

## **MINUTES**

### **October 3, 1997**

Members Present: Senator Toni Harp (Chair), Representative Vicki Nardello, David Parella, Jim Gaito, John Simsarian, Cynthia Matthews, Marilyn McMellon-Cormack, Eva Bunnell, Lisa Sementilli-Dann, Judith Solomon, Dr. Wilfred Reguero, Marie Roberto, Pat Baker, Paula Armbruster.

Also Present: Barbara Casey, Judy Bell, Jim Linnane, Dr. Thomas Meehan, Dr. Thomas Van Hoof.

Senator Harp introduced John Simsarian as the DMHAS Council representative.

#### **CPRO Report**

Dr. Thomas Meehan presented an overview of the Peer Review Method for Quality Assurance. Previously, this process focused on case-by-case problem chart review that identified outlier problems rather than the mainstream care. Peer Review now identifies how care is given over a greater number of cases in a collaborative effort with reviewers, health plans and care givers. The process involves the selection of a project and target population, interpretations of patient outcomes based on practice guidelines derived from a consensus of experts, review of data and performance feedback to practitioners and managed care organizations regarding individual and group outcomes which is used to improve disease management programs.

Two patient focused studies were presented. Dr. Meehan summarized the Pediatrics Asthma study which aims to improve care quality through improved implementation of recommended best practices and reduce treatment costs while improving patient outcomes. The information from this study will improve interventions by plans by focusing on patient education and appropriate use of resources and provider education.

Judy Bell presented the formative stages of Behavioral Health Discharge Planning involving Appendix K which defines discharge planning for inpatient DCF children. Appendix K provides step-down or sub-acute placement prior to home discharge, with an expanded thirty day reimbursed hold-over provision that reportedly allows placement planning. The study will be completed in the summer, 1998.

Council discussion following the presentations indicated a concern about the number of clients in Behavioral Health carve-out programs and the movement to reduce or replace day hospital treatment with outpatient visits. Dr. Reugero questioned if there is research

to support this change in treatment programs. Dr. Van Hoof reported that there is none at present. Dr. Reguero stated that decisions regarding programs need to be data-based and research-based, not solely financially driven. DSS stated that the Department is aware that fiscally based- decisions that may not be based on best practices do occur in the sub-contract organizations and that CPRO needs to move forward aggressively to monitor this through QA audits and that sub-oversight of sub contract plans is needed. Jim Gaito stated the DSS and MCO are routinely meeting with partial hospitalization providers to identify the best use of these services. Senator Harp noted the importance and relevance of the CPRO External Quality Review process in improving Medicaid Managed Care and expressed the hope that CPRO will work closely with the QA subcommittee on this.

Judy Bell completed the CPRO presentation with a review of the compliance audit of best practices, identifying the strengths of specific MCO's in improving access, providing outreach programs and addressing cultural competency programs.

### **DSS Report**

David Parella noted that at the last Council meeting it was reported that time was running short for obtaining the legal authority to operate the Medicaid Managed Care program. HCFA has provided the Department with a 90 day extension, to the end of the calendar year, for waiver authority. The 1915 Waiver renewal formal submission has been delayed, in part because of differences of opinion between DSS and HCFA in defining both retrospective and prospective waiver cost effectiveness data. Issues regarding administration cost items (IE funding to CHC as part of the Medicaid program as an administration cost) is being negotiated with HCFA and DSS. A completed retrospective cost effectiveness study will be republished for public comment and will be presented at the next Council meeting. At the same time DSS will publish prospective UPL for 1998 as the Department moves into a new contracting cycle. Also included in this publication will be new rate cells, changed from 48 cells based on age, sex, county to 36, based on age and eligibility grouping. DSS noted there will be a separate rate cell for newborns under age three years, isolating these costs in a rate table. This will be presented at the next Council meeting. After publication of the cost effectiveness data, there will be a period for comment, then the Department will move forward to a formal submission of the Waiver renewal to the Committees of Cognizance, hopefully by the late fall of 1997.

### **Expanded Health Insurance Program for Children**

David Parella provided an overview of the DSS Husky Plan, the Title XXI program, funded in part by the federal government, to provide health insurance to uninsured children. Connecticut will receive 35 million dollars in federal funds beginning October, and the federal options include use of straight Medicaid, a federal employee package, a state employee package or combination of these. The state proposed plan includes the following features:

\*accelerated implementation of the past session legislation that will allow Medicaid

coverage to children of 18 years at the 185%FPL by Jan. 1,1998 instead of July. This allows for coverage of these children under Title XXI, increasing the federal share to 65% rather than the 50/50 state/federal cost share under Medicaid.

\* establishment of a non-entitlement program which offers the state employee equivalent benefit package to children with household incomes between 185% to 300% FPL.

-in the 185-235% FPL range, families would be subject to standard co-pays on medical and prescription services, but no monthly premium

-for children in the 235-300%FPL range, the proposed coverage is under the 1115 research and demonstration waiver option and participating families will pay a premium of \$30/month/child up to a family maximum of \$50.

-families above the 300%FPL can enroll their children in the plan at 100% of the group premium rate; no state or federal support will be used.

\*for children with special health care needs that are not met under the benefit package, the state is considering the development of an enhanced version of the existing Title V program that includes expanded outpatient mental health services.

DSS stated that the goal is to see the Ct Access program and the Husky program as one, in outreach efforts, with consumers being directed toward the appropriate benefit package according to income.

