

Meeting Summary: April 16, 2004

Chair: Sen. Toni Harp

(Next Meeting: Friday May 14, 9:30 AM)

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Dr. Ardel Wilson (DPH), Thomas Deasy (Office of Comptroller), Barbara Parks Wolf (OPM), James Turcio (DMHAS), Dr. Victoria Niman & Auralee Wilson (DCF), Jeffrey Walter, Ellen Andrews, Doreen Elnitsky, Janice Perkins, Dr. Edward Kamens, Dr. Wilfred Reguero, Kim Turner for Rev. Bonita Grubbs.

Also Present: Hilary Silver (DSS), William Diamond (ACS), Catherine Conlin (Program Review and Investigation legislative Comm.), Paula Armbruster, Paula Smyth, Dr. Elizabeth Malko (Anthem), Sylvia Kelly, Dennice Pair, Tressa Spears (CHNCT), Maureen Fiore (Health Net), James Gaito, Laurene Casey (Preferred One), Margaret Dickenson & Dr. Abraham (Mercer Quality Review contractor).

Legislative Program Review & Investigation Committee Study

Catherine Conlin from the Legislative Program Review and Investigation (PRI) Committee reviewed the scope of the approved study on the Medicaid Eligibility Determination Process. The study focuses on the DSS implementation of the application and eligibility determination process for the Medicaid program and the impact of staff reductions and department restructuring on this process (see attached PRI study). Ms. Conlin outlined the Committee process:

- Interested parties will be invited to a general hearing on the study in early September.
- The PRI staff will analyze the study findings, provide recommendations for review and approval or revisions by the legislative committee. If legislation is required to implement any of the study recommendations, these would be presented at legislative public hearings.

Senator Harp, a member of the PRI Committee and supportive of the study, thanked Ms. Conlin for her presentation, noting that the study can be instrumental in initiating changes in the DSS eligibility system.

Subcommittee Reports

Behavioral Health Subcommittee: Jeffrey Walter (Chair) outlined several work group initiatives within the subcommittee:

- Pharmacy work group is addressing drug prior authorization barriers through collaboration

with DSS, MCOs, and providers. The current focus is on 1) streamlining the required PA information among the MCOs; however this may be difficult, as several MCOs have dual business lines and programs in other states and 2) developing a PA drug reference guide for providers that may be added to the HUSKY web site.

- Claims work group, which will meet May 5, will initially focus on MCO information on the common BH claim denial reasons. This would be followed by collaborative sessions to identify steps to reduce the percentage of denied claims.

The subcommittee continues to monitor the intensive home based services implementation and the proposed future program changes in BH services in Medicaid.

Quality Assurance Subcommittee: Paula Armbruster (Chair) reported on several initiatives and focus areas:

- HUSKY Obesity work group is working with MCOs and providers to define obesity-related services and differences for HUSKY A children, HUSKY B children and HUSKY A adults. Health practitioners will present specific recommendations to the work group in May that may then be brought to the Council.
- The comprehensiveness of adolescent health in HUSKY will be followed in the Subcommittee. HUSKY practitioners will be invited to an evening meeting (June 9) with the 4 MCOs to review the plans' adolescent quality initiatives as well as recommendations for more explicit adolescent anticipatory guidance items for the State EPSDT form.
- Based on recommendations from the Council Chair, the MCOs have been asked to provide information on: 1) HUSKY adult and child ED/hospitalization reasons with attention to a public health intervention as appropriate and 2) comparable reports based on the HEDIS 2004 reporting guidelines on appropriate use of asthma medication for adults and children.

Consumer Access Subcommittee: Irene Liu and Christine Bianchi (Co-chairs) and the subcommittee have worked with the MCOs and DSS on attempting to resolve incorporating the member address changes into the DSS system, timely eligibility determinations for pregnant women. In addition, the subcommittee brings this recommendation to the Council for consideration:

It is recommended that the Department of Social Services implement a statewide on-line application and renewal process for the Medicaid and HUSKY programs.

