

## **MINUTES**

### **July 11, 1997**

Present: Senator Toni Harp (Chair), Senator Mary Ann Handley, Representative Vickie Nardello, Cynthia Matthews, Judith Solomon, Lisa Sementilli-Dann, Dr. Wilfred Reguero, Jim Gaito, Pat Baker, Eva Bunnell, Marie Roberto and Jeff Walter.

Also present: Dr. Edward Kamens, Rose Ciarcia and Paula Armbruster.

#### **Legislative Update**

Senator Harp reported that Governor Rowland chose to veto SB-637, An Act Concerning the Recommendations of the Medicaid Managed Care Council and Early Periodic Dental Screening. DSS has committed to including the language from the bill in the RFP and the contracts and the Governor's office has echoed that commitment.

Senator Harp also noted that DSS has agreed previously to include the Council's representative, Judy Solomon, in all contract negotiation sessions; she will report back to the Council on the progress of those negotiations. Senator Harp also reported that the legislature expanded eligibility to 5,000 uninsured adolescents under Medicaid Managed Care. She also reported that the Council is awaiting a reply to their request for a meeting with the Governor to discuss guaranteed eligibility.

She noted that a draft of the Council's July Quarterly Report was distributed to all members. She asked that members get any proposals for changes to staff by August 1; any proposals will be sent to all members for a vote at the next meeting.

#### **Nurse Midwives and Medicaid Managed Care**

Debbie Cibelli, Chair of the Connecticut Chapter of the American College of Nurse Midwives, addressed the Council. She stated that nurse midwives have practiced in Connecticut over 20 years in many different settings; they have been licensed since 1993. Nurse midwives have a long history of caring for Medicaid patients, seeing thousands of Medicaid recipients each year. They work in collaboration with physicians under written protocols and practice guidelines. At her site, Yale-New Haven Hospital, 20% of all births are attended by midwives. Nurse midwives also provide a full range of gynecological services. Under federal law, Medicaid clients are guaranteed access to nurse midwife services. She noted that in Connecticut, it is very difficult for nurse midwives to get a Medicaid provider number; she waited almost ten years to get her number. Under fee for service, nurse midwives are reimbursed at 90% of the physician rate, so the use of nurse midwife services saves money. Under managed care, many plans do not include nurse midwives in their provider panels, and consequently clients in those plans are denied access to those services.

Last year DSS changed its policy and revoked nurse midwives' Medicaid numbers. They were instructed to bill for services under a physician's number. Consequently, they are being paid at the higher physician rate, so DSS is paying more for the same services.

She asked the Council for help in ensuring a guarantee of access to nurse midwife services under Medicaid Managed Care.

Jim Gaito responded that nurse midwife services are covered under Medicaid and DSS has recognized nurse midwives to serve as PCPs. There are now 48 nurse midwives registered as providers in Medicaid and seven of the 11 plans include nurse midwives in their networks. He stated that it is DSS' position that access to nurse midwife services means that a client must have access to a plan that includes nurse midwives, not that all plans must include them in their provider panels. He also stated that plans are not required to pay for nurse midwife services delivered out of the network. They have received an interpretation of federal law from HCFA that agrees with DSS' position. He noted that the capitated payments to plans are based on historic claims experience that includes nurse midwife services. DSS wants to encourage the inclusion of nurse midwives in networks, but will not require their inclusion.

Marie Roberto asked for a list of which plans don't include nurse midwives. Jim Gaito stated that it will be difficult to get that information as some nurse midwives are practicing within physician practices and not listed separately. Marie Roberto asked if some plans are excluding nurse midwives; Jim Gaito answered that DSS doesn't know if that is happening. Debbie Cibelli offered to get that information to the Council.

Judy Solomon noted that because four plans are not including nurse midwives and it is DSS' policy is that they don't have to include them and DSS will not pay for their services under fee for service, that this constitutes a lack of access to those services.

Pat Baker noted that in some plans nurse midwives are not listed on the provider panel but are credentialed and are reimbursed within a medical practice.

