

MEETING SUMMARY
OCTOBER 15, 1999

Present: Sen. Toni Harp (Chair), Dr. Wilfred Reguero, Rep. Vickie Nardello, Robert Gribbon (Comptroller Office), Judith Solomon (CHC), Lisa Sementilli Dann, Dr. Leonard Banco, Marie Roberto (DPH), Lorraine Millazo, David Parrella and James Gaito (DSS), Ellen Andrews, Arthur Evans (DMHAS), Dr. Edward Kamen, Gary Blau and Dorian Long (DCF), Barbara Parks Wolf (OPM).

Also present: James Linnane, Rose Ciarcia (DSS), Sheila Allen Bell (Benova), Debra Russo and Judy Bell (Qualidigm), Mary Alice Lee, Debby Hine (ABC), Catherine Jackson (PHS), Sara Calatayud (CHNCT), Glenn Wright (P-1) and Mariette McCourt (Council staff).

Department of Social Services Report

Kaiser Exit

David Parrella reported that the transition of Kaiser members to the remaining health plans is progressing: As of 10/13 there are 1677 members remaining in Kaiser HUSKY A and 64 in HUSKY B. The default numbers were being compiled on 10/14. The State's contract with Kaiser will end 10/31/99. A \$100,000 withhold will be retained by the State beyond the termination date to ensure compliance with administrative responsibilities such as data reporting. The Council had questioned the timeliness of the provider credentialing process at the September meeting. James Gaito reported that ABC is contracting with the Permanente Group providers. Approximately 50% of the providers have been credentialed and 30-40% are being processed. The health plan expects that 75% of these providers will be in the ABC network by November 1, 1999.

TANF Medicaid Administrative Funds

Federal funds, totaling \$500 million, were set aside to provide states with financial assistance in outreach associated with the de-linking process of Welfare with Medicaid. Connecticut was allotted \$5.7 million (at a 90% federal, 10% state match) to draw down in the three years from 1996 through September 30, 1999. Sixteen states, including CT, will lose their TANF administrative funds on 9/30/99. There is a congressional bill to extend these funds beyond the termination date. The Health Care Finance Administration (HCFA) has allowed states to review their outreach spending over the time period, which was funded at a 50% federal match and apply for the additional 40% match. States have 2 years to file for the additional federal match. The State has been able to document \$3.1 million spent on outreach and expect additional review will allow the State to document spending close to the \$ 5.7 million dollars.

Mr. Parrella stated the Department is looking into the establishment of an account to allow federal monies to remain in the DSS budget for continued outreach and system enhancement associated with maintaining Medicaid enrollment for eligible individuals leaving welfare; however the response from the /Comptroller's Office was not favorable in doing this. Robert

Gribbon stated that establishing the account is possible but he is unaware of the technical aspects of this particular issue. Mr. Gribbon will work with DSS to assess the feasibility of doing this. Sen. Harp had recommended the Department look into the establishment of such a ‘roll-over’ account and commented that perhaps there would be a need to create an opportunity for the Department to retain the matching funds through legislation. Sen. Harp stated that these special account funds, not subject to the State spending cap, are necessary to allow the State to ensure that eligible individuals remain insured. The Council will ask for an update at the November meeting.

Qualidigm HUSKY A External Quality Review

Judy Bell presented the 1999 external audit of HUSKY A managed care organizations. The purpose of the audit was to measure the MCO’s operations process and contract compliance. This was not a quality of care audit, rather an audit of operational process measures and implementation. The sources of the audit criteria were the current HUSKY A contract, previous audit criteria and managed care industry practices. The six audit criteria were subcontractor oversight, utilization management and documentation, access/availability including preventive services, member services and quality management. Credentialing and a financial review were not included. An acceptable score was increased from 50 in 1997 to 70 in 1999. The review process included management interviews/demonstrations, analysis of policies, procedure, workflow, UM records and direct observation.

Utilization management (UM) was a major focus and more heavily weighted in the scoring. The encounter data was used to identify cases with three or more inpatient admissions within six months, indicating a need for case management. A convenience sample of 10 charts/MCO were selected and evaluated for case management that included assessment, evaluation, care plans, re-evaluation, discharge planning. EPSDT case management was looked at within the case management review process.

The following summarizes the audit findings by the six criteria, showing the comparison of 1999 scores with 1997 scores.