The Council discussed the recommendation:

- Several states have developed web-based application systems for a variety of Medicaid programs as well as a single point of entry for other state/federal programs. An online system would allow individuals to apply or renew HUSKY/Medicaid applications from their home, at health provider sites and other program sites.
- Would such an online system totally replace the current paper system? Rose Ciarcia (DSS) replied that an electronic application system would be an addition to the current system.
- Such state program costs range from \$50,000 pilots in Georgia to a \$1 million full expansion across programs in California. The Department was asked to provide more detail and proposed costs that would be necessary to implement an online application program in CT.
- The benefit of such a program was noted, given the current difficulty encountered with entering member address changes into the system and other critical shared information. It is

conceivable that the up front costs of an online system would be offset by a reduction of administrative costs (i.e. re-mailing Medicaid notices) and reduce the extraordinary burdens experienced by the regional DSS staff since the loss of staffing resources.

Senator Harp stated that the proposed legislative Appropriations budget included money to be directed toward the development of an online system. The DMHAS system allows on line application through a home- grown system that links to providers either electronically or through paper applications.

The Chair asked Council members to review information on online systems and be prepared to vote on the recommendation at the May 14th Council meeting. Resources for on line applications:

Ø <http://www.nga.org/cda/files/SCHIPTECH053002.pdf>

Ø www.nashp.org A State Guide to Online Enrollment for Medicaid and SCHIP: Jan. 03

Ø www.utahclicks.org obtain information on the UAS web-based application process for Utah families with young children, especially those with special needs.

Medicaid Council Quarterly Report: The 1stQuarter Report for 2004 was accepted without change.

Department of Social Services

Program Changes

Rose Ciarcia reviewed the status of program changes:

ü The 2nd Circuit Court of Appeals issued a decision in favor of the plaintiffs in the class action suit related to adults with earned income and their continued enrollment in HUSKY. Legislation in 2003 changed the parent income eligibility from 150% FPL to 100%FPL. Approximately 15,000 adult parent/caregivers of HUSKY A children with earned income, at risk of losing health coverage, will continue to be eligible for Transitional Medical Assistance (TMA). Connecticut statute provides for 24 months of TMA. These adults received TMA under a the court injunction April 1, 2003 and will continue in HUSKY A under TMA through March 31, 2005. The DSS will inform families of this court decision and continued coverage.

ü Service carve-outs:

o Dental carve-out for both Medicaid Fee-For-Service (FFS) and HUSKY A & B implementation date is now slated for October 1, 2004. The Commissioner of DSS has not yet announced the selection of the ASO bidder.

o The implementation of a BH service carve-out is dependent on 2004 legislation.

ü HUSKY B cost sharing changes: premium changes were implemented February 1, 2004 that included a new premium for Band 1 (186 -235%FPL) and increase of Band 2 premiums (>235-300%FPL).

o Band 1: *monthly*, \$30 per child, \$50 for >one child –family monthly maximum.

o Band 2: *monthly* increase from \$30 to \$50 per child, \$75 family maximum.

The HUSKY B benefit package is expected to be restructured as of July 1, 2004. This would result in the benefit coverage changing to one similar to the largest CT commercial HMO benefit

with similar co-pays (Increase in HUSKY B) and deductibles. The HUSKY B benefit restructuring was done through a State SCHIP Amendment that has been approved by CMS.

As was discussed at the March Council meeting, 2400 children (17% of those enrolled in B as of 3/1/04) faced dis-enrollment from HUSKY B for the families' failure to pay the monthly premiums. As of April 1, this number has increased to 2900 children (20% of children enrolled in B as of 4/1/04). Discussion points:

- At the May 14 Council meeting, the DSS will provide information on those facing loss of HUSKY enrollment by band as well as cumulative numbers versus 'new' payers/non-payers.
- To date children have not been dis-enrolled from HUSKY B for families' failure to pay premiums. However, *dis-enrollments will begin May 15* for those families that have not paid their April monthly premium and/or back premiums. The enrollment broker ACS has been informing families of this.
- Within the proposed Appropriations Committee budget, cost sharing remains for HUSKY B but eliminated for HUSKY A and Medicaid FFS. The General Assembly has not yet formally addressed the budget for FY05.

