

Meeting Summary: September 13, 2002

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, Jeffrey Walter, Janice Perkins, Patrick Carolyn (HMOs), Dr. Wilfred Reguero, Dr. Edward Kamens, David Parrella & Rose Ciarcia (DSS), Barbara Parks Wolf (OPM), Dr. Ardell Wilson (DPH), Phyllis Rotella, Judith Solomon, Lisa Sementilli, Irene Liu.

Also present: William Diamond (ACS), Chet Brodnicki (Child Guidance Clinics), Sylvia Kelly (CHNCT), Deborah Hine (Anthem BCFP), Dr. Marilyn Sanders (UCHC), Lisa Kinakin (Doral Dental), John Joensen (HN Disease Mgmt), John Harper, MD, (Health Net Medical Director), M. McCourt (staff).

Managed Care Organizations Reports Health Net Dental Projects

Janice Perkins and Lisa Kinakin (Executive Director Doral Dental) described four points of the Health Net Dental Enhancement Plan, the goal of which is to implement an access program that meets the EPSDT 80% participation goal:

- Postcard mailing targeting members who had no dental service visit from 7/1/01 to 6/30/02, outbound follow up call within 3 months of mailing, gift incentives to those members that had a dental visit. PCP mailing to 1400 HN participating pediatricians and family practice physicians, reminding them to refer members for dental exam and provided offices with dental educational materials. Doral assessed the number of providers seeing HUSKY children and added pediatric dentists .
- Collaborative Community and professional organizations initiatives:
 - Pilot program with the Stamford *Club Be Well*, which targets adolescent access to health care, in “Clean Not Green” health fair program, in which students showed evidence to the school nurse of a dental exam, rewarded by a prize. Future initiatives of this type will include identification of the MCO members and follow up of those without a dental exam/treatment referral
 - Stanford Health Dept Sealant program: Health Net and Anthem purchased portable sealant equipment and expanded the pilot from 2 to 12 schools. Second grade students (466) teeth were sealed, representing 56% of those students who qualified for sealants.
- Collaboration with the UCONN school of Dental Medicine and Head Start programs: UCONN students provided oral health education to parents and teachers; the primary audiences for outreach were pregnant teens, parents of young children, school age children and Head Start programs.

Dental access was increased to approximately 39.5% in FY02, from 27% the previous year (this may be higher as utilization numbers from June 2002 are added. Based on HEDIS dental measures, annual dental utilization in Health Net increased from 40% to 48%.

Health Net Asthma Disease Management

John Joensen, Director of Disease Management for CORsolutions, Health Net Healthy Options DM vendor, described the program and outcomes. The voluntary High Risk Asthma DM program, begun in March 2001, has enrolled 249 CT Healthy Options adult/child members that have had one or more hospital admission based on an asthma diagnosis (primary diagnosis). The DM interventions include:

- Asthma welcome packet, education on the disease process & asthma triggers, use of medications (routine meds and rescue medications), written asthma action plan, importance of a smoking cessation program (Healthy Options “Quitting Matters”).
- Intensive RN case management, which involves review and implementation of health provider’s plan of care and follow up with the member, periodic patient summaries to the provider.
- 24-Hour support phone line staffed by RNs in addition to case management,
- Speech recognition (phone) modular education program accompanied by written materials.
- An educational newsletter, child and adult version, with seasonal reminders, asthma disease management information.

Quarterly Outcomes of the Asthma DM Program were described: Mr. Joensen observed that the data suggests that the length of time in the DM program (average is 6.6 months) is related to lower ED use and hospitalization rates. Member self report of indicators suggest a positive impact of the program, with improvements in physical activity, emotional status, appropriate use of non-steroidal rescue medications, less interrupted sleep, reduction in missed school/work days, some improvement in asthmatic members receiving flu shots (22%) compared to CDC reported rates of 10%.

John Harper, MD, Healthy Options Medical Director, described the Enhanced Asthma Program for 2002 that refines the acuity groupings, population and care management, with primary interventions for high and medium acuity patients, while monitoring pharmacy, ED and hospitalizations of all acuity groups of members aged 2-56 years, ICD 9 codes: 493; 493.0; 493.1; 493.9x.

Acuity Level

Criteria

Interventions

HIGH

- >2 ED visits in 6month period
- >1 Hospital adm in 12 month period
- >6 scripts for short acting beta agonist over 12 month period

- Case management involving clinical pathways
- Member mailings

MEDIUM

- 1 ED visit in 6 month period
- > 6 scripts for short acting beta agonist in a 12 month period

- Member mailings
- Case management as necessary

LOW

- NO ED (6 mo)/hospitalization (12 mo) for asthma
- < 5 scripts for short acting beta agonist in 12 month period

Outcomes measurements will include member self report and internal MCO data that include HEDIS Effectiveness of Care Measurements. Senator Harp thanked Health Net for their efforts to improve dental access and asthma management for their members.

