

Connecticut
Medicaid Managed Care Council
Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307
www.cga.state.ct.us/ph/medicaid

Meeting Summary May 9, 2003

Present: Sen. Edith Prague, Rep. Vickie Nardello, Rep. Mary Ann Carson, Rep. David McCluskey, David Parrella (DSS), Dr. Victoria Niman (DCF), Thomas Deasey (Comptroller Office), Barbara Park Wolf (OPM), Michael Hoffman (for Dr. Ardel Wilson, DPH), Janice Perkins (MCO representative, Health Net), Dr. Wilfred Reguero, Dr. Edward Kamens, Ellen Andrews, Doreen Elnitsky, Henry Goldstein, Dr. Alex Geertsma, Dorothy Allen.

Also Present: William Diamond (ACS), Kevin Loveland, David Dearborn (DSS), Tanya Barrett (UW Infoline), Irene Jay Lieu, Chet Brodnicki, Jesse White Fresse, Sylvia Kelly (CHNCT), Greg Maddry (ABC FP), Joan Morgan (Preferred One), Lisa Sementilli, Judith Solomon, Paula Armbruster, Dr. Mary Schwab-Stone, Maureen Mullen, M. McCourt (Council staff).

Quality Assurance (QA) Subcommittee: Comprehensive Adolescent Health in the HUSKY Program

Paula Armbruster, Chair of the QA subcommittee, introduced Maureen Mullen (Hartford Action Plan), the chair of the Subcommittee work group that submitted the Adolescent Health report and recommendations to the QA subcommittee, and with the subcommittee's approval, to the Medicaid Council. The work group, comprised of managed care organizations, health providers, adolescents and state agencies, focused on what happens during an adolescent preventive care visit, based on previous quality reports by Qualidigm, and strategies to improve the comprehensiveness, quality and documentation of adolescent EPSDT services.

As a group, adolescents are healthy, generally seeking out health care for acute illnesses, mandated school physicals and family planning services. Preventive care visits are infrequently seen as important or useful to youth, yet the majority of morbidities in this age group are preventable. Underutilization of preventive health services and incomplete documentation and follow through of identified clinical or lifestyle problems are not unique to Connecticut. National and state-based data both support the importance of preventive care and health risk assessments at this vulnerable age and identify the barriers that lead to low utilization and the comprehensiveness of these services.

The adolescents that participated in the work group significantly influenced the formation of the recommendations. Their common-sense approach to preventive care was illustrated in comments to the Council:

- Nazmie Ojeda, a Hartford public high school student and active work group participant, once again took time to speak to the adolescent perspective on preventive care. Ms Ojeda emphatically stated that teens want time to talk over their health concerns with their health providers. Completion of a standard health assessment form prior to the face-to-face visit leads

to more efficient and focused use of the teen's time spent with their health provider. Ms. Ojeda suggested that such a form could also be used prior to sports physicals or episodic visits, those 'missed opportunities' of contact with the adolescent. Teens and health providers have deemed such a form, used in Ms. Ojeda's high school, as useful.

- Lara Ramin works with about 30 teens as the adolescent health leader for the Postponing Sexual Involvement Program in the Hartford public high schools. Based on her own experience with her 13 year old daughter's primary care experience and that of the teens she works with, as well as an independent survey of health providers' use of a health assessment form, Ms Ramin supports the use of some type of health assessment form. When providers do not know the health concerns of teens, then it is impossible to connect the individual to appropriate services. Ms Ramin acknowledged that certain questions may be difficult to ask of teens, in particular questions about sexual activity, depression or suicide thoughts (often not asked of black teens), however Ms Ramin cautions that failure to assess these issues can result in devastating consequences to the youth and their family.

Maureen Mullen stated that hearing directly from adolescents or their representatives presents a far more compelling case to develop strategies to improve adolescent preventive care quality through the implementation of 'best practices', examples of which can be found among CT providers & clinics such as school based health clinics. The work group recommendations focus on 3 areas (please refer to the executive summary & report for more detail):

- Quality processes that include more inclusive age-appropriate anticipatory guidance guidelines, consistent use of health risk assessment tools that guide interventions and provider/patient clarification of confidentiality policies.
- Provider education on preventive teen health care with collegial sharing of 'best practices' and teen feedback on 'what works'.
- Micro system issues such as care fragmentation within the HUSKY program and macro system issues involving statewide adolescent health care issues.

Senator Prague requested the Council review the recommendations and vote on them at the June meeting.

