



# Connecticut Council on Medical Assistance Program Oversight **Quality Improvement (QI) Committee**

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## **Current Mission Statement:**

*The purpose of the Quality Improvement (QI) is to provide recommendations to the Council to ensure consistent comprehensive of medical, dental, and behavioral quality health care for Medicaid population. The Committee serves as a forum for concerns regarding quality of service delivery in the program, advises the Department of Social Services (DSS) on subjects and methods of investigations in the problems that arise, and suggests solutions. The Committee will work with all Medicaid Administrative Service Organizations (ASO's) and DSS to develop recommendations utilizing CQI process.*

Co-Chairs: Debbie Poerio and Rep. Toni Walker

## **Summary for March 14, 2013** **9:30 AM-11:00 LOB ROOM 2600**

### **Attendance:**

*Stephanie Knutson CSDE, Richard Spencer CHNCT, Gail DiGioia CHNCT, Robert Zavoski DSS, Lynnwood Patrick DSS, Christopher Savold CTDHP, Les Holcomb Regina Roundtree, Marcia Benson DSS, Steven Moore VO CT, Mark Heuschkel DSS, Peter Pristic HP, Lori Grice HP, Roberta Geller CHNCT, Debbie Poerio (Chair)*

**There was introduction of the committee members. The meeting began at 9:40 AM.**

## ***Attribution Data Report: February 2013 Attribution Data*** presented ***by Gail DiGioia***

The report is broken down by county, member count, age group, % attribution.

*Attribution to PCPs- Member Count by County and Age Group-February 2013*

Adult % Attributed- 52% , Child % Attributed 80% Total % Attributed % 66 %

Total Member Count is 423, 668. Please see report for more details.

*Unattributed Members to a PCP- Count by County and Age Group*

Adult 167,944 – 72% Child 60,987 28%

*Unattributed Members to a PCP with Claim History*

Adult 141,089 -73% Child 50,884 27%

*Unattributed members to a PCP (Members without Claim Activity Length of Enrollment*

Total 26,958 Adult 16,855 -63% Child 10,103 -37%

Comments made about how some members are attributed to specific to codes. There was search the database to EME, 218,000 and did not have claims with those codes. The overall population that did not have a claim is due to many reasons. The claims that remain are specific to the type of Services. There was discussion about billing for a ED visits are bill through revenue center codes and CPT codes. There was a question about the number of uninsured in the state and how do you define uninsured. The next attribution is done in May and CHNCT will present in June. Attribution is a work in progress. 90% of the people are unattributed are not getting services. Les Holcomb inquired about Geo Access Report get by to towns for recruitment. Chris Savold inquire if they Attribute to an individual or Attribute to the provider to which the service. They attribute to an individual who's the Billing provider and the rendering provider.

***Mark Hesuschkel DSS Manager of Medical Operations- Provider Enrollment Presentation – see attachment.***

The committee requested to know more information about the credentialing and enrollment process.

- Presentation Goals provide legal background/framework for Medicaid Provider Enrollment, with emphasis on new requirements from Affordable Care Act. Explain process in CT, including roles of DSS Division of Health Services, HP MMIS Contractor and DSS Office of Quality Assurance
- Enrollment Requirements- General Requirements- Provider Specific Requirements
  - o Assignment provider agreements
  - o New Screening Requirements
- Affordable Care Act Sec 6601- Intended to strengthen program integrity. More rigorous screening requirements. Please see slides 3 and 4 for more detail.
- States can have more frequent screening.
- Implications of new Affordable Care Act requirements: having to screen (Enroll) many more individual practitioners. All those individual practitioners. Re-do minimum screening every 5 Years. Edits to enforce requirements for ordered service
  - o Pharmacy claims
  - o Laboratory Claims
    - Hospice, Methadone. Specific services.
- DSS Division of Health Services Responsibilities- Enrollment regulations, policy, operational process. Oversight of MMIS Contractor HP Operation.

- HP Enterprise Services
  - o Web Portal for Enrollment for most provider types.
  - o Process enrollment//reenrollment applications
  - o Sent Enrollment Approval and Reenrollment letters
- DSS Office of Quality Assurance Required Screening, informal desk review process.
  - o Enrollment Portal – Does reduce documents- Does not need as many follow up document. Provider Enrollment Link [www.ctdssmap.com](http://www.ctdssmap.com)
- Discussion about Group Physician practices: Organizational Screening. Additional enrollment and reenrollment. It is the easiest and least involved version of enrollment.
- There was a specific instance discussion is a provider doesn't wish to see to be a Medicaid provider but sees a specific family who has Medicaid. There would be a notation. Enforce the screening process at the pharmacy. The individual can go through the screening process and can pick organizations to be associated with in the wizard.
- Enrollment Process Online- The system dynamically responds and the choices that are applicable. Can see the provider specialty.
- Electronic Submission- Looking at the provider agreement. It can allow someone who's authorized. It is designed for the typical in the office setting.
- Some do need to submit follow- up documentation. There is a tracking number that is provider to check the status of the application.
- Web Enrollment Portal – Captures information that previously has to ask for separate documents on.
- Provider not supported by web- Most provided around waiver services. Long Term Care provider who have a different provider agreement.
- Put in a cue. Providers are notified with approvals and disapprovals via HP.
- Reenrollment- goes out in advance.
- MMIS HP Provider Data base passed every week. Verification National Plan for Provider enumeration system.
- Specific quality measure questions from Roberta. There are some requirements for specific fee services like supporting documentation. Documentation is done through DPH. Licensures are requirements. Interface with DPH with State of CT licensure. Out of State provider- documentation is collected from the provider.

