

Meeting Summary: October 15, 2004

Next Meeting: Friday November 19, 2004 @ 9:30 AM in LOB RM 1A

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), Thomas Deasy (Comptroller Office), M. L. Fleissner for Dr. Ardel Wilson, (DPH), Robyn Hoffman, Doreen Elnitsky, Dr. Edward Kamens, Dorothy Lucas for Janice Perkins, Linda Pierce (MCO rep), Dr. Alex Geertsma.

Also Present: Hilary Silver, Dr. Donna Balaski (DSS), William Diamond (ACS), Deb Poerio (SBHC), Judith Solomon, Mary Alice Lee, Sylvia Kelly (CHNCT), Paula Smyth (Anthem BCFP), James Gaito, A. Tedeshi (FirstChoice/Preferred One), M. McCourt (Council staff).

Department of Social Services DSS/MCO Contract Update

- The contract, set to expire 9/30/04, has been extended from **10/1/04 through 1/31/05**.
- The next contract period would be **2/01/05 and beyond**, and will include MCO rate adjustments to reflect the dental restructuring scheduled to begin 2/1/05 and the proposed BH restructuring implementation during the time period 4/1/-7/1/05.

Program Restructuring

Dental Restructuring: (see www.dss.state.ct.us "dental information –new"- updated on 10/26/04 with waiver/State Plan amendments). The restructuring involves the HUSKY A (child & adult) and HUSKY B populations. The Medicaid Fee-For-Service (FFS) clients may be phased in at a later time.

- New NOI published in the CT law Journal 10/26/04, which includes a revised financial analysis.
- Time frame changes:
 - o 11/10/04 - submission of the 1915(b) waiver amendment and SCHIP state plan revision to the legislative Committees of Cognizance,
 - o 12/10/04 -submission of the 1915(b) waiver amendment to CMS,
 - o 2/1/05 submission of SCHIP State Plan revisions to CMS.
- Client assignment to one of the 2 Dental Benefit Mangers (DBM), previously referred to as the Administrative Service Organization (ASO). The DBMs are: 1) **Doral**, current dental subcontractor for Health Net and 2) **United Health Care** (previously DBP), the current dental subcontractor for Anthem BCFP.
- o Current HUSKY members in Anthem will be assigned to United Healthcare and current

Health Net members will be assigned to Doral.

- o CHNCT and First Choice/Preferred One (PONE) members will be assigned to a DBM that has the current treating dental provider in network. If there is no treating dental provider on record or the provider is not enrolled in either DBM, then default assignment will be split between the 2 DBMs to equalize enrollment.

- o New eligibles will choose their DBM at the same time they choose their HUSKY MCO.

- Client notification of changes in dental service delivery system will begin in early December, with a DBM assignment letter mailed 12/29/04. This letter will inform members about the opportunity to change their assigned DBM, and how to do this.

- Practitioner notification of changes in the dental service delivery system will be through DSS letters to dentists in the state, inviting them to participate/contact information and the DBMs communication with their existing network of providers.

- Continuity of dental care will be ensured through information shared by CHNCT and PONE with the new DBM regarding prior authorization, UM history.

Discussion

Rep. Nardello asked about the status of the DSS dental administrative and clinical committees, encouraging the DSS to involve these committees in the transitional restructuring processes. Dr. Balaski, the Medicaid Dental director, stated the DSS is working on membership for these committees, both of which should be in place by mid-December 2004.

Behavioral Health Restructuring

- **The BH restructuring will include HUSKY A, B, and DCF voluntary programs only.**

www.dss.state.ct.us) with proposals due 10/29/04. This RFP reflects the program population change that will not include SAGA or Medicaid FFS.

- The reconfigured Medicaid Council Behavioral Health subcommittee will serve as the interim oversight committee for the BH restructuring and ongoing KidCare implementation.

State Administered General Assistance (SAGA) Program Update

- Primary Care Provider (PCP) “lock-in” became effective 10/1/04. Prior to this period SAGA clients could change their assigned/usual PCP through CHNCT, the ASO for non-inpatient services.

- The CHNCT provider network continues to expand:

- o Community Health Clinics enrolled in CHNCT effective 10/1/04 – there are now 518 PCPs participating in SAGA, which has a population of about 30,000 eligible clients.