New Haven School System Social & Health Assessment (SAHA)

Mary Schwab-Stone, MD, Associate Professor of Child Psychiatry & Psychology, Yale Child Study Center (YCSC), described the decade-long collaborative initiative undertaken by the New Haven public school system and the YCSC to assess the impact of the community's social environment on students' school performance, risk-taking behaviors and health status. The information gleaned from a 300-item questionnaire, administered verbally in English and Spanish by college students to approximately 4000 students in the 6th, 8th, and 10th grades in New Haven, West Haven, East Haven and Hamden, is used to document the state of youth & their competencies, provide information on the effects of school-based prevention and early intervention programs as well as guide comprehensive school policy and program development. Early in the development of the questionnaire (SAHA), the team validated the content and students' interpretation of the items through focus groups held in 1993.

Since 1992, seven administrations of the SAHA have provided data that assesses changes and trends in urban and non-urban student perceptions of safety and other factors that influence

academic success and health/mental health status. Dr Schwab-Stone provided examples of the data comparisons, over time, that have informed the schools and communities about predictors of health and academic success, which have led to research-based prevention and early intervention programs:

- The witnessing of violence in the community, higher in the 1994 urban student reports (41%) compared to suburban students (8%) had significant correlations with mental health problems such as depression, anxiety and substance use, risk taking behaviors such as initiating fights, which are associated with a diminished perception of the impact of these behaviors, decreased school performance and lower expectations of a positive future. The schools and the community initiated urban youth projects that targeted violence, resilience, psychopathology, and high school academic failure. Local community policing programs and reduction of gang activities were also implemented. Over time surveys showed changes in the incidence of witnessing violence:
 - o In 1994, 41% of students witnessed violent events, information substantiated by mapping violent events within the community; this decreased to 20% in 2000, again supported by mapping violent crimes.
 - o In 1994, 35% of 8th & 10th grade students acknowledged carrying knives or guns to school; in 2000, less than 20% reported this.
 - o Perceived family & parental support and peer support were the resilience factors found to be effective in coping with community violence. Information on the impact of violence enabled schools and the Psychiatric Counseling Center to assist students in strengthening positive coping strategies to prevent school drop out.
- Data assessed over the past 7 survey cycles have led to the development of academic 'drop-out' predictors:
 - o On the individual level: low income families and neighborhood settings, grade retention in the early grades and permissive parenting in families with > than 2 siblings.
 - o School environment: student's perception of safety in school & teacher support.
- Depression and anxiety rates have declined since 1992. Approximately 17% of students report feelings of hopelessness, although 10th graders reported more optimism about the future compared to 1992 reports.
- Younger students (6th grade) perceive no risk associated with smoking or inhaling drugs.
- About 50% of 10th graders report feeling pressured to engage in sexual activities compared to 40% of 8th graders.

Council comments/questions related to the adolescent health recommendations and SAHA:

- Jesse White Frese commended the work of the subcommittee. School based health clinics are working with the Department of Public Health in piloting core components of the GAPS tool. Overall, adolescents that use SBHC services feel 'safe' in that confidentiality measures are in place.
- Dr. Geertsma stated that group continuous medical education (CME) programs have been show to be less effective in promoting practice change compared to brief office site educational visits.
- EPSDT in Medicaid refer to the range of services that can be provided, differing from commercial medically necessary services. The EPSDT screens are similar to screens recommended by the American Academy of Pediatrics.
- The SAHA data can track a student over time in middle/high school years however the

demographic items do not include parental/caregiver resources.

Department of Social Services

HUSKY Reinstatement Update

Kevin Loveland, Director, Family Division, DSS, reviewed the changes to the HUSKY eligibility program mandated by PA03-2; the Department’s compliance with these mandates and the DSS response to the court temporary restraining order (TRO) issued March 31, 2003. The restraint order was based on the inadequacy of the DSS notices to clients and clients’ potential eligibility for transitional medical assistance (TMA).