Perinatal Regionalization

Marilyn Sanders, M.D., Associate Professor of Pediatrics, University of CT Health Center, described the changes in neonatology and the development of regionalized perinatal care centers that have impacted the survival rate of high-risk newborns. In 1977, the March of Dimes, in collaboration with the American Academies of Family Physicians, Pediatrics and Obstetrics and the American Medical Association proposed levels of care for pregnancy and neonatal services:

- Level I: uncomplicated deliveries and newborns.
- Level 2: some complicated pregnancies, deliveries and newborns.
- Level 3: full services for ALL pregnancy, delivery and newborn care.

In 1993, the Committee on Perinatal Health and the March of Dimes recommended:

- Continued support of the 3 levels of perinatal/neonatal care.
- New focus on prevention and ambulatory care for pregnant women.
- Importance of data, documentation and evaluation.
- The designation of formalized perinatal regions with oversight.

The expectations of subspecialty (Level 3) centers were further defined to include:

- Inpatient care for maternal/fetal complications.
- Fully equipped NICU and NICU follow up.
- Coordinated transport, consultation and referral arrangements with other specialty (Level 2) and subspecialty centers.

- Educational opportunities for community providers.
- Development and maintenance of perinatal database and evaluation
- Linkage to basic and specialty care centers.

Recent research has evaluated the impact of the regionalization of perinatal care on neonatal mortality comparing the survival of high-risk newborns over the past two decades. There has been a dramatic increase in the survival of extremely low birth weight (1lb 2oz-2lb 3oz) and very low birth weight (1lb 2oz-3lb 5oz) infants and preemies. Infants at 34 weeks gestation now have a 90% survival rate without serious complications. Studies that looked at the impact of the hospital of birth for at-risk, very/extreme low birth weight (VLBW, ELBW) newborns showed no significant survival advantage for births in Level 2 centers over Level 1 centers; those born in tertiary Level 3 centers had the lowest rates of deaths compared to the other two levels.

Mothers “at-risk” for lacking access to tertiary newborn intensive care units are young, non-English speaking, with inadequate prenatal care and uninsured. Health system financial pressures and institutional competition among the informally designated levels of care centers raise the following questions for Connecticut:

- Are CT mothers at-risk for delivery of VLBW infants able to access appropriate perinatal and neonatal care?
- Are there racial, cultural, demographic, or financial barriers to access tertiary (level3) care?
- Would CT infants and families benefit from formalizing perinatal/neonatal systems of care?

Senator Harp thanked Dr. Sanders, both for her work in improving birth outcomes for at-risk newborns and for a presentation that increased the Council and legislative understanding of the issues surrounding access to care, both preventive and treatment, for high-risk mothers and fragile newborns. Rep. Nardello commented that this exceptional presentation raises important questions for Connecticut about who is and is not receiving appropriate levels of perinatal/neonatal care. Both legislators agreed that the information presented would inform future policy recommendations of the Council and the legislature.

Department of Social Services Report FY03 HUSKY MCO contract status

David Parrella reported that the HUSKY MCO contracts have been extended to the end of September 2002. The Department hopes to resolve the rate issues involving the Upper Payment Limit with the Centers of Medicare and Medicaid (CMS) in order to issue capitation rates to the MCOs for the contract period beginning 10/1/02 to 6/30/03. This contract will also contain changes to comply with the new CMS regulations for the Title XXI (HUSKY B) program and legislative initiatives that include reductions of Medicaid optional services for members 21 years and older (applicable to HUSKY A adults only). In response to Sen. Harp’s question regarding the processes to change the Medicaid State Plan, the Department outlined the timeline:

- The State Plan changes are based on the interpretation and implementation of the State budget:
 - Medicaid optional service cuts include services by psychologists, naturopaths, chiropractors, physical, occupational and speech therapists and podiatrists.
 - State Assistance (SAGA), a state-funded program, will have the above service cuts

as well as home health care and vision, including optical hardware, services.

- The Department is expecting to implement the service cuts December 1, 2002.
- Public notice of the State Plan changes will be issued in November 2002 and the State Plan changes will be submitted to CMS with the effective date December 1, 2002.
- Subsequent to the State Plan changes, amended regulations reflecting these changes will be published in the Law Journal.

Senator Harp asked if CMS ever denies State Plan changes. The Department responded that this has occurred; however these service cuts are not mandatory Medicaid services; the Medicaid State Plan must abide by federal directives only for mandatory services. The State Assistance (SAGA) program is not under the federal guidelines; it is solely a State-funded program.

