Connecticut
Medicaid Managed Care Council
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MEETING SUMMARY
OCTOBER 9, 1998

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella and James Gaito (DSS), Dr. John Raye, Lorraine Millazo, Marilyn Cormack, Dr. Helen Smits (HRI), Janice Perkins (MD/PHS), Robert Gribbon (Comp. Office), Lisa Sementilli-Dann, Eva Bunnell, Dr. Wilfred Reguero, Ellen Andrews, Peter Johnson (DCF).
Also present: James Linnane, Rose Ciarcia and David Dearborn (DSS), Barbara Casey (CPRO), Mary Alice Lee, Paula Armbruster and Mariette McCourt (Council staff).

DSS Report

Contract Process

David Parrella reported that the draft contract was sent to all the managed care organizations (MCO), accompanied by a cover letter that requested plans submit written comment to DSS by October 14, 1998. The Department will review these comments and then meet with all the plans on October 19, at which time the Department will respond to the comments and move forward with the negotiation process toward a final contract.
The Department stated that contract discussions would not include the Appendix K (Special Services to Children) nor the rates: these have previously been agreed upon and are not open for further negotiation. Mr. Parrella stated that the October 19 discussion will involve the spirit of the contract items; however the Department is going to adhere to that which was laid out in the draft contract. Mr. Parrella noted that the Council had requested to review the draft contract; however the Department is not free to disclose the contract draft as they enter into negotiations with the plans.
The current contract rates are in effect until 6/30/99, after which time there may be rate adjustments. The actual contract period will continue through 6/30/2000. The Department reserves the right to implement two, one-year extensions after June 2000.
Rep. Nardello requested the Department elaborate on the contract sanctions. Mr. Parrella replied that there are sanctions in every aspect of the contract that relates to MCO performance. There are generally two levels of sanctions:

Class A sanctions which have a lower financial penalty threshold.
Class B sanctions that will be invoked, with more substantial financial penalties, for more serious infractions.

These sanctions may well be the source of lively debate in the 10/19 meeting, according to DSS. Rep. Nardello stated that the Council has, in the past and continues, to strongly support sanctions and incentives as a necessary part of the contract that ensures the quality of the Medicaid managed care program. Council members further stated for the record that sanctions regarding timely reporting of data, financial reporting and the grievance/fair hearing process be substantive in order to ensure quality plan performance. Mr. Parrella stated that the Department has clearly heard this and the intent is to have sanctions and incentives as part of the contract that support

these concerns.
Janice Perkins (MDHP) stated that the new language in the contract raises concerns. It is unclear to the MCOs how the sanctions will be monitored. The MCOs look forward to working with the Department about the serious issues, from the MCO perspective. Mr. Parrella responded that the Department appreciates the MCOs willingness to work with them. Federal provisions in the Balanced Budget Act (BBA), which has been signed into law, is reflected in the contractual language (IE definitions of emergency department provisions and provider reimbursement), whereas sanction are not federal mandates. Recently, other draft federal regulations have been released that relate to Medicare/Medicaid program management. These are expected to be finalized by HCFA in the spring of 1999 and would be incorporated in the next contract. Dr. Smits requested clarification of the BBA federal provisions. Mr. Parrella stated the Department would forward an appendix of a position paper compiled by the National Association of State Health Policy that outlines the BBA provisions, to the MCOs prior to the October 19 meeting.
The Department reviewed the contract incentive plan that sets aside 1% of program expenditures, targeting EPSDT participation, dental access, and Behavioral Health measures that provide an objective measurement without undue financial burden on plans. Mr. Parrella reported that behavioral incentives are currently being developed with Council participation (Paula Armbruster, Peter Johnson, Eva Bunnell), MCO representation and consultant expertise. There was a productive meeting October 7, which will be followed by two more meetings to define objective, measurable behavioral incentive measures. The fourth incentive category will target measures regarding MCO/client communication. The Children's Health Council is also developing a uniform client satisfaction survey, which will allow comparisons across plans.
The Department believes that incentives will allow the identification of best practices, recognition of individual plan excellence as well as encouragement of all plans to improve overall performance. Sen. Harp stated that the incentives are a very important part of this contract. Sanctions are also an integral part of the contract in providing options other than plan contract termination in the event of infractions, thus protecting both the health plans and the State. As Council Chair, Sen. Harp strongly supported the Department's efforts in both rewarding excellence as well as ensuring plan compliance with the contractual language through sanctions, thus protecting the quality and integrity of the Medicaid program.
Husky Enrollment
The application and enrollment numbers for 6/1/98 through 10/7/98 are:

HUSKYA and B applications total 7300, with 4300 referred to DSS for HUSKY A eligibility determination.