Regarding the business proposal for the Husky plan, bidders presently participating in the CT Access plan can bid to participate in both plans, while those not currently participating in Medicaid can bid only the Husky plan. DSS intention is to extend the current Medicaid contracts (previously extended to Jan 1,) to April 1, 1998 to allow the Department to complete the process of developing the new RFP. The time frame is:

\* Ct Access business proposals to DSS week of 10/6

\*Husky business proposal to DSS in late November

\*DSS review of both proposals in late January, 1998

\*both programs in place by April 1,1998.

Council discussion following this presentation focused on clarification of the points presented, the timing of the implementation of the new contract MCO requirements, and the pro/cons of placing the XXI under the Medicaid program related to projected costs. Dr. Reguero questioned if the Department has accurate numbers of children in the FPL categories which are based on the interim census data. Judith Solomon observed that 1996 National population data show that uninsured children are representative of less employee-based, more the Medicaid- eligible population. The latter may reflect the effects of Welfare reform and the barriers in accessing Medicaid. Ms. Solomon noted that the state employee benefits program has three plans with differing co-pays and questioned how the Department will adjust for these differences and also provide services for medically complex children. DSS replied that the state will probably look at the state package and provide additional adjustments to reflect major medical costs for children that would exceed the state employee plan. David Parella observed that the state package premiums are high because of the population enrolled which includes

retirees 55-65 years of age with significant morbidity who are not Medicare eligible. The Department needs to have details of the plan clarified before the Husky plan can be presented to the Legislature.

Rep. Nardello questioned if all Medicaid Managed Care plans will remain in place until April 1 and if there will be a delay in implementing the 6 month lock-in. DSS replied that no changes in plan participation will occur before April. The Department has identified specific requirements for contract extensions and will negotiate this as DSS and the plans proceed with the amendment process. Rep. Nardello stressed the importance of keeping the Council informed about requirement changes during the extension period and DSS agreed to this.

Paula Armbruster questioned the statement in the Husky Position Paper that Medicaid benefits are more expensive than the state employee plan and Senator Harp requested DSS to identify what makes Medicaid more costly than commercial plans. David Parella stated that the definition of medical necessity, as defined by Medicaid, contributes significantly to the cost difference as Medicaid defines this based on physician orders. Other items such as medical transportation are costly and may not be needed in the Husky plan as groups that have higher incomes are included. There are increased administrative costs in the Medicaid program because of the impact of the regulatory structure impact on agencies and plans. DSS stated that the Title XXI can be administered by any state agency; DSS hopes the Department will be chosen, however noted that this is an administrative and legislative decision.

Marie Roberto asked if DSS has looked at the Benova September data that showed the primary cause of plan changes was related to hospital/clinic choice availability within plans. DSS has preliminary data from the enrollment broker and will report back to the Council in November. Senator Harp also asked DSS to discuss the impact on the changes in the Hyde amendment as they relate to the CT Access program; DSS will do this in the November meeting

Senator Harp noted that the CT Children's Health Program study revealed that families report paying out-of-pocket for some services because of the fear of getting a bad credit rating. DSS reported they are aware of this and noted that if services are denied, families should not pay for services given during the fair hearing process, nor should the client pay for services provided by a participating Medicaid provider incurred prior to their enrollment in Medicaid (if they were Medicaid-eligible during this time). Families should report these problems to DSS if they require assistance. The legal process becomes more difficult when the client obtains services from non-participating providers: DSS will intervene for the family. If a service is denied after a fair hearing, clients may choose to maintain the service and will then be responsible for the costs.

### **Subcommittee Reports**

1. The Behavioral Health Subcommittee has developed and approved a standard Outpatient Health Reporting form created with the collaboration of providers, health plans, consumers and DSS. The committee requests the Council approve this form. The

Council unanimously approved the form, commended the committee for their work and recommended DSS request plans to use this standardized form in communication between plans and mental health providers.

2. The Public Health Subcommittee will bring proposals from the committee to the next Council meeting.

3. The chair of the Quality Assurance Subcommittee reported a lack of involvement in CPRO patient- focused studies and have requested a meeting with DSS, DCF, CPRO and Senator Harp to clarify the role of the subcommittee.

4. The EPSDT/Access Subcommittee had no report at this time.

### **Quarterly Report**

The quarterly report had been sent to all Council members. Pat Baker summarized her feedback to the report, noting that she takes exception to the tone of the report and observed that this is the first she was aware of the QA subcommittee issues with CPRO. Paula Armbruster noted that the subcommittee minutes have reflected this. After further discussion, Senator Harp moved that the report be accepted and the Council agreed to approve the report with the stipulation that future minutes of the Council and the next quarterly report reflect the results of the upcoming meeting of the involved parties.

Senator Harp requested that DSS present a summary of the Health Plans Work Plans, based on the June audit, in which the plans have communicated to DSS their proposed actions to correct deficiencies. DSS reported that the corrections are to be in place December 31, 1997.

Senator Harp closed the meeting with a personal comment that the Medicaid program brings accountability, as seen in the CPRO audit, to the provision of health services to children. Collaborative work has made the system better and has the potential to improve the quality of services even more. Senator Harp expressed the hope that this accountability will be reflected in the uninsured children's program.

The next **two** meetings of the Medicaid Managed Care Council will be:  
**Friday, November 7, 9:30 am and Friday, December 5, at 9:30 am.**