

Connecticut
Medicaid Managed Care Council
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Meeting Summary: May 14, 2004

Chair: Senator Toni Harp

(Next meeting: Friday June 4, 9:30 AM LOB RM 1D)

Present: Sen. Toni Harp, Rep. Vickie Nardello, David Parrella & Rose Ciarcia (DSS), Ardel Wilson & Martha Okafor (DPH), Dr Victoria Niman & Naidia Arcenes (DCF), Dr Wilfred Reguero, Ellen Andrews, Marjorie Eichler, Dr. Edward Kamens, Janice Perkins & Linda Pierce (MCOs), Dr. Alex Geertsma, Jeffrey Walter.

Also Present: Mark Schaefer (DSS), William Diamond (ACS), Judith Solomon, Deb Poeria, Paula Armbruster, Paula Smyth (Anthem BCFP), Sylvia Kelly (CHNCT), Douglas Hayward & James Gaito (Preferred One), Dr. Alan Kazdin (Yale Univ.), Dr. Paule Couture, Denise Stevens (Matrix), M. McCourt (staff).

Department of Social Services

HUSKY Changes: 2004 Legislation

- Co-payments are eliminated for HUSKY A, Medicaid and SAGA adults effective July 1, 2004 (*PA 04-258*). (*Premiums {Sept SS, PA03-1, Sec 11} for non-managed care Medicaid clients were also eliminated*). Public notice and consumer, health providers and HUSKY MCOs notification of the changes will be done by June 1, followed by changes to the State Medicaid Plan.
- Money was included in the budget for parent/caregivers with earned income (16,000 adults) to continue enrollment in Medicaid for the second year of the TMA period ending April 1, 2005. This was based on the recent 2nd Court of Appeals decision.
- While imposition of new and increased premiums for HUSKY B band 1 and 2 continue, members will not be dis-enrolled in May 2004. The Department will submit a report to the legislative Committees of Cognizance by June 1, 2004, which will indicate how the DSS plans to proceed with this issue after June 1, 2004 (*HB 5801, Sec 107*). Approximately 2000 children are in families that have not paid premiums and could potentially be dis-enrolled from HUSKY B.
- The DSS may move pharmacy benefits for HUSKY and Medicaid to a separate contract with a Pharmacy Benefit Manager (PBM) or within the DSS Preferred Drug List. (*PA 04-258, Sec. 7, effective July 1, 2004*). The carve-out decision has not been made nor is DSS certain about the impact of this provision in relation to the timing of the DSS/MCO contract cycle. The DSS complimented the Council members and BH Subcommittee on their continued work toward streamlining the existing HUSKY formulary operations.

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HUSKY service carve-out status was reviewed:

- The DSS intends to implement the Dental service carve-out October 1, 2004. This change would be part of the next DSS/MCO contract cycle. All four MCOs have signed a current contract extension through September 30, 2004.
- The BH service carve-out remains uncertain, although the DSS is looking toward the possibility of carving out BH services within HUSKY. The 2004 legislation did not authorize the creation of a full Behavioral Health Partnership (BHP) with BHP dollars within separate agency (DSS, DCF & DMHAS) accounts.
- No decision has been reached on a pharmacy carve-out (see above).

Comment/questions from the Council included:

- Regarding the dental carve-out, the DSS is close to making the decision on the dental ASO and will communicate the decision in writing to the Council.
- Regarding HUSKY B premiums, the DSS stated ACS, the enrollment broker, has anecdotal information from follow-up reminder calls: some families have declined continued coverage, perhaps returning to employer-based insurance when the HUSKY B cost share increased, and some families have paid in response to the calls. Dr. Reguero stated there is concern that over 2100 children could be uninsured as some hospitals are reluctant to take non-emergency free ambulatory care for the uninsured due to their budgetary constraints. The DSS is aware of the serious impact of cost sharing on children's insurance and will consider that as the agency makes the policy decisions. The June 1 report will outline the HUSKY B DSS policy for FY05.
- Behavioral health services:
 - o Changing the delivery model for BH Services in HUSKY A & B would require an amendment to the 1915(b) waiver with revision of the actuarial soundness of the MCO capitation rates and State Plan changes. Both require CMS and legislative committee approval. These changes would also significantly impact the MCO per member per month capitation rates.
 - o The BHP collaborative spirit continues with the three agencies working together. However reaching consensus on major issues such as operational responsibility and provider reimbursement is difficult to achieve between the two branches of government. The DSS commented that the current system does not work well because of structural barriers rather than the fault of providers or clients.
 - o The time line for implementing a HUSKY BH carve-out may go beyond 2004 because it is a lengthy process.
 - o Sen. Harp asked how we moved from the original KidCare legislation three years ago that created collaboration between DSS and DCF to the three agency BHP. Dr. Mark Schaefer stated that administrative costs associated with implementing KidCare alone exceeded the available appropriations. At the time that KidCare was developing, DMHAS began discussions with DSS on adult mental health. There seemed to be common goals (administrative efficiency and clinical management by the specific agencies) for child and adult BH services. The BHP was thought to respond to the need for administrative efficiency through a single administrative (ASO) entity, which would provide service integration across ages among the three agencies. Currently one possibility is to implement KidCare through a BH carve-out with an ASO, implement the structural changes to the administrative operations and build credibility and trust among stakeholders as community alternatives to institutional care are expanded and/or developed.