Rep. Nardello asked why DSS changed policy and denied them separate provider numbers. Jim Gaito stated that between 1986 and 1996, only one nurse midwife applied for a number. Debbie Cibelli noted that two nurse midwives in her practice had numbers. She got a letter from DSS last year stating that they could no longer bill directly to DSS and will have to bill under a doctor's number. The reason given in the letter was to reduce double billing. Rep. Nardello asked Jim Gaito to investigate the situation and report back to the Council.

Senator Harp noted that this issue merits further discussion and asked the Access/EPSTDT Subcommittee to look into the problem and report back to the Council.

Judy Solomon and Dr. Reguero, as Chairs of the Subcommittee, agreed.

### **DSS Report**

Jim Gaito reported that DSS has applied to HCFA for an extension of the current 1915 (b) waiver from October 1, 1997 to December 31, 1997; DSS expects the request to be approved. DSS intends to go forward with submitting the waiver package to the committees of cognizance, with both the prospective and retrospective cost effectiveness information, in early September.

Regarding the RFP process, DSS has answered plans' questions about the bid for three month contract extensions in writing, including new questions about FQHC reimbursement, and has extended the deadline for those bids until July 25.

DSS expects to release the new RFP this Wednesday, July 16, with a bidders' conference on July 29. Plans will have until Sept. 12 to submit bids.

Rep. Nardello asked about planning for the transition periods. Jim Gaito reported that Aetna members and providers are now being notified that Aetna will not be participating in the program after October 1.

He reported that Healthchoice Family Plan is merging with Yale Preferred Health and that Yale is also in the process of acquiring Bridgeport Hospital Family Plan. Clients will be notified of this change and given the opportunity to switch plans or they will be automatically transferred to Yale.

Lisa Sementilli-Dann asked about the enrollment broker's role in the transition. Rose Ciarcia outlined a transition plan with time lines for mailing and a description of the broker's work plan for the transition.

Judy Solomon asked if staffing will be expanded to meet the challenge. Rose reported that Benova is planning to increase staff for December and January.

Senator Harp asked whether DSS will have the waiver renewal application decision back from HCFA with a decision about lock-in approval in time to lock clients into plans in January. Jim Gaito stated that they intend to have the waiver renewal submitted and approved by that time.

Marie Roberto asked Jim Gaito to discuss the financial reports with medical loss ratios distributed to members before the meeting. Jim Gaito noted that most plans average 86 to 87% of spending on medical services. He offered to have DSS give a full report on medical loss ratios at the next meeting. Senator Harp agreed to put that on the next agenda and asked DSS to be prepared to discuss industry standards for medical loss ratios.

Marie Roberto asked why the financial information is not specific to the Connecticut Access program but includes commercial business as well. She noted that it is important to understand how plans are using taxpayers dollars. Jim Gaito noted that the Department of Insurance requires plans to report on administrative costs for the whole business. It would be difficult and a new reporting requirement to ask for Connecticut Access information separately. Senator Harp expressed confidence that with their sophisticated data systems, plans could report that information to the state. She requested that the requirement be included in the next contracts. She also felt that the information would only be meaningful if all plans used Generally Accepted Accounting Principals (GAAP) as the basis for accounting, so that the state could compare plans to each other. She emphasized that it is essential that the taxpayers of Connecticut have the information necessary to be sure that their money is being spent wisely.

Rep. Nardello asked how HealthRight can maintain that their financial information is not subject to Freedom of Information Laws. Jim Gaito stated that DSS is pursuing that matter with the Attorney General's office. He reported that HealthRight has reported the information to DSS, but has asked them not to release it to the public.

Dr. Reguero repeated his recommendation that the state commission outside auditors to investigate the spending of tax dollars in this program. He emphasized that spending on behavioral health services has been drastically reduced and the plans have maintained that they are spending that money on other services, but there is no evidence to support that claim.