ü The HUSKY A Program Quality Review contractor was announced. The William Mercer, Inc has been awarded the HUSKY EQRO contract, a federally mandated state agency oversight activity. Margaret Dickinson is the CT Project Coordinator and Dr. Ashish Abraham is the CT Project Medical Director. The Mercer described their strengths as an EQRO: experienced clinician resources, positive performance in other state EQRO contracts and objectivity in the review process that is flexible, accurate and based on best practice outcomes. Mercer will be looking to accept input from stakeholders on their projects. Sen. Harp requested the Council subcommittee chairs be included in this process.

HUSKY A Data Reports

CMS 416 Report for FFY 2003 well visits: At the March meeting the DSS provided an overview of the EPSDT screening/participation ratio five-year trends across age groups, based on the CMS (HCFA) 416 reports. The 2003 data adds to that information.

	<1	1-2	3-5	6-9	10-14	15-18	19-20	Total A	Total B*
Screen 2003	92.5%	102.9%	73.5%	52.6%	56.5%	42.4%	28.9%	71.1%	74%
Participation Ratio 2003	84.6%	78.8%	65.4%	49.9%	52.9%	37.2%	24%	56.4%	61.4%

**Addendum: HUSKY B from the CT Annual report to CM, not presented at this meeting..*

Council discussion key points:

- The participation ratio (% of children receiving well visits) is lower than the screening ratio (% of recommended well visits received). The DSS stated this may indicate that not as

many children are getting into care, but those that are connected to care are receiving EPSDT screens.

- There is a significant drop off between ages 3-5 and 6-9. This may reflect that families forget the yearly screens in Medicaid, as schools require well visits in K, 6th and 10 or 11th grade, rather than yearly. Immunizations are required by age 10, which may be a motivation for schools to direct families to well visits after age 9.
- Can it be determined that all age-appropriate components of a screen are included (i.e. lead screens, dental immunization, anticipatory guidance) ? The DSS noted that some children may receive a component of a well visit when the parent/member seeks acute care, but not a full EPSDT visit that is coded as such. Chart audits would provide information on the comprehensiveness of well visits
- Rep. Nardello recommended and strongly encouraged the DSS to identify the practice site of the screens. The DSS stated this could be part of Council recommendations to DSS for contract amendments or could be done through the Quality Review contractor for the HUSKY program.

Follow-up within 30 days of the date of discharge after hospitalization for mental health or chemical dependency diagnoses: the HEDIS measure includes ambulatory BH encounters with a BH practitioner, day/night treatment services and visits with other than a mental health specialist (i.e. primary care provider - PCP).

Follow up (F/U) of MH services within 30 days in HUSKY A

Age	F/U with MH provider	F/U with other provider	Total % F/U	Total %F/U Chem. Dependency.
0-12	66.5%	5.6%	72.1%	31.3%
13-17	62.6%	1.8%	64.5%	50%
18-64	66.4%	0.2%	66.7%	46.5%
TOTAL	65.2%	2.2%	67.4%	45.9%

There is a somewhat higher overall follow-up and non-BH provider follow up 30 days after discharge for MH diagnosis for younger aged members than adolescents and adults. The major differences in the data presented was observed among health plans:

- Health Net reported the highest overall percentage of F/U visits (80.8%)with all F/U by MH providers rather than non-BH providers.
- CHNCT reported the lowest % of F/U visits and higher percentages of non-BH provider visits than the other plans. The health plan will recheck their data.

Differences within health plan populations and service delivery models (i.e. inclusive services at clinic sites versus separate medical/BH service sites) may account for some of the variation. There is only two years of this data available, so it is currently not possible to identify trends within HUSKY. There has never been a contract performance provision in this area. Further discussion of this important indicator will take place at the BH subcommittee as part of the work

group discussions as well as at future Council meetings.