Dental Carve-out & Proposed Joint Medicaid/State Employee Plan

The DSS/MCO contracts for FY04, which begin July 1, 2003, will include the dental and Behavioral Health service carve-out from the Medicaid managed care program. The Department is committed to the dental carve-out, as dental was not included in the internal claims compliance process with HIPAA, which must be implemented in October 2003. States that fail to comply with these HIPAA provisions will be fined \$10,000/day for non-compliance. The RFPs for the dental and behavioral health Administrative Service Organizations (ASO), BH claims vendor and for the HUSKY A & B procurement should be released in October 2002.

The Medicaid Council Public Health Subcommittee had requested DSS to explain the rationale for the Medicaid dental carve-out and “linked procurement with the State employees” at this Council meeting. Mr. Parrella presented the following information:

Ø The dental carve-out will: simplify the administrative process for providers, improve technology & customer service through a single ASO, provide direct accountability to DSS for services previously provided by several dental subcontractors, allow DSS to self-insure the cost of increased access and utilization outside the managed care capitated/risk model and provide direct integration of the program management with special access initiatives such as the pending Robert Wood Johnson grant.

Ø The rationale for the linked procurement with the State employee dental program includes the ability to track costs and access across lines of business, tie State employee contracts to improvements on Medicaid access goals and is a small step toward developing future efficiencies gained through joint purchasing of health care services across state agencies.

Mr. Parrella stated that the ‘joint’ procurement is NOT intended to mitigate the current litigation issues, nor is it a plan to increase Medicaid dental fees. The State employee and Medicaid programs (HUSKY A & B, FFS and SAGA) will have separate contracts with the statewide ASO, different PMPM rates and different provider panels. The ‘joint’ procurement will:

- Bring the best selection of dental benefit managers into the ASO RFP process.
- Improve technology & administrative efficiency across both lines of business.
- Establish targets for incremental improvements in dental access and utilization.
- Apply financial risk only to the ASO administrative cost, with accompanying performance measures, not service costs.
- Organize the delivery of all Medicaid dental services into one ASO.

The Department broadly addressed concerns outlined in various stakeholder communications to DSS:

- *Medicaid dental access will decline as dentists choose to contract with State employee program rather than the Medicaid program.* Mr. Parrella stated that dentists currently choose state employee or private pay business over Medicaid. The Department does not believe the linked procurement will worsen Medicaid dental access. The dental management ASO will have their overall contract performance with the State evaluated based on Medicaid access, which should lead to improved Medicaid access.
- *Dental fees will not be high enough to attract dental providers to Medicaid.* The Department's stance is that fees are not the issue in this linked procurement, nor in the Medicaid carve-out; fees are the issue in the Medicaid litigation. Litigation will address fee issues through a court injunction, settlement, etc. The Department stated these dental program changes are about access, management and improved State purchasing.
- *Lack of public input.* The Department repeated their concerns expressed in the July Council meeting about full public disclosure in the setting of the litigation and the state rules around service procurement. Mr. Parrella stated that once the RFP is released, DSS will form a policy committee that will include input from various levels of dental service providers.

Council questions/recommendations:

- Lack of a true 'joint' procurement for the State employee and Medicaid programs (i.e. separate rates, contracts) leaves no future repercussions for the ASO for the State employee contract. The Department commented that DSS is not in the position to dictate particulars about the State employee contract to the Office of the Comptroller or the unions. The Medicaid contract will hold the ASO responsible for dental access for Medicaid clients; poor performance in this area would impact future ASO vendor selection.
- If there are delays or lack of approval for the linked procurement by the Health Care Cost Containment Committee and State unions, how will DSS proceed? The Department is committed to doing the Medicaid dental carve-out, although the intention is not to do the Medicaid component alone.
- Has the methodology for evaluation of the new system been developed and will DSS continue to report dental access to the Medicaid Council? Mr. Parrella stated the RFP addresses program performance evaluations over a three-year period to assess the impact of the program. The Department will continue to report dental utilization on a quarterly basis to the Medicaid Council.
- Since the Dental Advisory Council (authorized in PA 00-2) was never convened, will the DSS dental policy committee be responsive to the issues of that Council? The Department stated that the procurement always included the policy committee. It may address some of the issues intended for the Dental Advisory Council. Rep. Nardello requested Mr. Parrella bring back the following "strong" suggestions from the Medicaid Council to DSS:
 - The policy committee should include representation of the various levels of direct-service dental providers in the State.
 - There be an ongoing independent evaluation of the program and impact by an objective entity. Mr. Parrella responded that this may be an initial issue for the

policy committee to consider.