- o 1269 specialists, 230 dentists, 588 pharmacies are enrolled as SAGA providers.

- The CHNCT pharmacy benefit manager for SAGA follows the DSS Medicaid FFS pharmacy benefits and prior authorization plan, which DSS described as the plan previously presented to the legislative Committees of Cognizance.

HUSKY A Data Reports: Hilary Silver (DSS)

Performance varied by health plans on several indicators. Sen. Harp requested the MCOs come

prepared November 19th to discuss variances outside the average for specific indicators and what corrective actions they plan to take in these areas.

- ü **Inpatient data:** of the three indicators (per 1000 member months (MM), inpatient days, discharges, average length of stay-ALOS):
 - o CHNCT had the highest number of inpatient days and discharges, while PONE had the lowest. Excluding newborn hospitalization, CHNCT stated the *inpatient days* represented adult med-surg. diagnoses; the health plan did not know why their inpatient rates were higher than the other MCOs (about 35 days/1000MM versus the average of about 23 days/1000MM).
 - o ALOS was on average lower in these last 6 months (10/03-3/04) compared to the previous the 6 months. There was little variation among MCOs, however Anthem, CHNC and Health Net had rates somewhat higher than the average.

ü **Emergency visits** per 1000MM have steadily increased since the 1Q02 with the highest average rate of about 60visits/1000MM recorded for the period 10/03-3/04. Fee-For-Service (FFS) rates were about 72/1000MM in 1994 prior to managed care. Of the four health plans, Anthem and Health Net were under the average 6-month rate, while CHNCT (about 65 visits/1000MM) and PONE (about 62/1000MM) exceeded the average visit rate of the four MCOs. (*Kaiser State health facts: for the past three years CT has had a higher overall ED visit per 1000 population: in 2002, 403 compared to the US rate of 382. See www.statehealthfacts.org*).

Discussion

Neither the MCOs nor DSS commented on the reasons for the upward ED utilization trends and plan variation. Dr. Kamens suggested the hospital and ED data be broken out by diagnostic categories. The Quality Assurance Subcommittee had recommended reports on ED/hospital use by age (to access adult data), gender and ‘top’ diagnoses associated with these services. Rose Ciarcia (DSS) stated Mercer, the state Quality Review contractor, will report on diabetes and asthma diagnoses associated with ED/hospitalization; DSS will consider including reports by age. Hilary Silver (DSS) stated that not all ED visits result in hospitalization. The MCOs will look at ED data, starting with asthma & diabetes ED diagnoses, gather baseline data, identify members with these diagnoses that were admitted or had follow up outpatient care. The MCOs will then identify steps to decrease ED use for these diagnoses.

ü The percentage of clients receiving “*any Behavioral Health Service*” has on average increased to about 9% over the 6-month reporting period. PONE was well under this level at about 4%. The health plan will be reviewing their data reports for this time period.

ü **Maternal health care** included three indicators: % of women enrolled in HUSKY in the 1st trimester, women with at least 80% of expected prenatal (PNC) visits and women that received ‘timely’ postpartum visits (PP), defined as those visits within the specific time frame of 21 – 56 days after delivery. Missing data for deliveries & postpartum care make the interpretation of the average MCO performance and plan comparisons, and assessment of quality MCH care in HUSKY difficult.

o 1st trimester HUSKY enrollment rates have increase to about 60% (members who change plans are excluded). Anthem was well below this rate; however the plan reported 318 deliveries with insufficient data.

- o The percentage of women that receive 80% of PNC visits decreased in the 2nd half 2003 (80%) compared to >85% previously. Anthem exceeded the average, while Health Net reported 75% and PONE 68%.
- o The % of women that receive timely PP visits remains under 60%, actually decreasing by about 5% during the 2nd half 2003. Missing data on PP care outside the indicator parameter makes this performance data difficult to assess.

