

MEETING SUMMARY
MARCH 12, 1999

Present: Sen. Toni Harp (Chair), Rep. Nardello, David Parrella and James Gaito (DSS), Gary Blau and Lou Ando (DCF), Steve Netkin and David Guttchen (OPM), Robert Gribbons (Comptroller Office), Marie Roberto (DPH), Lena Holleron, Judith Solomon, Ellen Andrews, Janice Perkins, Dr. Wilfred Reguero, Dr. Edward Kamens. Also present: Dr. Van Hoof for Barbara Casey (Qualidigm), Arnie Pritcher and Rose Ciarcia (DSS), Sheila Bell (Benova) and Mariette McCourt (Council Staff). Senator Harp introduced new Council members: Lena Holloran, representing Sen. Cook, Dr. Lou Ando from DCF and David Guttchen from OPM.

DSS Report

Quarterly Encounter Data

With the exception of prenatal and postpartum care, which reflects the second quarter 1998 (2), this aggregate unaudited data submitted by the MCOs to DSS represents the third quarter of 1998. The reporting quarters are based on the calendar year: first quarter is January-March, second quarter is April-June, third quarter is July-September, and fourth quarter is October-December. Arnie Pritchard (DSS) highlighted the following from the data report:

Behavioral Health: There was a decline in the percentage of members receiving services across all plans, with the average penetration rate reduced from **5.09% to 4.52%**. The more pronounced reduction was in mental health services rather than substance abuse services; the reasons for the reduction is unknown.

Council questions:

The data shows separate visits, not separate individuals, thus dually diagnosed enrollees accessing both mental health and substance abuse services would be 'double counted' in that the visits are reflected in the penetration rate rather than an unduplicated count of member access. The penetration rate of individual access to services is actually lower than the reported rates. The Department stated that Fee-For-Service (FFS) data is comparable to the managed care rates, as FFS was not an unduplicated report of individual service access.

In view of the decline in service utilization and concerns about behavioral health services, the Department was asked about DSS plans to perform more in-depth monitoring of behavioral health services. Mr. Parrella responded that an outcomes study tied to the contract behavioral health incentives is being developed in consultation with Yale University, which will provide information about the efficacy of outpatient services.

Mr. Parrella commented, in response to Judith Solomon's observation that FFS comparisons may be irrelevant because of HUSKY population changes, that the impact of welfare to work reform has changed the composition and case mix of the HUSKY program. There is a greater percentage of DCF children with more intense needs in the

HUSKY program now compared to 5 years ago. Program measurement still consists of spending levels (is less spending better?) and gross measurements of access. What we don't know is who is not appropriately accessing services and what the effect is of the services provided on the child and family. Measurement of outcomes, especially for dental and behavioral health services, is important in determining the best way to deliver these services, perhaps outside of managed care. The Governor's budget includes a proposal to study the managed mental health services under DMHAS to assess the feasibility of carving out this population.

Sen. Harp stated that perhaps special services such as dental and Behavioral Health service delivery is not working under managed care. While the State chose not to carve out these services, the health plans did through subcontracting. We need to look at the impact of this 'carving out' within managed care and determine the impact of this as we move forward toward determining the best way to provide these services.

HealthTrack

Data is reported by screening ratio that refers to all screens performed compared to those that should have been provided and participation ratio that is the ratio of all screens that should have been done according to the periodicity table and those that were done. There was a significant increase in the participation ratio in this quarter **(85%)** compared to the same quarter in 1997 **(65%)**. The improvement may in part be related to:

A seasonal effect in the third quarter when school physical's are done.

School-based health clinics contracts with MCOs for primary care developed between 1997-98.

This new relationship may be responsible for an increase in screens in addition to the seasonal effect. This explanation is plausible as the ratio for school-aged children increased while the ratio for children under one year remained unchanged, averaging 65%.

The next quarter reporting format will change because of a more rigorous federal reporting format and the new periodicity schedule that includes more screens. Mr. Pritchard stated that DSS expects a decline in screens in 98(4) because of the loss of the seasonal effect and more rigorous reporting requirements.

Emergency Department

Under FFS, non-emergent visits were reported as well as emergency visits, whereas MCOs reported only emergency visits until this quarter. Managed care rates for both emergency visits (26.9/1000member months (MM)) and non-emergent visits (19.9/100MM) are significantly lower than FSS rates, which were 34.4 emergency visits and 37.7 non-emergent visits. These numbers suggest that under managed care there is more appropriate ED use. Mr. Pritchard stated that plans report ED data by hospital and there are huge differences between emergent/non-emergent ratio among institutions, even in the same city. Managed care is required to pay for case assessment for those who use the ED inappropriately but are not required to pay the ED fee. Under FFS, DSS reviewed ED utilization and reduced reimbursement for non-emergent visits.

