

Meeting Summary: December 10, 2004

(Next meeting Friday Jan. 21, 2005, 9:30 AM)

Present: Rep. Vicki Nardello, Rep. David McCluskey, David Parrella & Rose Ciarcia (DSS), M. L. Fleissner for Dr. Ardel Wilson, (DPH), Robyn Hoffman, Doreen Elnitsky, Dr. Edward Kamens, Janice Perkins, Linda Pierce (MCO rep), Dr. Alex Geertsma, Aurele Kamm for Dr. Niman (DCF), Barbara Parks Wolf (OPM), Rev. Bonita Grubbs, Jeffrey Walter

Also Present: Commissioner Wilson-Coker (DSS), Dr. Mark Schaefer (DSS), William Diamond (ACS), Deb Poerio (SBHC), Chet Brodnicki (Child Guidance Clinics), Mary Alice Lee (CTVoices), Sylvia Kelly (CHNCT), Paula Smyth (Anthem BCFP), David Smith (Preferred One), M. McCourt (Council staff).

Department of Social Services

Human Service Infrastructure Overview: Commissioner Wilson-Coker

Commissioner Wilson-Coker described the initiative in the context of budget issues that prompted the need for a more cost efficient and comprehensive human service system that promotes opportunities for CT residents to achieve self-sufficiency.

- The Initiative goals include better use of existing resources, connecting clients to community resources before, during or after DSS interventions, having clients be better prepared to use the DSS services efficiently at the regional office level, coordinate all “helping” services within the human service infrastructure.

- The Initiatives foundational partners include: the DSS, the 211 Infoline and the CT Community Action Network (CAAs), which are a federally designated Anti Poverty Agencies, that are linked together by a single software system. Statewide partners also include all health & human service agencies/organizations. A non-profit Human Services Cabinet will convene a Partners Committee to build on the involvement of the foundational partners.

- This Initiative represents a “new way of doing business” through multi-agency coordination, which will break down the silos between programs and among agencies. This “one-stop” opportunity at CAA sites will support the approach to a holistic assessment of the individual/family service needs. The initiative was piloted at 3 CAA sites during March-June 2004 and all CAAs began implementation July 2004.

- The Human Service Infrastructure process at the CAAs include:
 - o Universal intake that includes a common set of data elements on all clients.

- o Pre-Assessment for client triage.
 - o Full assessment for clients with multiple needs that require case management.
 - o Pre-applications assistance for DSS programs, including Medicaid & HUSKY.
- The statewide CAA system can track service use, referrals and changes in client status.
 - o During July –Sept 04, 3,873 clients were seen, with 19% receiving an universal intake and DSS referral only, 59% had and the additional pre-assessment and 22% had a pre or full assessment & referrals.
 - o 2,901 had at least one referral to another CAA service; the most frequent were for employment, emergency services and ‘self-sufficiency’.
 - o 1,792 received external referrals to community-based organizations: the most frequent referrals were for employment and housing.
 - o 344 statewide referrals were made to DSS; the most frequent referral was for food stamps, followed by HUSKY, SAGA medical and TANF.

The Commissioner related success stories of clients connected to the Initiative and highlighted the TVCCA partnership in New London. Mary Lou Underwood stated that the 3-year grant brings together a consortium of health providers, institutions and CAA to assist uninsured individuals. Consortium members address both health needs and social needs in a standardized intake, with appropriate health and human service needs referrals. The commissioner is hoping to adopt the TVCCA model statewide, connecting health and other human service needs.

Council comments/questions:

- ü Council members commended the Commissioner for her leadership in developing this comprehensive initiative, given limited resources. Rep. McCluskey and others’ questions addressed the current and future *evaluation of the initiative*. The Commission identified the following evaluation processes:
 - o The program will track clients along the self-sufficiency continuum, initially identifying resource use across agencies and community organizations and changes in client status. Eventually this system will provide cost value of services used, assessing the cost benefit of coordinated assessments and service provisions for clients with multiple needs.
 - o While the DSS does not have funding for a full evaluation, the department has submitted grants targeting program evaluation.
 - o There will be monthly evaluations within the Partners committee as well as client focus groups.
 Rep. McCluskey stressed the importance of the initiative evaluation, identifying trends in service utilization, which may initially increase but may result in measurable longer-term benefits of family stability, shorter length of service utilization and reduced re-entry into the system.
- ü *How confident is the agency that people will use the 211 Infoline, one of the key partners?* The Commissioner stated that Infoline is a great State resource, receiving many calls daily. However there is a need for more public awareness of this service that the Partners Committee can facilitate.
- ü *The reality is that service needs for some referrals to 211 cannot be met, especially those involving housing or shelters. What happens when a resource cannot be identified at Infoline?* The Commissioner answered that 211 staff would attempt to find appropriate assistance through

CAA. Both 211 and the CAAs are collecting data on unmet needs. Rep. Nardello stated that it is vital that this information be communicated formally and in a timely manner to the legislature to inform policy makers' decisions about allocation of funds.

HUSKY Dental Carve-out

David Parrella announced that the **February 1, 2005 implementation date has been postponed**, as the DSS has received many comments in response to the public notice of the proposed restructuring in the CT Law Journal at the end of October. Many questions focused on provider fees and client access to services, which are issues included in the dental litigation. The Department was asked if the ongoing delays in program changes, which impact MCOs, providers and clients, could be prevented in the future. The DSS noted that absent budget considerations, the restructuring could move forward; however comments received have direct budgetary impact.

Behavioral Health Carve-out

Mark Schaefer (DSS) stated that the agency is reviewing the rather extensive RFP bidder responses and expect to announce the successful bidder in December, with a BH ASO contract with DSS and DCF in place in February 2005. The April-July 2005 implementation time frame remains. The rate methodology, and transitional issues will be reviewed in the BH Oversight Committee, which meets next January 12, 2005.

Overview: HUSKY Enrollment

Table 1: Total HUSKY A Enrollment 2002-2004

Table 2: HUSKY A Enrollment < 19 YRS 2003-2004

Table 3: HUSKY A Adult Enrollment 2003-2004

There continues to be a July-August decrease in children's enrollment after the May peak numbers (Above tables), with the loss of enrollment most prominent in 2003. The 2003 enrollment recovery after August through December remained a bit lower than that May peak enrollment; this was not the case in 2004.

Table 4: HUSKY A 12-Month Growth From January & December Enrollment Data for 2002-2004

Using the enrollment numbers provided by ACS, overall enrollment in HUSKY A continues to increase, although at a lower rate than in 2002(table 4). Legislation passed in 2003 made significant changes in HUSKY A eligibility (see OLR report 2003-R-0846) including:

- PA03-2: reduction of income limits from 150% to 100% for adult/caregiver coverage, elimination of children's 12-month continuous eligibility and adult 6-month guaranteed eligibility, effective March 31, 2003.*

- PA03-3 eliminated presumptive eligibility for HUSKY A children, effective October 2003.

HUSKY B enrollment is gradually increasing, with the highest enrollment since 1998 in Dec. 2004 (15,254) and a gain of 634 members from January to December 2004. The DSS returned the Band 1 & 2 co-pays back to the pre- February 04 level effective June 1, 2004.

Preferred One Report

ED Visit rate

David Smith, Interim COO for FirstChoiceCT/Preferred One (PONE), a CT Medicaid-only health plan, reviewed the calculation of the ED visit rates, in response to previous questions about the interpretation of the December 2003 ‘938ED utilization’ number. Using Oct 2003 numbers, 671 is the # of ED visits per 1000 member months per year. The DSS reporting represents 1000 members per month, which for Oct 2003 is 56/1000 members per month. (Given this methodology, the Dec 2003 number of 938 visits per 1000 member months per year, represents 78.2 visits per 1000 members per month).

Data Reporting Analysis

Mr. Smith, who joined PONE in the past month, stated that it has been apparent over the last several years that the inability of PONE to consistently provide accurate and timely data reporting has resulted in data that has often been “recast” due to omissions/errors and has brought into question the plan’s credibility. The steps for future data integrity include:

- Implement a Corporate auditing mechanism for technical & clinical peer review groups.
- Reconcile all data reporting, to be completed prior to submission to DSS/Mercer.
- Create a Regulatory Reporting Committee.
- Establish Corporate oversight of all regulatory reporting.