Lisa Sementilli-Dann asked if all plans are using the same definition of medical loss ratios. DSS attached the HEDIS definitions to the report, but some plans are not NCQA accredited and it is not clear that they use that definition. Jim Gaito stated that DSS will make a full report at the next meeting and will send as much clarifying information as possible before the meeting.

Senator Harp asked DSS to look into changes in formulary policies by plans and report back at the next meeting.

## **Quarterly Report**

A draft of the Council's Quarterly Report for the period of April 1 to July 1, 1997 was distributed to members and discussed. Members were asked to get any proposed changes to staff by August 1, for distribution to members. The proposals will be voted on at the next Council meeting.

Pat Baker asked that it be noted that references to spending levels in the program are on a cash basis, which is the state budget standard. In response to her concerns, Senator Harp, Judy Solomon and Rep. Nardello clarified that the recommendations come from discussions of the Council and the Subcommittees and all members receive extensive minutes of all meetings. Any member with questions is free to contact the Subcommittee Chairs to clarify issues.

Jim Gaito asked if the recommendation that DSS publish report cards for clients is redundant given that the Legislature passed a bill requiring the Dept. of Insurance to publish a general report card on managed care plans in the state. Jeff Walter noted that not all Medicaid Managed Care plans are licensed HMOs and so do not report to the Dept. of Insurance. Jim Gaito stressed DSS' strong interest in ensuring that clients have full access to all the information necessary to make choices, but wants to be sure the process is appropriate. Senator Harp emphasized that a report card for clients would be particularly useful in the coming months, with two transitions and a potential lock-in, to reduce confusion and allow clients to make careful decisions that are right for their families. Eva Bunnell emphasized that consumers have trouble understanding the information that is now being released in its present form; it needs to be put into a format that consumers can use.

Pat Baker asked if DSS still plans to require Medicaid-only plans to be licensed by the Dept. of Insurance within three years, as was her recollection, and those plans would eventually come under their report card program. Jim Gaito stated that there was never a requirement that all plans become licensed by the Dept. of Insurance, only that partially capitated plans convert to full capitation within four years. After September 1997, there will be no partially capitated plans in the program.

## **Subcommittee Reports**

Eva Bunnell reported for the Behavioral Health Subcommittee that the forum to develop standard reporting forms is progressing well. A draft form has been distributed and was discussed at the last meeting, some minor changes will be made and a final draft will be ready for the next forum on September 11 at Putnam Park. At the last forum, it was pointed out that the form isn't appropriate for methadone treatment services and the Subcommittee is considering another forum to address that issue. Eva will send a letter to all the plans and methadone treatment providers to see if there is interest in developing a form for that service. The Subcommittee is also monitoring plan policies in transporting unescorted minors by plans and is working to develop a focus for future work. There is interest in investigating low behavioral health penetration rates, PCPs delivering behavioral health services, behavioral health outcome measures and working with CPRO on their behavioral health patient-focused study.

Dr. Reguero reported that there is agreement to use two standard dental billing forms, the dental society's and EDS' forms. He proposed that Council recommend both forms be approved for use. Without objection, Senator Harp added that to the recommendations in the Quarterly Report.

Rep. Nardello reported that the Public Health Subcommittee is planning a forum on

School-based Health Centers and ways to promote their integration into health plans' networks. The Subcommittee is working with DPH to design the inventory of safety net providers in Connecticut.

Eva Bunnell asked DSS about their internal behavioral health group and what progress they have made in studying the program. Jim Gaito noted that in the last quarterly utilization report from plans, the behavioral health penetration rate is close to what it was under fee for service. DSS has included DCF and DMHAS in their internal mental health team; nothing definitive has come from that group.

Marie Roberto noted in Benova's last enrollment report that the most common reason given by clients for switching plans has changed from PCP not in the plan to hospital not in the plan. Senator Harp stated that the Council will invite Benova to the next meeting to report on enrollment and plan switching.

The Council decided not to meet in August. The next meeting will be Friday, September 5, 1997 at 9:30 a.m. in Room 1D.

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**[Return to Councils' homepage](#)**