HUSKY B applications total 3000 with 1986 approved, 1600 are enrolled in managed care plans, 191 pending cases and 823 denials (most because of insurance, often HUSKY A).

The Department's follow-up of HUSKY A referrals from Benova, as requested by the Council, for 6/1/98 through August 1998 includes:

2300 applications with 1600 granted, 508 denials.

1631 children were enrolled in Husky A plans during this time period.

Although the estimated number of uninsured children in Connecticut may be less than the projected 90,000, the current application numbers represent approximately 10% of estimated uninsured children, with most applications originating from mail and the phone system. The Council appreciated the Department's efforts to summarize the enrollment status. The following issues were raised:

Identification of the reasons for the HUSKY A denials: DSS will present a summary of denials

by reason code for the 508 cases at the November meeting.

The Department has analyzed reasons for the HUSKY B denials. The Council questioned if the Benova staff as well as the public are aware of the crowd-out provision (uninsured for 6 months) and exemption reasons. The Department stated the staff is aware of the exemptions and that the State is adhering to the federal crowd-out provision. All denials are reviewed to ensure adherence to the federal policy. Families are encouraged to apply to HUSKY as they may qualify for HUSKY B under the exemptions, even if they were insured within the last 6 months.

The Department plans to evaluate the impact of the outreach efforts by region, identifying where outreach efforts need to be intensified for target populations.

Husky Outreach

David Dearborn reviewed the Department's outreach efforts in the following areas:

Community-Based RFP: The evaluation team is reviewing the applications and contract awards are expected to given by the end of October.

School Outreach: Husky packages with over-the-counter pharmaceuticals are being distributed in targeted schools, school systems are putting Husky information in parent newsletters, on school menus. Deputy Commissioner Starkowski will be meeting with school nurse supervisors to develop strategies to identify uninsured children and bring the HUSKY message to their parents.

Public messages: HUSKY information has been in included with United Illuminating bills and MVD registration renewals, radio announcements that will include Spanish-speaking stations, CPTV service announcements, information will be on Stop & Shop bags and staff have given information out at local and regional fairs.

Training: A Husky training video is being developed for child health care providers and HUSKY information is included in child care assistant training programs.

Community-sponsored outreach: Churches sponsored a HUSKY Sabbath in August, delivering information about the program to parishioners. A Child Sabbath will be held later in October, sponsored by Community Providers Association (contact Kim Harrison).

Mr. Dearborn reported that INFOLINE calls have increased and Benova is averaging 1000 calls/month. Over 5800 calls inquiring about HUSKY B have been generated from outreach efforts. The Department welcomes the opportunity to work with the Council's Consumer Access subcommittee and will attend the November 12 meeting. Sen. Harp thanked the Department and look forward to collaboration with the Department and the Consumer Access subcommittee in enhancing HUSKY outreach strategies.

Outstanding Health Plan Claims

James Gaito reported that the outstanding substance abuse claims have reached a manageable level. The Department is currently working with the Attorneys General office to determine the legal process (mediation versus arbitration) to resolve the remaining claims. (On September 30, Commissioner Thomas responded to a letter from Sen. Harp that requested the Department include a standard for the timely processing of payments to providers in the draft contract. The Commissioner stated, in her letter, that such a standard has been included in the draft contract with a Class A sanction for failure to comply with the contractual standard).

Implementation of Plan Lock-in

Rose Ciarcia reported that there is no definite time established for implementing plan lock-in. Implementation is dependent upon the HCFA renewal of the 1915b waiver. Once the waiver is renewed, the plan is to phase in plan lock-in with existing HUSKY members over a five month period. Monthly, 20% of the population will be notified of the lock-in provision; the statewide

phase-in will be based on the last digit of the Head of Household client ID number. A federally required 60 day open enrollment period will be provided at the onset of the plan lock-in as well as annually. Once clients choose a plan, they will have a 90 day free-look period, also a federal mandate. Prior to the lock-in, clients will receive a notice from DSS notifying them of the above as well as the right to request a hearing if they do not agree with the Department's decision regarding "good cause reason" to change plans once lock-in is initiated. DCF children will be allowed to change plans as they change out-of -home placements.
The current 1915b waiver is extended until December 24, 1998. Once the State actuarial consultant completes the cost effectiveness numbers (by the end of October 1998), the waiver application will be complete. The waiver will then be presented to the legislative Committees of Cognizance for approval and then to HCFA. This will occur after December 1998.

Health Plan Follow-up of Utilization Data.

1) HealthRight, Dr. Helen Smits

The prenatal data was internally reviewed and corrected, with new numbers reflecting prenatal participation rates similar to the other health plans. The correct data for the Fourth quarter 1997:

Deliveries: **235**

Deliveries without missing data: **235**. The plan has difficulty obtaining data from facilities. Indeed, one hospital will not provide the plan access to the charts; however this facility did extract the information from the chart for HRI.