Dental & Prenatal Care Reports: Mary Alice Lee, CTVoices

Dental Utilization in HUSKY A for 2003(see report www.ctkidslink.org)

This report, based on the DSS HUSKY A enrollment data, describes dental utilization for children ages 3-19 that were continuously enrolled between January 1 and December 31, 2003. According to the EPSDT schedule for preventive care, children in this age group should receive preventive dental care every six months. Findings:

- 140,728 children ages 3-19 were continuously enrolled in HUSKY A in 2003, a 17% increase from 120,193 children in FY2002. (Note: *MCOs are paid a PMPM rate per enrollee*).
- While the number of children receiving dental services increased related to increased enrollment, the utilization of services remains stagnate. See summary taken from previous reports for 2001-2003:

Dental Utilization Report	FFY01: 10/1/00-9/30/01	FFY 02: 10/1/01-9/30/02)	Calendar Year 2003 1/1/03-21/31/03
# Continuously enrolled (3-19 Yrs)	104,470	120,193	140,728*
% Any dental care	45%	47%	47% (66,142 children)

% Preventive care	35%	38%	40%
% Treatment	20%	21%	21%

*In 2002 & 2003 there was an increase of 9,000 children per year that received preventive care.

- In CY2003, most of the children (40% of those continuously enrolled) had only one *preventive care* visit; 13% had 2 visits.
- Preventive care visits were higher for children aged 6-11 years, those living in Hartford compared to other cities, towns, and for Hispanic children compared to other ethnic groups.
- 9% of the 21% of children who received *dental treatment* had two or more treatment visits.

Mary Alice Lee noted that those children in the communities that received financial support from the CT Health Foundation to build a dental infrastructure received more dental services compared to other communities that did not have these additional infrastructure dollars.

Rep. Nardello noted that currently there does not appear to be a way to identify what the treatment rates would be compared to the preventive percentages (i.e. for those children that receive preventive services what % of them required dental treatment and what number of them actually received treatment). This may require additional funding to assess the impact of preventive dental interventions on dental treatment need.

(Addendum: below is the BH and dental expenditures reported to DSS by MCOs presented at the July 2004 MMCC meeting. BH PMPM \$ increase % was twice that of dental PMPM dollar % increase).

Total Dental and Behavioral Health Expenditures 2002-03

	2002	2003	Percent Change
Member months	3,441,027	3,575,789	3.9%
Net BH Expenditures	\$49,463,122	\$57,726,691	16.7%
\$ per member per month	\$14.37	\$16.14	12.3%
BH Reinsurance \$	\$23,107,956 (47% of all BH Expenditures)	\$27,837,092 (48% of all BH expenditures)	20.3%
Dental Expenditures	\$26,282,728	\$28,057,622	6.8%
\$ PMPM	\$7.64	\$7.85	2.7%

Prenatal care: Effect of Medicaid Coverage on PNC & Birth Outcomes

This report (see report on www.ctkidslink.org) is similar to other states' findings on the increase in access to PNC through Medicaid coverage, but lack of evidence of the impact on PNC alone on improving birth outcomes. In this report, based on 2001 CT Birth Registry data matched with HUSKY A enrollment data, 43% of women that gave birth while in HUSKY were enrolled in HUSKY before pregnancy; 57% were not enrolled when they became pregnant (assume uninsured).

Early Enrollment Reduced Risk for Inadequate Prenatal Care (PNC)

When a mother enrolled in HUSKY A:	Before Pregnancy*	1st Trimester	After 1 st Trimester
Delayed/no PNC	21.4%	10.6%	25.3%
Less than adequate PNC	22.1%	14.6%	22.7%
Low Birth Weight	8.8%	7.3%	7.0%
Preterm Birth	9.4%	8.3%	7.6%

*Women already enrolled in HUSKY A when they become pregnant may be at risk for adverse birth outcomes due to factors beyond insurance status (Effective 4/01, parent/caregivers of HUSKY A children with incomes at or below 150% FPL were eligible for HUSKY A, whereas as of 3/31/03 the limit is 100% FPL).