Eligibility Changes PA03-2	DSS Compliance with Statute	DSS Compliance with TRO
HUSKY A adult reduced to 100%FPL from 150% effective 4/1/03	-Computer eligibility modified 3/8 -Notices to 23,000 adults sent 3/11 -Reports ID 650 elderly/disabled clients, 160 reinstated -MCOs ID pregnant women & >140 clients were reinstated. Reg. Offices ID many other clients with income changes, reinstated them	-List of closed adult cases sent to reg. Offices for reinstatement 4/3 -MCOs re-enrolled all clients by 4/3/03. -Mass data correction on 4/5-7 reinstated all adu active cases (12,558 of 17,500) -All regions reported completing reinstatements by 4/11. -Reinstatement notices sent to all clients 4/9 & 5/2, advising clients to contact DSS worker for income changes/ eligibility for other programs
Eligibility Changes PA03-2	DSS Compliance with statute	DSS compliance with Court TRO
Continuous Eligibility –Children (12 months)	-Computer mass modification 3/15 -Notices for 5150 CE kids sent 3/17	-List sent to reg. Offices for manual reinstatement 4/3 -CE data reestablished on 4/5; corrections led to >rapid reinstatement -List of 18yo CE sent to regions with reinstatement instructions.

Guaranteed eligibility – adults (1 st 6 mo)	-Computer mass modification 3/15 -Notices to 170 adults sent 3/17	See above
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Current status:

- Court hearing on motions for preliminary injunction & class certification were held on 5/6.
- Judge Robert Chatigny received oral argument & testimony; the parties are awaiting the Judge’s ruling*.
- DSS may again terminate benefits for those not otherwise eligible for clients temporarily reinstated after 4/1/03; the DSS is awaiting court decision before proceeding.
- **The PA03-2 provisions are being implemented except for those clients covered by the TRO (i.e adults with incomes >100%FPL, CE for children and GE for adults).**
 - Transitional Medical Assistance (TMA) is being provided to those in that category and those who become ineligible for health coverage due to increased earnings (>100%FPL) or child support. TMA, required by federal law, applies to those families with earned income covered under 1931 of the Social Security Act who become ineligible for 1931 because of income earnings.
 - Hearing notices that prompted the TRO have been corrected: clients that grieve the process within 10 days of the notice or up to the date of implementation will retain coverage until a grievance decision is made.

**{Addendum: On May 30 Judge Chatigny’s decision upheld the elimination of HUSKY A adult coverage for those >100%FPL and elimination of continuous & (adult) guaranteed eligibility as mandated by PA03-2}.*

Council comments:

- Health advocates commended the DSS for their rapid work in reinstating the adults and children that were set to lose eligibility April 1, 2003. Points raised:
 - o The TRO does not affect the other adults and children that will lose eligibility based on the PA 03-2. This can only be remedied by FY 04-05 budgetary provisions.
 - o The Immigrant health coverage is due to sunset after June 30 (for about the fourth time). If the sunset provision is not once again extended, the DSS cannot approve applications after June 30, 2003.
 - o The DSS will clarify if phone verbal income declaration as part of the HUSKY application is acceptable. Legislation allows income self-declaration, rather than presentation of pay stubs. This legislation removed one significant barrier to enrollment.
- The disenrollment/reinstatement process was labor intensive for the agency, resulting in additional labor costs and re-prioritization of the DSS efforts away from non-critical tasks, toward ensuring those eligible for programs did not lose access to programs. The DSS was asked to quantify the costs of this process for the next meeting. Mr. Parrella stated this was difficult to do as a great deal of staff overtime involved administrative staff. Rep. Nardello stated it is important to understand the consequences of developing health policy through the judicial process; which is an ineffective way to managed health policy issues.
- At Senator Harp’s request, Sen. Prague requested the DSS to assess regional delays in granting newly pregnant women HUSKY eligibility. Further, the DSS was requested to apply the current presumptive eligibility (PE) process to pregnant women. Sen. Harp had requested specific information on delay times from the Hartford area in order to better understand the extent of the delays. The average notification time was 29.3 days, ranging from 15-78 days. The

Department stated that the 'presumptive eligibility' for pregnant women was implemented in early 1990, prior to the more developed policy for children. Hence pregnant women did not receive immediate medical coverage (under Medicaid FFS) for 30 days, as children's PE allows, rather their application processing was to be expedited within 3 days. Adhering to this policy has become more difficult with the staffing resource strains on the central and regional offices, the upheaval created by the disenrollment/reinstatement events and most important, reductions in the Healthy Start funding. In the past, Healthy Start programs acted as case managers in ensuring the woman completed the application process and received health coverage based on eligibility. Mr. Loveland stated the DSS would assess the enrollment delays and noted that pregnant women should be considered for PE. Dr. Reguero urged the DSS to take action on this, as delays in prenatal care beyond the first trimester can lead to adverse outcomes for the mother and infant.

Other agenda items were deferred to the June meeting. **The Medicaid Council will meet Friday June 27, 9:30 AM in LOB RM 1D.**