- Does the RFP design address integration of other services that remain within the HUSKY MCO responsibility (i.e. pharmacy, transportation, consumer support issues)? The Department expects MCOs to retain responsibility for transportation and pharmacy; the funds for these services would remain in the MCO capitation rate. The Department will have the responsibility of ensuring that the carved out dental and behavioral health services be integrated with physical health. The Department made the transportation decision from the client perspective, in that the member calls only one number (MCO member services) for all transportation needs, whether for dental, behavioral health or physical services. The Children's Health InfoLine evaluated HUSKY A transportation issues per vendor and made recommendations that hopefully will be reviewed by DSS in the development of new contracts.
- Will the linked procurement improve state dental plan benefits that are currently not as broad as the health care benefits? While DSS cannot recommend a benefit package to the Comptroller, the state unions have interest in improving the dental benefit package.

HUSKY Enrollment

HUSKY A enrollment continues to trend upward, though at a slower rate since June 2002 as compared to late 2001 and early 2002 that saw a 3-4000 monthly membership increase.

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HUSKY B enrollment also continues to increase, though at a slower rate than HUSKY A, with a total of 13,460 children enrolled in September 2002. Over the past 12 months, the monthly enrollment increased, on average, 350 members/month. Enrollment in October 2001 was 9,264 children.

Council comments:

- Judith Solomon (Children's Health Council) noted that an evaluation of HUSKY A enrollment data suggests that the procedural changes implemented by DSS to improve retention of HUSKY A members has contributed to the increased enrollment numbers. Ms. Solomon quoted the Kaiser issue brief that reported that **Connecticut has the 2nd lowest rate of uninsured children in the nation.**
- Sen. Harp requested DSS to comment on the following related to constituent issues:
 - The Federal requirement for plan choice (minimum of 2 plans/coverage entities within geographic areas) in Title XIX programs does not apply to non-entitlement Title XXI programs. However, in CT, three of the four HUSKY A MCOs participate in HUSKY B throughout the state.
 - There is no guarantee that members can keep their provider when they change health plans if the provider is not part of the new MCO provider panel. There can be out-of-network service agreements with providers in special circumstances.
 - There is an existing situation in New Haven County that impacts continuity of provider when a member moves from HUSKY A to HUSKY B eligibility. Anthem BCFP enrollment remains frozen in New Haven County due to an inadequate dental provider/patient ratio. Members previously enrolled in a HUSKY A plan that does not participate in HUSKY B and whose provider contracts only with Anthem would not be able to enroll in Anthem during the freeze in order to keep their

provider. There may be exceptions made if the member is moving from HUSKY A Anthem to HUSKY B Anthem.

- Plan lock-in has been implemented in HUSKY B only. Members choose a plan and have a 90-day “free-look” period to decide if they wish to remain with that health plan; if they do NOT wish to change to another plan, the 9 month plan lock-in is started, during which the member may not change health plans.
- Sen. Harp thanked Sylvia Kelly (CHNCT) for her health plan’s intervention with their BH vendor for a constituent that had serious problems accessing emergent intensive psychiatric services.

The Council and Sen. Harp commended Chet Brodnicki for his 15 years of dedicated service to children in the child guidance clinic system and wish him continued success in his important work.

Subcommittee Reports

Public Health: Rep. Nardello reported that the dental issues raised in this Council meeting reflect the issues brought forth in the subcommittee; there will be continued follow up on the progress of the dental plan.

Behavioral Health: Jeffrey Walter reported that DSS, DCF and DMHAS have been most cooperative in reviewing the BH Partnership plans as the subcommittee is a format for stakeholders to ask questions, obtain information and make recommendations. The BH Outcomes study will be completed late Fall.

Quality Assurance: Paula Armbruster submitted the following written report:

1) As a result of the Pediatric Obesity Forum, the Medicaid Managed Care Oversight Council Quality Assurance Subcommittee is working with managed care plans to understand what they provide in the way of nutritional services associated with key clinical conditions (e.g. obesity, diabetes, eating disorders) for Husky A children, Husky A adults and Husky B children. In response to the MCO request, clinicians and medical representatives across the state are being asked to identify effective nutritional programs. This information will be available to managed care providers. Additionally, we are creating a grid as an informational tool for providers to show how they can obtain authorization for these services for their patients.

2) The Adolescent Comprehensive Preventive Health Services Work Group has been formed and is meeting regularly. Participants include MCO’s, DSS, DPH, health care providers and teens. The group will prepare a report on teen health needs to be ready by January 2003.

3) The MCOs provided information to clarify the basic asthma equipment (dust mite barriers, spacers, nebulizers and nublizer accessories) carried by pharmacies and local vendors in Waterbury and New Haven, as well as whether these pharmacies deliver to consumers. Now we are disseminating this information to health plans and to the providers in these two cities. We will ask health plans, nurses, practitioners and professional organizations to help in this endeavor. The goal of this initiative is to improve members’ ready access to asthma supplies and medication.

The Medicaid Council will meet Friday October 4 at 9:30 AM in LOB RM 1D.