HUSKY MCO Adolescent Health Quality Improvement Projects

At the request of Sen. Harp, each of the HUSKY health plans agreed to provide the Council with a brief description of their adolescent health quality action plans. The Medicaid Council had recommended the DSS include a contractual provision for MCO action plans related to adolescent access to and comprehensiveness of preventive care. The 2004 DSS/MCO contract extension provision focuses on increasing the volume of adolescent well care visits, improving the quality and completeness of these well visits and improving the health risk assessments and anticipatory guidance during the visits. While each health plan's approach is unique, Janice Perkins (Health Net) observed that collectively the adolescent initiatives would serve to improve adolescent care in the HUSKY program. The following summarizes the key focus areas of each plan's initiative:

Initiatives	Anthem BCFP	CHNCT	Health Net	POne
Presenter @ MMCC meeting	Dr. Elizabeth Malko	Tressa Spears, Dennice Pair	Maureen Fiore	Laurene Casey
Broad Focus	Performance Medical Record Reviews, provider education & feedback on quality well care.	Outreach to Teens. Youth advisory group to guide activities.	Study approach of collecting baseline data, providing interventions to improve access to & quality of teen well care	Identify coding issues to better capture well visits, focus on OR to younger teens, provider education on comprehensiveness & guidance components.
Key Components	<ul style="list-style-type: none"> · I- Clinical Medical Record Review · II- Data analysis and data trends · III-QIPs: provider education, develop new EPSDT documentation forms as needed. 	<ul style="list-style-type: none"> · Out Reach to aid members in accessing EPSDT well care · S.T.R.E.E.T. program involving youth advisory group to guide the plan's OR to teen members & inform teens of the importance of preventive health care. · F.O.C.U.S. engaging teens in well care, identifies attractive incentives for well care visits. 	2004: <ul style="list-style-type: none"> · Education campaign to teens & providers about importance of well care & health risk assessments, anticipatory guidance. 2005: <ul style="list-style-type: none"> · Tool to document guidance, check off billing as chart form. · Education on confidentiality laws, practice guidelines for specific issue, promote appropriate BH screens and 	<ul style="list-style-type: none"> · Work with providers regarding billing codes. · Vaccination reminders 11-19, HOH reminder for EPSDT visit for 13-14 YO. · Provider letter on comprehensive visit components, expand anticipatory guidance items, parent info. on importance of youth & provider time in the visit.

Timeline	<ul style="list-style-type: none"> · Phase I: 1Q04 -4Q04 · Phase II: completed 1Q05 · Phase III: QIPs implemented by 2Q05 	<ul style="list-style-type: none"> · STREET, begun in 2002, continues to evolve. · FOCUS, developed in 2003, continues with new teen info. in 2004. 	See above for 2004/2005 activity plans	Build on current work with providers on billing, OR to teens, provider education 2004-05
----------	--	---	--	--

Anthem BCFP also briefly described several other clinical quality programs: high risk pregnancy detection program, BH/substance abuse in pregnancy and a BH Transitional Program with Waterbury Hospital.

Sen. Harp commended the DSS for addressing adolescent health care issues as requested by the QA Subcommittee and Medicaid Council and the MCOs for taking a serious interest in teen health, as evidenced by the innovative projects described by each plan.

HUSKY Enrollment

- Incoming calls to the HUSKY call center returned to over 20,000 calls in March. The majority of language-assisted calls represented Spanish, Bosnia, Portuguese, Albanian, Polish and Russian.
- HUSKY A enrollment increased by 1100 to 303,112
 - o HUSKY A adults increased by 361 to 90,629
 - o HUSKY A <19 increased by 750 to 212,483
- HUSKY B net enrollment increased by 11 to 14,266
- In March 44% of applications were referred to DSS for HUSKY A eligibility determinations.
- HUSKY B top 3 reasons for denials were 1) incomplete documentation, 2) employer sponsored insurance and 3) now receiving HUSKY A insurance.

The Medicaid Council will meet Friday May 14th at 9:30 AM at the LOB.