% Deliveries with no prenatal care: **2.1%** rather than 23.1%.

% with over 80% of recommended visits: **73.6%** instead of 61.8%

Dr. Smits stated that all HRI pregnant or soon-to-be pregnant women are eligible for case management. The MCO uses a high-risk form similar to the pregnancy clinics; the plan also focuses on domestic violence and poor housing as additional high risk factors.
The barriers to timely enrollment in the health plan that enables case management and early prenatal care were discussed, including:

Transition from fee-for-service (FFS) to Medicaid managed care: in the first quarter 1998, 50% (21) of the women enrolled in the last trimester were from FSS.

Plan change: 32% (13) of the women enrolled in the final trimester had switched plans. HRI will focus on current third trimester enrollments, identify those resulting from plan switching and will perform a phone survey to ascertain the reason for the switch late in the pregnancy. In response to Sen. Harp's question, Dr. Smits stated that HRI's OB/GYN provider panel has been stable, so plan changes may not be related to clients following their health care provider.

Women with substance abuse, in particular cocaine, often tend to refuse prenatal care. While women in Methadone programs access care earlier, their infants remain hospitalized for a month because of withdrawal. Dr. Smits hoped that new medication would reduce the physiological toll on the baby and the emotional distress for the mother who has demonstrated a willingness to lead a drug-free life.

Dr. Smits stated that the transition issues and plan changes need to further be addressed by the Department and the Council in order to prevent late prenatal care access.
Sen. Harp thanked Dr. Smits for the presentation and asked how difficult it was for the plan to correct the data errors. Dr. Smits replied that this process was helpful and has resulted in an internal process whereby data will be more quickly obtained from providers and corrected, reducing retrospective data review and correction.
Sen. Harp and the Council members congratulated Dr. Smits on her position as HealthRight CEO

and President.

2) Anthem Blue Care

Debbie Hines reported that a review of the vision exam/1000mm was corrected to 15 visits/1000mm as opposed to 8/1000mm. Ms. Hines stated that ABC reviewed and corrected the encounter data problems with their vendor, and expect the second quarter data to be more accurate.

Children's Health Council (CHC) Report

Mary Alice Lee reported on the following CHC activities:

On time EPSDT monitoring had been delayed until plans resubmit their data from July 1, 1997. Two codes will be used until HCFA determines a standard code to be used.

Adolescent ambulatory care utilization will be reported at the November meeting.

Evaluation of dental care access revealed that 31% of those continuously enrolled for 12 months have received preventive care and only 20% have received treatment. CHC is working with DSS, dentistry and DPH to attempt to improve dental access.

Although RWJ has not indicated approval of the outreach grant, CHC is coordinating efforts to ensure that all newborns are enrolled in Husky A or B before discharge and is working with Healthy Children CT to identify uninsured, develop onsite enrollment through child care providers.

Other Council Concerns

Rep. Nardello observed that the Benova data for August 1998 showed that 35% of those who change plans do so because the health provider (PCP) is not in the plan. This is an increase over the April 1996 through September 1998 overall percentage (29.32%). Rep. Nardello asked if there were any significant changes in PCP networks. The Department stated they were unaware of any unusual events, noting that members may change plans to follow their PCP. The Department monitors the adequacy of provider networks within plans, assessing the ratio of enrollees per PCP and specialty providers. If a PCP leaves a plan in the managed care program, the plan is responsible for finding another provider for the member. In Medicaid FFS, the client can contact DSS for help in securing another provider if their PCP is no longer available. The Department cannot legally compel any provider to keep open slots for Medicaid clients; indeed a provider may be listed as a Medicaid provider but may only see a particular family who recently entered FFS but had been in the PCP practice prior to Medicaid.

Sen. Harp asked if the Department could provide a breakdown of network capacity by plan. The Department noted that they do provide quarterly reports for provider networks in both Medicaid managed care and FFS. The Department would provide a report on network capacity within specific Medicaid plans and FFS at the January meeting.

Subcommittee Reports

QA: There will be a meeting 10/20 with the Behavioral Health subcommittee and CPRO to provide feedback to CPRO regarding projects for the next year. The Department has agreed to implement the subcommittee recommendation regarding ED utilization reporting by emergent/non-emergent use.

Women's Health: DSS will present an overview of adult Medicaid eligibility at the 10/14 meeting.

Public Health will meet 11/18 and focus on the feasibility of addressing Community Benefits.

Consumer Access will next meet 11/12, begun to identify a draft work plan and mission.

Dr. Reguero reported that the Hospital of St. Raphael will sponsor a dental van for 1999.

The next meeting of the Council will be Friday November 6 at 9:30 AM in LOB RM 1D.