- Regarding the possible pharmacy carve-out, Rep. Nardello encouraged the DSS to make the financial basis for any decision for a different delivery model transparent, given national attention to PBM issues.
- The DSS stated, in response to Rep. Nardello's question, that the State is not pursuing the HIFA waiver nor any form of a Medicaid block grant approach for HUSKY A (HB 5801, Sec.106).

HUSKY Enrollment May 1, 2004

- ü Overall the May HUSKY A enrollment increased by 1521 members (average monthly increases have been 1000 members). Within HUSKY A, adult enrollment increased by 627 (monthly increases average 4-500 members), those <19 years enrollment increased by 894 (monthly average increases are 500/month).
- ü HUSKY B enrollment peaked in October 2003 (15,241), leveling to the low to mid 14,00's since October 03. In May, HUSKY B enrollment increased by 257. The number of HUSKY B families that did not renew their coverage peaked in March 2004 (382), but fell to 246 in April. The increases in premiums began February 1, 2004.
- ü Since October 2003 the number of non-renewals per month climbed to >250/month while this number remained about 150 or less May-September 2003.
- ü Consistently, approximately 45% of all applications and renewals received by ACS are referred to DSS regional offices for HUSKY A determinations.

The Department was asked to report on monthly enrollment losses, reasons for dis-enrollment and the percentage of those dis-enrolled that were enrolled in the following month (RWJ grant).

Recommendation for On-line Applications: Medicaid Council

The Council had been asked to review the information about on-line eligibility applications established by other states provided to members after the April Council meeting in order to vote on the recommendation from the Consumer Access Subcommittee. Prior to considering the recommendations, Sen. Harp asked the MCOs if they had noted any impact on their operations that potentially could be related to delays in eligibility determinations. Mr. Hayward (POne) stated they have seen a higher percentage of pregnant women enrolled in their plan in the 3rd trimester in 2004 compared to 2003. Many premature deliveries are associated with late enrollments. Whether the delays are due to eligibility delays is unknown at this time. Sen. Harp asked the health plans to review this, perhaps focusing on pregnant women's timely entry into their plans. Agency early retirements and staff layoffs have significantly impacted the staffing resources at the regional offices.

The recommendation that the DSS implement on-line applications for Medicaid and HUSKY was approved, with the DSS abstention. Sen. Harp stated that while no new money was attached to this provision in the budget (*PA 04-216, Sec. 26, subsection d*), the DSS was asked to look at the process and parameters for on-line applications, reporting back to the Council in several months. Sen. Harp noted that a later recommendation could be entertained for OPM to include a budget option in the next budget year.

Behavioral Health Outcomes Study: HUSKY A- report is on Council web site under BH subcommittee: www.cga.state.ct.us/ph/medicaid

Dr. Alan Kazdin, Yale University School of Medicine, the evaluator for the BH Outcomes study that focused on outpatient care, reviewed the study findings with the Council. The intent of this study, initiated by the Medicaid Council in collaboration with the DSS, was to examine the impact of treatment on a child's functioning, comparing pre and post treatment assessments of multiple characteristics of children and families as well the broad types of BH services provided. Of the anticipated 4000 completed forms (based on a percentage of outpatient (OP) BH service utilization for children in HUSKY A), 893 completed pre and post forms were available for the study.

The key findings were:

- ü Children in OP treatment demonstrated statistically significant improvement; however the magnitude of change, measured by global functioning (GAF) and reduction in mental, emotional, medical/health and role performance impairment, was relatively small.
- ü Most children received multiple and diverse combinations of treatment, with some type of individual and family therapy being the most common combinations.
- ü Treatment outcome was influenced by socioeconomic (SES) disadvantage and severity of initial impairment. Greater SES disadvantage and severity of the presenting impairment was predictive of less improvement.
- ü Family involvement in treatment influenced change and the parent's rating on desired treatment outcomes met; more family involvement in treatment was associated with greater change in the children post treatment.
- ü There were few differences in treatment outcomes that were associated with the health plans, whether or not these differences were controlled.