Medicaid Managed Care Health Plans Scores

Rank	Criteria	Blue Care	CHNCT	Kaiser	PHS	Preferred One
1	Subcontractors	99 / 97* 88%/79%	99 / 97 100%/79%	99 / 97 78%/35%	99 /97 100%/64%	99 / 97 100%/56%
2	UM	98%/92%	84%/98%	98%/96%	100%/90%	90%/94%
3	UM Grid	93%	73%	56%	85%	94%
4	Access	94%78%	95%/80%	90%/70%	96%/75%	96%/82%
5	Member Services	100%/88%	94%/75%	90%/90%	97%/90%	97%/83%

6	Quality Management	100%/100	75%/94%	100%/98%	100%/98%	100%/68%
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* 1997 scores approximated from the Qualidigm bar graph

The following recommendations were made based on the audit results:

All MCO's need to improve on case management that includes programs and process, documentation, training and system support.

The Medicaid-only MCO needs to continue to build operations infrastructure through strengthening core functions (UM/QM) and program features on par with the multiple product MCO's. Ms. Bell commented that the Medicaid-only plan was at a disadvantage because it does not have the financial resources not the sophistication of commercial plans to develop the infrastructure that was already in place in the commercial plans.

Council members raised the following issues:

Identification of the member services items: Ms Bell stated that wait times and linguistic access were evaluated. While there were some pockets of problems, 90% of the call were answered within 60 seconds and Spanish/English information was available.

Did UM reflect outliers? Ms. Bell stated this was a convenience sample and while not generalizable, did not reflect outlier cases.

Availability benchmarks from other states is not available; DSS is not aware of other states performing similar audits.

Case-by-case review reveals problem areas not reflected in the overall audit performance. Mr. Gaito stated that the perspective is overall performance; this does not suggest there are areas that require improvement.

It was recommended that NCQA standards be used to measure quality, and documentation of the MCO's work plans be done in future audits.

DSS stated that the Department's view of the audit in light of other information about quality is that other information was used to establish criteria for the audit and that Qualidigm is doing other projects that evaluate quality care through record review. This was a systematic review of MCO operations and documentation. The Department is funding the CHC and the Children's Health Infoline to follow up on individual cases.

Quarterly Data Review

The Department stated that the quarterly review of the data in the Council influences plan efforts for improvement. The areas of improvement noted were in lower non-emergent ED use compared to FFS, suggesting that more members may using their PCP, higher rates of enrollment of pregnant women in MCO's in the first trimester, improvement in EPSDT participation rates in adolescent access. It is difficult to compare the EPSDT screening ratios with past quarters in that PHS data was inconsistent and not included and Kaiser is showing inordinately high ratios > 100%. Behavioral Health penetration rates continue to decline; DSS explained this quarter's decline as related to the PHS/MD merger in which the two plans have opposite rates (highest and lowest penetration rates) that, when merged have a 3.91%, well below the MD rate in previous quarters.

While more women are enrolled in a plan during the first trimester of pregnancy, the variation among plans in enrolling women early in pregnancy demonstrate that some plans may be more successful in this endeavor and could share their strategies with lower performing plans. Debbie Hine (ABC) observed that the plan is dependent upon the provider to submit timely data; if the data is sent late, then it cannot be included in the report. Dr. Reguero stated that women may deliver before pre-authorization is possible and the MCO will then refuse payment. This creates little incentive for the provider to send in this data to the plan. Postpartum visit rates

remain well under 100%, with rates in the 60% range. Preferred One has a 70% visit rate; it would be useful to have the plan explain their strategies in engaging women in follow postpartum care.

Dental access is reported in a different manner, separating out preventive, restorative and any service. The rates remain abysmally low. Only 12.8% children received preventive services, 8.7% received dental treatment services with 19.2% of Medicaid managed care children receiving any dental service this quarter. Children aged 3-14 years received the highest percentage of services.

Comments from the Council regarding dental access stress that fees increases alone will not improve dental access. Sufficient numbers of private dentists are not going to care for the Medicaid population. Mr. Parrella observed that the state of the economy has some influence on private dentist participation in Medicaid. During the recession ten years ago, people were less apt to pay for services out-of-pocket and Medicaid dental clients were more readily accepted in private practices. A good economy is associated with more clients paying cash for restorative work making discounted Medicaid fees unattractive to the private sector. There needs to be a public/private partnership to expand the dental network to improve access. There are known solutions to the significantly limited dental access in the Medicaid program; however the State must be willing to commit resources to create a more diversified and adequate network. In dental care, it is more difficult to document that improved prevention access will avoid higher costs as can be more readily demonstrated in the primary care medical system. An addition factor is the lack of public awareness of the benefits of preventive care; commercial rates of dental access are 55-60%.