Discussion

- Dr. Geertsma noted that early PP visits may be related to maternal complications, which have different CPT codes. While this may affect only a small percentage of PP visits, it may be useful to identify other PP visits beyond the HEDIS time-specific visits.
- The CTVoices will perform the DPH/Medicaid birth linkage, based on the DSS/DPH MOU, for CY 2002. There is no funding for matching the 2003 data at this time.
- Missing data is a problem: one contributing factor is the redundant reporting by practitioners to the MCOs & the administrative time spent by the MCOs in gathering clinical information that are data indicators on the birth certificate (*addendum: birth certificate data elements include mother's age, ethnicity, month PNC began, total # of PNC visits, clinical estimate of gestation in weeks, gestational age in days, as well as maternal risk factors, complications of labor/delivery, newborn conditions*). The question for the future is can that level of data be available from the birth certificates in "more real time" for the MCO reports to DSS?

ii *Preventive Care Services*

- The positive aspect to the reports is that 45-50% of both females and males aged 13-17 years enrolled in an MCO for at least 11 months, received preventive visits. As the age increases for both females and males, preventive care visits decline, most markedly for males.
- What is troubling is the low percentage of women enrolled for at least 11 months in a MCO that received breast & cervical cancer screens. Only **30%** received mammograms in 2002 & 2003 (**The HEDIS Medicaid rate is 55.3%**). Cervical cancer screens averaged **40%** in 2002 and 2003. (*Kaiser State health facts-CT: in 2000, 86% of women ages 50-64 had a mammogram within the last two years while 88% of women ages 18-64 reported having a Pap smear within the last 3 years.*)

Discussion

- How complete is the billing from School Based Health Clinics (SBHC)? More preventive care may be provided (through middle and high school SBHCs) than what is reflected in the data. Most SBHC services are preventative. All of the MCOs contract with SBHC, so data should be in the encounter database. The SBHC representative outlined some of the billing challenges:
 - SBHC are not designated PCPs, therefore in some cases an EPSDT screen may be performed but not reimbursed. Rose Ciarcia (DSS) stated the reimbursement is based on that SBHC's contract with the MCO.
 - SBHCs are mandated by their funder, DPH, to bill for Medicaid services, however a clinic may not have adequate administrative funds to support the billing process.
 - DPH receives quarterly data from the SBHCs on services provided.
- Sen. Harp and Rep. Nardello requested the SBHCs bring information on their billing to the next MMCC as well as DPH data, which hopefully also identified the student's insurance

status.

- The DSS was asked to outline the HEDIS parameters for MCO data reports. The DSS agreed to do this at the November meeting.

FirstChoice/Preferred One Report

The Medicaid Council requested PONE provide information on their low EPSDT performance, corrective plans and an explanation of the CY 2003 Revenue/Expense Report specifically related to medical loss ratio and per member per month margins. Anthony Tedeshi presented PONE information based on the Council requests:

- *EPSDT Services:* the plan demonstrated an improvement in the percentage of EPSDT screens from 1-2Q03 to 1-2Q04, with ratios increasing from 65% to 74%. EPSDT participation ratios show a similar increase from 52-59% in 2004. PONE specified reasons for the 2003 low performance rates:
 - o Limited provider network strength hurt performance in early 2003.
 - o Rapid membership growth beginning 1/03 through 6/04 (62% increase compared to single digit percentage membership increase in the other three plans) hampered PONE intervention efforts with their rapidly expanding membership.
 - o Significant PONE changes including increased member intervention efforts & PCP network growth of 200 practitioners are expected to result in an 80% EPSDT screening ratio in 3-4Q04.
- *2003 Medical Benefit Ratio (MBR): this reflects the medical expenditures/revenues for a given period of time.* In CY2003 the MBR was 79.9% (*an average range tends to be 83-85%, noted in previous DSS presentations*). Reevaluation of the billed but not received (IBNR) data in 6/30/2004 showed an 82.8% MBR. Reasons for the 79.9% MBR were described as:
 - o Lack of tertiary care contracts in 1Q & 2Q 2003 drove the favorable member selection process. PONE did not have a contract with YNHH, which reportedly influenced their member case mix.
 - o The plan stated the MBR in the 3rd & 4th quarters of 2003 and 1st Q 2004 increased to 85.7%. This was attributed to the YNHH and their Primary Care Clinic contract, rapid membership growth and significant increases in late term pregnancy enrollees.