Council comments:

- This study is an important step in beginning to evaluate outcomes. Going forward, it is important to evaluate treatment modalities, which are evidenced based and associated with what outcomes. Evaluation and identification of effective treatments in the face of limited resources is crucial to making informed policy decisions. Dr. Kazdin stated there is growing evidence on BH techniques that impact the most people, some of which may be less costly yet widely disseminated. (i.e. parent training videos are available: parent intervention is key to managing aggression, oppositional disorders, which account for about 50% of BH referrals). Dr. Niman (DCF) stated she would like to work with Dr. Kazdin regarding parent training for foster families.
- How can outcome information be obtained in the future? Dr. Kazdin stated that the current measures could be streamlined and put into a provider-friendly form that would lend it to be more easily coded.
- Clinician training is an important part of the process of applying evidenced- based practices.
 - o Yale Child Studies Center works with three levels of trainees in clinical skills development

and appropriate use of evidenced-based interventions.

- o Dr. Schaefer (DSS) stated that evidenced-based practice is crucial to the BHP, in improving system efficacy and efficiency as well as promoting continued clinician education. The proposal for 'enhanced clinics' that could receive financial incentives, provides an opportunity for applying these concepts and evaluating how to promote best practices throughout the system of care.

- o The State and/or credentialing boards require certain health care specialties to maintain certification through continuous education credits (CEU). This may be a mechanism in the future that could be applied to other disciplines to maintain knowledge of "what works and for whom". Jeffrey Walter, Chair of the BH subcommittee, stated the subcommittee would further discuss the study and findings. Sen. Harp and Rep. Nardello thanked Dr. Kazdin for his work with the Medicaid Council on this project and look forward to continuing this work with him in the future.

Department of Public Health: Medical Homes Prove Quality Care to Children with Special Health Care Needs (CSHCN) (see accompanying power point doc)

Martha Okafor introduced Denise Stevens, from Matrix that assessed family and provider perspective on needs related to CSHCN and the effectiveness of "medical homes" for families and CSHCN.

Approximately 10-43% of families reported needing but not receiving services for their child with special needs. The key obstacles reported were insurance coverage and access to resource information and care coordination.

Pediatricians described obstacles to providing effective care for CSHCN. These included insurance issues, coordination of services and family issues.

Case managers for CSHCN identify and help families access appropriate services, thus reducing redundancy and more costly interventions. Evidence is emerging that the *medical home model*, which encompasses primary care provider (PCP) family-centered, comprehensive, coordinated and continuous care, are associated with better health outcomes and lower care costs. Annualized costs for care coordination in a community-based pediatric practice providing 774 visits for 444 patients ranged from \$22,809 – 33,048 (*see the May 2004 supplemental issue of the journal Pediatrics for more information*)

The major barrier to the development of medical homes is the increased use of provider/staff time that is not associated with increased reimbursement. Effective coordinated care is associated with longer office visits, care coordination with multiple payer systems and consultation with multiple specialty services that is only partially reimbursed, if at all.

Dr. Paule Couture, a pediatrician in a private practice of 15,000 patients that include Medicaid and ethnically diverse families, participated with her staff as one of the three practice sites in the CT medical home collaborative. The practice screened children for special needs, developed a care plan with the family and coordinated care, linking state systems and medical specialty systems into a coordinated treatment approach with the family. The most beneficial and

powerful change, from practice perspective, was the inclusion of parents in care planning through review of the pre-visit questionnaire and development of a treatment plan.

The DPH currently is expanding the medical home collaborative in CT to a total of 10 practices, identifying CT pediatricians interested in becoming a medical home (44 CT practices), soliciting proposals for Regional Medical Home Support Centers that will provide technical assistance, family support and care coordination to medical homes in their region and creating a curriculum of a CT Medical Home Academy in partnership with the CT AAP Association. The DPH would support a QA improvement project by partnering with key stakeholders to establish medical homes and monitor the performance provided.

Council members commended the DPH and practitioner efforts to implement a more coordinated approach to care for CSHCN at the practitioner level and the Matrix report on medical homes. What is needed is identification of the interface between practice care coordination vs. more distant coordination, identification of appropriate care coordination codes, uniform criteria for care coordination and intensity of need and integration of medical and behavioral health services for this population. Since the BH subcommittee had previously worked with DSS and the MCOs to create criteria for reimbursed provider-based case management for children with complex MH needs, Sen. Harp requested DPH, DSS, the HUSKY MCOs, Jeffrey Walter and Dr. Geertsma meet as an ad hoc group to address this and other issues related to the above identified areas.

Next Council meeting is on Friday June 4 at 9:30 AM, in LOB RM 1D (note room change)