Rep. Nardello asked what percentage of the 1998 capitation rates paid to the MCO were expected to be allocated to dental access and what are plans' actual spending on dental services. The department did not have that information but would provide it to the Council. The Department stated that the dental MCO's could comment on dental spending. The Council will request this information from the MCO's for the December meeting.

HUSKY Enrollment/Family Expansion

Kevin Loveland, Director of Family Services at DSS reported that there are efforts being made in the Department to operationalize the inclusion of parent and needy relative caretakers to be included in Medicaid at 185% FPL, without an asset test, under the Social Security Act 1931 option on in July 2000. HCFA has stated that no waiver is needed. The State has until September 30, 200 to submit a State Plan change. Mr. Loveland stated that potential enrollees are known in that the 49,000 children enrolled in HUSKY A would be eligible. The Department is developing a strategy to identify these adults and include them in the automated verification system.

This is a summary of six months of cumulative net enrollment reports of selected categories provided by Benova:

Cumulative Net Enrollment by Coverage Group

	April 1, 1999	May 1, 1999	June 1, 1999	July 1, 1999	August 1, 1999	September 1, 1999
FO1	81,807	79,592	77,698	75,488	74,372	72,502

FO3	72,617	74,308	75,554	76,836	76,893	77,219
FO7	6,533	7,213	7,693	8,453	8,971	9,403
F 25	41,423	42,707	43,907	45,589	46,326	46,536
HUSKY A enrollment	228,703	229,960	231,051	230,217	230,730	229,747

FO1 is the AFDC Medicaid TANF cash program coverage group.

FO3 is the transitional Medicaid coverage group.

FO7 1931 coverage group, <100%FPL.

F25 is the HUSKY A coverage group (<_185% FPL) for children.

Monthly, approximately 15-1600 families leave HUSKY A, with 900 Medicaid only and 550 TANF families. It is thought that some families may be insured through work or leave the State; however others have not followed the redetermination process and may re-enter Medicaid within a few months. The United Way Infoline is working with DSS to develop a pilot to begin in November that will attempt to reach those who are disenrolled, determine the reasons and re-connect the families to HUSKY. Senator Harp had forwarded recommendations to the Department from advocates and providers that would address the difficult redetermination process. These recommendations included:

Enclosing a single 'alert' sheet with the warning notice that describes the pending loss of medical coverage, using 'Medicaid', 'HUSKY' and health plan names to clarify for clients that they are at risk for losing coverage if they do not contact DSS. The redetermination notice is long and complicated and families may not attend to the notice.

Provide clients with a pre-printed medical coverage form that has their last HUSKY application information the client can verify and mail to DSS rather than attend the face-to-face interview required for cash assistance redetermination.

Mr. Loveland stated that there is intent by the Department to implement these recommendations; however the associated system changes need to be given priority within the MIS department. The CHC and the Women's Health subcommittee offered assistance in simplifying the process and the application form for the adults eligible for the parent expansion.

Benova Report

Sheila Bell reported that application and call have significantly increased over the past month, attributed to the Kaiser change, redetermination as well as the outreach efforts of the DSS/Mohegan Sun/Hartford Courant mailing and the KMart project. Calls to Benova increased from 500/day to 900/day and 100-150 more applications were received. There were 292 responses to the Hartford Courant HUSKY insert. Callers inquiring about HUSKY reported where they heard about the program. The most common sources were:

Friends - 95

Schools - 83

DSS worker - 55

Provider office - 59

Relative 43

Hospital clinic - 33

HUSKY Infoline - 26

Employer - 26Town/community - 22

Radio - 19

Ms. Bell stated that the outreach grants, in particular the school outreach, has been reaching families. Rep. Nardello had requested, at the September meeting, that the school outreach efforts and outcome be reported to the Council. This will be on the agenda in November.

The next Medicaid Managed Care Council meeting is Friday November 5 at 10 AM in IOB RM 1E.

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