Prenatal Care

The percent of women, enrolled in a plan during the first trimester, receiving care in the first trimester has remained stable over the past three years, well below the general population rates (61.5% vs. 82.1%). Since the first quarter in 1997, the mean percentage of women in prenatal care that were enrolled in a plan during the first trimester has ranged from 38 – 44%. Women that enroll in a plan toward the end of first

trimester may not be seen until the beginning of the second trimester, even though they obtain an appointment within several weeks of enrollment. This visit would not be included in first trimester data. It is also important to note when comparing data that general population rates include all care from all sources whereas HUSKY data only includes care authorized by a health plan. The percentage of women that receive over 80% of the recommended visits while in the plan, according to ACOG standards, is comparable to the general population (83.7% vs. 86.2%).

Low Birth Weight

Data collection difficulties for low birth weights (LBW) from hospitals has improved over the past several quarters, perhaps contributing to the more accurate, but increased number of HUSKY LBW (10.8%) compared to the general population (6.7%). While it was unclear if DPH reports age-adjusted LBW in the general population, DPH does report LBW by city. The Department of Social Services stated that perhaps the HUSKY reports could include this also.

1915 (b) Waiver Process

Mr. Parrella outlined the present status of the waiver process:

The waiver has been published in the CT Law Journal on 3/2/99, which begins the public comment period.

DSS has sent notice to the General Assembly committees of cognizance (composed of the legislative Human Services, Public Health, and Appropriations Committees) that the waiver will be sent to the committees for review on or around April 5, 1999. The committees may require a formal public hearing before the waiver is approved by the committees of cognizance and then forwarded to HCFA for approval.

Upon receipt of the waiver, HCFA will have 90 days to approve the plan; if HCFA requests a response from DSS regarding questions about the waiver, the clock for the 90 days approval period stops until DSS can respond to HCFA.

The Department will request one to two more waiver authority extensions from HCFA, needed until the waiver process is completed, possibly by May 1, 1999.

Copies of the 1915 (b) waiver have been mailed to Council members; copies can be obtained from James Gaito (DSS). The document includes prospective and retrospective cost effectiveness information, Balanced Budget Act (BBA) provisions that include continuous and guaranteed eligibility, plan lock-in and presumptive eligibility provisions and change in the default assignment.

In response to Council questions about plan lock-in, DSS stated they are following the BBA guidelines, implementing this provision upon HCFA waiver approval. Enrollees have a 90-day free-look period with the health plan before they are 'locked-in' for the remaining 12-month period. If the enrollee then chooses another plan they had not previously been enrolled in, the 90-day free-look period restarts. If they choose a plan they had previously been enrolled in, there will be no 90-day free-look; the 12 month lock-in period will start with enrollment in that plan. The Department currently identifies reasons for plan changes. Once the lock-in provision is implemented in the HUSKY program fewer plan changes are expected, thereby making it easier to track plan change related to provider availability within the plan network.

HealthRight Transition Process

Rose Ciarcia reported on the number of HUSKY members in HealthRight (HRI) as of 3/8/99:

HUSKY A

1/99 there were **34,195** members

3/8/99 there are **21,085** members remaining; **13110** have moved out of HRI.

The following schedule deadlines have been established:

Second DSS mailing to HRI members requesting them to choose another plan was sent 3/8/99.

Automatic disenrollment from HRI on **4/9/99**.

Benova will manually assign high-risk (pregnant women in the third trimester or families with complex health needs) HRI members to plans that include their health provider in the network.

HRI will identify these individuals to Benova.

April 16 rotating default assignment to the four eligible plans (ABC, CHNCT

PHS, Preferred One) with plan assignment effective **May1, 1999**.

HUSKY B

1/99 there were **510** members, as of 3/8/99 there are **302; 208** have been moved.

Second DSS mailing was sent 3/10/99

4/15/99: Automatic disenrollment /default assignment (CHNCT, Preferred One, ABC) for those who have not chosen a HUSKY B plan. Benova will manually assign high-risk members to plans that include their health provider in the network.

The Department is hopeful that the voluntary choice rate will increase over the next 30 days to ensure members enroll into a health plan that includes their provider in the network and avoid the problems experienced with Oxford in defaulting a large population into the other plans. The Department will update the Council of the HRI movement at the April meeting.

At least two plans, CHNCT and PHS have signed contracts with federally qualified health clinics (FQHC) providers. Default assignment for HUSKY A includes four plans as Kaiser enrollment is frozen; three plans will absorb HUSKY B default assignments.