- Question about if there is any intention to move to CAQH-in response to the Affordable Care Act requirements. It is not off the table in the long run. CAQH doesn't address Medicaid screening requirements. In Front end CAQH loaded into our process. It doesn't fit the organizational entities. It is a long range goal. Comments about how it is an added resource.
- Comments about how to providers it is time consuming to do all these applications. Comments made about how many providers are we losing to enrolling into the program. There needs to be a balance.
- Regina Roundtree asked if there will there be backtracking for a requalification.
- Reenrollment began in of November.
- All the individual practitioners are coming to enrollment process. Discussion about the reenrollment process.
- Changing process is the required screening. Affordable Care Act requirements for a year and a half.
- Discussion about the Time frame for reenrollment. There is a shorter turnaround time now. Completed time online. Prior to the change 60% of the applications were failures. The clean up the enrollment process and application process. Reenrollment-present the information what they have at the database to the provider. It saves a lot of time. It is an advantage.
- NPI- Enrollment- Do they have to enroll if they are under the organization. The organization has to ensure they are working with. After the individual enrolls. They can manage the members of the organization. A panel in the wizard an individual can choose which organizations they are associated with.
- Comments about specifics in the wizard: Providers and I Directory with PCP. Make a notation.
- Comments made about Disenrollment of providers that have not been doing claims in the last 6 months. It is suspended.
- Aggressive outreach effort to providers from Connecticut Dental Health Partnership.
- There is a struggle to enroll providers. Providers get to see a specific family and enroll the provider into Medicaid. They want to keep the provider into Medicaid.
- Providers being suspended Medicaid for not having claims.
- Specific instances of those should be forwarded to Mark Heuschkel.

***CHNCT Network Development Retention/ Recruitment/Outreach presented by Richard Spencer CHNCT***

- Mentioned from Director of Specialists groups, Stephen Frayne in CT Hospital Association.

- Network development is dynamic. Work providers do for development. Goal is to reach out to those providers.
- Total CMAP Providers
- **2011- END of MCO Risk Contract - 17,130**
- PCPs: 2,359
- Specialists: 14,771
- **2012- Beginning of Accountable Care Organization CHNCT - 21,219**
- PCPs: 2,914
- Specialists: 18,305
- **2013- After Two Months of Reporting - 21,103**
- PCPs: 2,315
- Specialists: 18,788
- Note: 2011&2012 - PCPs include OBGYNs, 2013 - Specialists include OBGYNs.
- **Total Newly Enrolled Providers**
- 2012: 5,814
- 2013: 220
- Total: 6,034
- **Total Terminated Providers**
- 2012: 2,439
- 2013: 263
- Total: 2,702
- **Reasons for Termination:**
- Rates
- No shows
- Did not re-enroll
- Retired/moved
- Change in ownership
- Data Integrity comparison is done weekly with HP Provider file
- Providers who are terminated are identified for outreach or a visit is scheduled
- Beginning in the second quarter of 2013, specific tracking on these providers will occur
- First Goal is to maintain the network and continue to work on recruiting new providers

- **Total Office Visits**
- **2012:** 3,617
- **2013:** 424
- **Total:** 4,041
- **Total Providers Visited**
- **2012:** 10,755
- **2013:** 1,163
- **Total:** 11,918
- **Total Specialists Visited**
- **2012:** 359
- **2013:** 51
- **Total:** 410
- **Total Specialists/ Providers**
- **2012:** 871
- **2013:** 138
- **Total:** 1,009
- Run the reports. Represent what we are given as active providers.
  - o Defined because it is a state of Flux and the work the providers have to do.
- CHNCCT do onsite visits every day. Go into provider's office and education on every component of changes. Educate them on the better applications that go through. They can walk through the application process with them. They can confidence from the providers. Affordable Care Act Rates and to get the rates you need to fill out the form. The form is prefilled. 20-25 Minute application process.
- Dr. Geerstma comments about the PCP is upward- Attribution upward. OBGYN into the specialist's
- Retention- Keep providers from leaving- education and the outreach. To keep the network: the
- Intuitional Medicaid providers.
- Open and Closed Panels discussion. The Direction of Affordable Care Act – the potential for expansion. Is always good to expand the number of patients for provider.
- They are in the process of doing a Provider Survey and Mystery shopper. They will have a quantifiable data.

- Work with HP and Terminate to turn around and enroll.
- Termination: Most don't end up being up termination after the office visit.
  - o 123 a week about
- CHN-CT Re-enroll. Data integrity. And CHNCT.
- Visit a plan that's a month ahead.

***The Adult Minutes of the Taskforce will be forwarded to the committee.***

***Child and Adolescent Taskforce update by Stephanie Knutson.***

- New Federal Regulations for School districts. March 18, 2013 consent and notification who receive services annually. Notification must be sent before the consent in order for the school to bill. If in a school district going to bill Medicaid.
- DSS Guidance to school districts in this regard.
- Look at Medicaid as it pertains to child and adolescent to look at developmental screenings. The focus three recommendations:
- 1. Reeducation- Reminder Bulletin for Developmental Screenings and Attach 211 Brochure.- When there due and reimbursements. Screening tools.
- 2. Linking electronic medical records. Including electronic medical recording system. There are some issues with this system. How to streamline those activities.
- 3. Data taskforce for reviewing analyzing around developmental screenings. Is the data accurate how much information do we have now? Review and analyze and evaluate CT Data around developmental screenings. To expand that into more data collection.
- Formal Report to QI. Next focus is Mental and Health and Behavioral health screenings.

Debbie Poerio ends the meeting at 11:00 PM.

**Next Meeting of Quality Improvement: April 11, 2013 at 9:30 AM in LOB Room 3803**