Health and Health Care Disparities Among Children Newly Enrolled in HUSKY A: Mary Alice Lee, CT Voices for Children (*See briefs at www.ctkidslink.org*)

The Connecticut Health Foundation funded and the Commissioner of Social Services supported a survey of families of newly enrolled children conducted by the Children's Health Council in 2002-2003. Previous CHC reports had described differences among racial/ethnic groups in accessing will-child care and preventive dental care. In this survey, newly enrolled families (893) with children aged 3-10 years were interviewed by phone about insurance status, health status and access to health services prior to enrollment. There were no significant variations associated with race/ethnicity. Family demographics showed that one-third of the parents of the children were born outside the US, compared to 16% of children already enrolled in HUSKY A, suggesting growing diversity in the program membership. Outreach initiatives and health practitioners will need to continue to consider cultural issues. Some of the newly enrolled families may have different expectations of the health care system, based on their experiences in

their own country.

After six months enrollment in HUSKY A:

- ü 7% more children had identifiable primary care providers.
- ü Fewer children relied on the ED for care, comparing 4.5% at enrollment to <1 % at 6 months of enrollment.
- ü Fewer children had unmet medical needs at 6 months with the exception of unmet dental care that remained at 20%.
- ü More children had preventive care.
- ü At one year, differences seen on enrollment between Black and White children in having a usual source of care, recent preventive care and trust in health plans and providers were eliminated.
- ü There was little change in families' ratings of the child's health status as fair/poor health (6%) at one year of enrollment.

HUSKY Enrollment

HUSKY Enrollment October 1, 2004

| HUSKY Program | May-July 04 Change # | July-Sept 04 Change # | October Change |
|-------------------|--------------------------|-------------------------|--------------------------|
| HUSKY A < 19 Yrs. | Decrease: 1202 enrollees | Increase: 421 enrollees | Increase: 906 enrollees |
| HUSKY A adults | Decrease: 479 enrollees | Increase: 75 enrollees | Increase: 492 enrollees |
| All HUSKY A | Decrease: 1681 enrollees | Increase: 496 enrollees | Increase: 1398 enrollees |
| HUSKY B | Increase: 30 enrollees | Increase: 94 enrollees | Increase: 40 enrollees |

HUSKY A Enrollment 2004

Rank order reasons for HUSKY B denied application:

- **51% Incomplete documentation**
- 19% Employer Sponsored Insurance
- 17% Client receiving HUSKY A
- 4% no eligible children, non-resident in CT, non-citizen

Applications referred to DSS from the enrollment broker for HUSKY A eligibility determination:

- 60% new applications

- 10.5% renewals
- 43.4% of Total Assistance Units (new & renewal applications) were referred to DSS.

Discussion:

- HUSKY B projected enrollment in 1998 was 90,000 children; despite significant outreach dollar expenditures, HUSKY B enrollment remained flat, while HUSKY A enrollment increased, yet we continue to have an estimated 75,040 children <18 uninsured and 280,150 adults ages 19-64 uninsured, based on CPS population data 2002-2003. For the period 2001-03, 42,000 children with income < 200% federal poverty level (FPL) were uninsured.
- The above CHC study of newly enrolled HUSKY A families documented that one-third the children had parents born outside the US. Don't know what percentage of the 42,000 uninsured lower income children are non-citizens.
- While outreach funding has been seriously reduced in DSS, community outreach dollars remain in the Community Health and SBHC system. The DSS stated it is important to include community-focused outreach to cultural sites that work with newly arrived populations.
- State funding for immigrant health care was suspended for SFY 04, but has been renewed for SFY05.
- Sen. Harp stated that two Medicaid policies, children's continuous eligibility (CE) and presumptive eligibility (PE), were eliminated in CT in 2003, yet HUSKY data (i.e. preventive care for adolescents continuously enrolled for 11 months is higher than other aggregate data reports) suggests that the longer a person is enrolled in the program, the more likely they are to obtain preventive care. Presumptive eligibility promotes access to health care coverage and immediate care while CE promotes continuity of health care and also reduces practitioner and MCO administrative burdens. Sen. Harp requested DSS to provide the Council with information on HUSKY enrollment under these two policies in order to determine a basis for recommending reinstating these two policies.

The Council will meet Friday November 17, 9:30 AM at the LOB RM 1A.