved HUSKY enrollment, based on the information from the groups included:

Objective evaluation of outreach methods is crucial to identifying successful methods, appropriate use of tax dollars and resource allocation.

Emphasize that HUSKY is available to 'working families', has reasonable costs and comprehensive benefits. Test HUSKY information and outreach strategies with families, taking into consideration cultural differences, in order to maximize the effectiveness of the message.

Create new approaches for outreach using new vehicles and including community leaders to bring the message to minority and second language communities.

Continue to monitor and improve the enrollment process, quickly correcting misinformation and response to complaints to minimize a negative public perception of the program.

Develop a plan to improve public opinion of publicly funded programs, emphasizing and broadcasting families' positive experiences with HUSKY. All too often one problem can overshadow the positive aspects of the program in the public opinion.

Getting people insured and keeping people insured requires attention, in part, to the number of providers, especially in rural areas and improvement in dental access.

Council comments supported the report, in that it emphasizes the importance of keeping the parent consumer in the forefront and part of the process. The MCO representative raised the issue of the MCO's taking a more active role in outreach, as has occurred in other states. Sen. Harp commented that this was an important participatory effort between the Council and DSS, in illuminating the complexity of the outreach process.

Children's Health Council

Judith Solomon reported on an effort to track enrollment data on a longitudinal basis, differentiating new enrollees from those in the net enrollment. The HUSKY A enrollment, which peaked in July has leveled off and is now decreasing. It is thought that the WtW reform may be accounting for families' loss of coverage. Of 1480 children enrolled during February to October 1999, 602 did not re-enroll in October. Those that were re-enrolled came back to HUSKY through cash assistance. Approximately 557 adults were not re-enrolled. Tracking the data longitudinally will allow findings to be incorporated into outreach efforts.

Subcommittee Reports

Quality Assurance: Dr. Robert Powers of Hartford Hospital reported that non-urgent ED use by Medicaid MC adults has decreased during day hours, compared to use prior to 1995. At

Hartford, there is an increase in non-urgent ED use by Medicare clients and the uninsured.

Behavioral Health: The denial/NOA processes have been reviewed and the Department has been asked to clarify the definition of a denial of service as it applies to the unified grievance/fair hearing process. DSS has asked the AG office to comment on this. The health plans and providers will continue to work on prioritized issues identified in the provider and MCO reports on Medicaid MC, that impact BH services.

Public Health: worked with DSS and the MCO's to identify the dental hygienist credentialing process, related to the 1999 legislation that allows hygienists to receive Medicaid reimbursement.

Consumer Access: Develop recommendations to DSS for the identification of special needs children at the time of enrollment in HUSKY to facilitate care management and quality of care measurement.

Women's Health: has completed the lactation services and support recommendations that will be presented to the Council in December. The working group also developed a state-wide resource inventory for lactation services and support (on web site under Women's Health November summary).

Sen. Harp thanked the subcommittee Chairs and participants for their hard work and very significant commitment of time, skill and interest in improving the Medicaid program.

The next Council meeting will be Friday December 10, 1999 at 10 AM in LOB RM 1D. The MCO quarterly data will be reviewed with the health plans and dental expenditures will be reported.