MCO Authorization Issues/DSS Response

The Department responded to the Council request to provide an update regarding the health plan compliance with the DSS policy for notice of action (NOA) and denial of services based on chronic care needs. These issues, discussed at the February meeting, are related to a series of letters from the CT Legal Assistance Association to DSS and Sen. Harp.

Mr. Parrella stated that DSS considers compliance with NOA policy a serious issue and would impose a class C sanction for MCO failure to comply with the State policy. However, a recent DSS meeting with MCOs to outline the operational issues of NOA and chronic care authorizations revealed the difficulties plans encounter in implementing the policy. Managed care utilization management and cost containment practices in Medicaid programs result in the tension between fulfilling the intent of Medicaid, preserving the right of the individual to secure an entitled service, and the operationalization of the process. The core of chronic care denial and NOA is the denial of services for specific periods of time vs. a negotiated approval for a shorter period of time than what was requested by the provider, subject to reevaluation. The latter may not necessitate a written NOA. The Department will:

Issue a letter to MCOs specifically speaking to the issue of authorization of acute/chronic care, probably at the end of this month.

Revise the policy that addresses NOA and continuity of care issues.

Develop a uniform NOA form to be used by all plans (draft expected to be completed 5/1/99).

The NOA content is of a legal nature and complex; members may benefit from accompanying educational materials that the Children's Health Council offered to develop. Mr. Parrella stated this would be helpful, as did Janice Perkins (PHS). Ellen Andrews suggested bringing the NOA

to consumer focus groups for an assessment of the readability and understanding of the notice.

Benova Survey of Incomplete HUSKY B Applications

Benova completed a phone survey February 1999 of HUSKY B applicants that had not completed the application process. Of the 220 applicants, 28% (61) participated in the survey; 48% (105) were unable to be contacted by phone. Clients were called three times. The reasons for non-completion of the application were:

43% (26) had difficulty completing the application because they could not gather verification materials, felt HUSKY required too much information or they did not understand what information was needed. Benova reopened the application process for those who required more time for completion.

33% (20) decided not to complete the process because they had other insurance, needed family coverage, thought HUSKY was too expensive or did not think they would qualify.

14% (8) applied for HUSKY at DSS by phone and were granted HUSKY A.

12% (7) either forgot to follow through or thought the documents had been sent in.

Benova also successfully surveyed 324 of 1280 (25%) pre-screened applicants that had not returned the application in 30 days. The reasons for failure to return the application were:

22% (71) were granted HUSKY A

20% (65) decided not to apply because of program costs, application difficulty, did not want HUSKY A or were no longer interested.

19% (61) did not have time to collect verification

18% (58) already had other insurance.

11% (35) lost the application or did not know it had to be returned.

Council questions involved the application form and income verification materials.

DSS stated that a task force is again revising the application form, making it easier to read, clarified the instruction sheet, and will provide contact numbers at DSS for application assistance. The revised application should be ready in a few months. Ellen Andrews stated that the draft would be included in the consumer focus groups for feedback.

DSS stated that the amount of verification is minimal, including income documentation and citizenship status of the child. The latter remains a barrier for some because of their concerns about involvement with the INS. HCFA allows self-declaration of income and other states using this find that people often overstate their income. DSS stated that CT's experience has been that people tend to under state earnings. The income verification requirement is for one month (4 pay stubs); however if they cannot obtain this, especially true for the self-employed, DSS will accept self-declaration of income. The Consumer Access committee will discuss income verification with Rose Ciarcia at a future meeting.

Recent enrollment numbers as of 3/10/99 were 3,044. Applications referred to DSS numbered 8998.

Other Issues

Rep. Nardello stated that school-based health clinics (SBHC) have difficulty identifying health coverage for children other than HUSKY A. While the clinic will have parent's signed permission for treatment, the insurance information is often not completed and there currently is no means for HUSKY B verification. Rep. Nardello stated that SBHC are unique in that, unlike primary care centers, children are seen unaccompanied by the parent, who could provide insurance information. Inability to verify insurance coverage prevents appropriate billing. The Department stated there could be consideration of including HUSKY B verification in the Benova contract, however the cost of this needs

to be considered.

The next meeting of the Council will be April 9 at 10 AM in LOB RM 1A.

The agenda items will include a review of the waiver cost data as well as a report on the MCO audited revenue/expense reports (this will be based on HUSKY plans' whole book of business; separation of the Medicaid book of business will be reported during the new contract period). A report on the 21-month exit interview data and WorkSteps program will also be provided.