Conclusions drawn were: 1) coverage in HUSKY A *prior to pregnancy* improves access to early & adequate PNC, (*note: those enrolled in the 1st trimester appear to have the least inadequate PNC*) but does not improve birth outcomes, 2) women enrolled prior to pregnancy need access to family planning services and access to early PCN, 3) early identification and enrollment of women into Medicaid facilitates access to early PNC, suggesting the importance of timely eligibility determinations, community-based coordination of early PNC.

Council comments:

- Is there any impact on timely & adequate PNC on birth weights? According to Ms Lee, population-based data do not show the impact.
- Rep. Nardello noted it is important to identify 'high risk' women at the time of HUSKY enrollment, and Dr. Kamens noted that identification of women with adverse birth outcomes & the women's co-morbidities would be an important part of the data evaluation.
- Ms. Lee and others noted that inter-conception coverage (i.e. HUSKY A adult coverage beyond the 60 day postpartum period for those at or below 100% FPL) has been shown in some states that have expanded the coverage to improve the women's health status.

School Based Health Centers: Deb Poerio

This report is a follow-up to the request of the Council Chair & Rep. Nardello for SBHC to provide information on their ability to bill/recoup Medicaid reimbursement. Ms. Poerio presented an overview of the 63 DPH funded SBHC, identifying the following:

- 70% of students the student population of schools housing SBHC are enrolled in SBHCs, with 46% using services, of which 62% are medical, 34% BH, 4% dental services.
- The insurance status of the SBHC students changed over time (2000-2004) with Medicaid insured increasing from 28% in 00-01 to 41% in 03-04, the uninsured increased from 27% in 00-01 to 30% in 03-04 and those privately insured decreased from 39% in 00-01 to 28% in 03-04.
- With the elimination of presumptive & continuous eligibility, current SBHC outreach effort are limited to staff referral and follow –up, staff care coordination for HUSKY patients. Reportedly 66% of the population is transient, making outreach & follow-up difficult.
- Barriers to SBHC billing/data collection include:
 - o SBHCs cannot bill as PCPs, & do not bill for confidential services b/c EOBs are sent to parents (not in HUSKY A).
 - o State funding levels, staff reductions, lack of TA for administrative support for billing, collecting co-pays for private insured, non-insured patients.
 - o Students often do not have insurance cards, information for billing.
 - o The BH DSM-IV system does not take into account short-term clinical issues.
- Recommendations from the SBHCs include:
 - o Increased funding to SBHC for the high number of uninsured students and for the Preventive SBHC Model services.
 - o Support reimbursements for mental health codes that are preventive, educational and short term in nature.
 - o Funding for consultants to develop a new data collections and billing system, outside the “Clinical Fusion” clinical database, specific to SBHCs.
 - o Creation of a Task Force among state agencies and the CT Association of SBHC to ensure provision and coordination of services to school-aged children in a seamless, cost effective manner.

Council comments/recommendations:

- Billing MH services through Child Guidance Clinics may capture more BH dollars.
- Rep. Nardello to follow up with Ms. Poerio, as preventive dental screens are reimbursable.
- The growing number of uninsured is troubling, as discussed in previous MMCC meetings. Representative Nardello asked the DSS for a commitment to bring parties together to identify and address the issues, and attempt to identify the percentage of undocumented students as part of the uninsured. Mr. Parrella stated the DSS has supported SBHC in the HUSKY program through ensuring contracts with HUSKY MCOs. The DSS agreed to work with rep. Nardello on this.
- Rep. McCluskey suggested:
 - o That SBHC & DPH work with the DSS Human Service Infrastructure to address the high percentage of students who move, and may lose contact with the Medicaid insurance system & SBHC services.
 - o Investigate the possibility of applying the statute (2-33A) for distressed municipal funding that is outside the spending cap to address some of the issues raised in discussion.

The Medicaid Council will meet Friday January 21, 2005 instead of the 2nd Friday, which precedes a state Holiday.