

**MEETING SUMMARY
APRIL 9, 1999**

Present: Senator Toni Harp (Chair), Rep. Vickie Nardello, Senator Prague, David Parrella and James Gaito (DSS), Marie Roberto (DPH), Steve Netkin and David Guttchen (OPM), Dorian Long representing Gary Blau (DCF), Robert Gribbons (Comptroller's Office), Judith Solomon, Eva Bunnell, Jeffery Walter, Janice Perkins (PHS), Lorraine Millazzo, Dr. Wilfred Reguero, Dr. Edward Kamens, for Sen. Gunther, Ellen Andrew.

Also present; James Linnane, Rose Ciarcia and Hilary Silver (DSS), Dr. Thomas VanHoof ((Qualidigm), Mary Alice Lee, Paula Armbruster, Holly Sullivan and Mariette McCourt (Council staff).

DSS Report

Review of the 1915 (b) Waiver

The Waiver was published in the CT Law Journal in early March and there were no public comments to the publication. The legislative committees of cognizance (Human Services and Appropriation Committees) responded to the DSS communication regarding the waiver submission to the committee, requesting that the waiver be submitted to the legislature the week of April 12 rather than April 5, 1999.

The waiver describes the current HUSKY A program, including the implementation of the 1997 Balance Budget Act provisions of continuous eligibility for children (12 months) and adults (6months) and the enrollee plan lock-in process. The latter will be implemented during the next period of the waiver renewal. Mr. Parrella stated the Department is anxious to secure the renewal of the waiver as the State is nearing the second year of waiver extensions.

The waiver retrospective/prospective costs, developed by Mercer, the State actuary, were reviewed. Prospective costs, using the 1995 fee-for-service (FFS) as the base year, were developed for two years of the waiver renewal. Projected cost savings in the waiver reflect the difference between FFS costs, (based on 1995 FFS spending), if FFS were still in place, compared to the current capitated system in managed care.

The following projections, based on the 1995 FFS year spending, are the basis for the application of the waiver to HCFA:

	Year 1	Year 2	Two Year Total
Projected costs in absence of waiver	\$431,156 million	\$467,865 million	\$899,021 million

Total capitation payments	\$415,120	\$444,354	\$859,474
Administrative payments	5,771	5,878	11,649
Total	420,892	450,232	871,123
Projected Cost savings	10,264	17,633	27,896

The Council raised the following questions:

Description of the administrative costs: DSS stated that program administrative costs include services from Benova (enrollment broker), EDS (claims processing), Children's Health Council, DSS staff and Mercer (actuary). These administrative costs receive a 50% federal match. While DSS did not have a breakdown of the costs by category, the Department indicated that DSS administrative costs are 14%. Rep. Nardello stated that this is of concern, in that the Department has a lower percentage of the administrative costs, yet has the greatest responsibility in the monitoring and surveillance of the program. Administrative cost allocation to the Department will take on greater significance because of the increased demands for monitoring related to new contract provisions. **The Council requested the Department present the breakdown of administrative costs by category at the next meeting.**

Description of the EDS function: Sen. Prague requested information about EDS costs. Mr. Parrella stated that there are two types of billing processes:

Passive billing in which DSS calculates the cost of a vendor service, based on known demographics, and pays the vendor without a claim submission for each service.

Payment based on monthly vendor claims for every member service provided. Individual claims processing costs \$.65/claim processed.

The HUSKY program, because of its size, currently uses individual claims processing. Potential savings could accrue with the elimination of the claim fee; an administrative decision regarding this will be made after the legislative session, when system expansion decisions have been made.

The EDS contract continues into the year 2001. While this issue is part of the larger State data processing issue, DSS expects to pursue re-procurement.

Actuarial accounting of incentives and the reinsurance models: Sen. Harp questioned if changes associated with provisions in the new contract were taken into account in the projected cost savings. Mr. Parrella stated that Mercer did include the incentive payments (\$4million) and the \$12.5 million in reinsurance costs in the savings calculation. The reinsurance payments to the plans have not yet started. This should begin this summer, retroactive to September 1998.

Audited Revenue/Expense Reports

Hillary Silver (DSS) presented the **audited** reports for the **complete line of business** for the managed care plans in the HUSKY program (noting that HRI and CHNCT are Medicaid only plans). **The Medicaid line of business will be reported separately by the MCO's for CY 1999 in April 2000.**

Financial Stability Indicators for All Lines of Business: CY 1997

	ABC	CHNCT	HRI	Kaiser	MDHP	Oxford	PHS	Yale P.
Overall Loss Ratio	96%	99%	100%	109%	101%	117%	108%	109%
Admin. Loss ratio	19%	14%	20%	18%	17%	17%	22%	19%
Medic. LR	77%	84%	79%	91%	84	100%	86%	90%
Operat. Profit Margin	5%	2%	2%	-7%	1%	-17%	-8%	-9%
Days in Receivable	31	28	33	21	9	27	25	34
Days in unpd claims	149	40	74	59	31	91	49	95

Ms. Silver identified important points to consider when reviewing this data (complete handout is available in LOB RM 3000):

Medical Loss ratio reflects the income and expenditures for health services. Administrative costs are calculated separately. Subcontractor administrative costs should be in the administrative loss ratio; DSS will verify the dispersion of plan/subcontractor revenue/administrative expenses. Health plans differ in the variability of their lines of business. For example ABC has administrative contracts, employer indemnity contracts, is a Medicare intermediary and has commercial and HUSKY HMO lines of business. CHNCT is solely a HUSKY plan. Plan size effects (unaudited) quarterly loss ratios, with smaller plans having greater variability and higher administrative costs.

Medical and administrative loss ratios (LR) are defined by HEDIS and acceptable ratio parameters, based on national standards for commercial plans, have been established.

Administrative LR should not exceed 16%, although most plans have exceeded this level in this report. Medical loss ratios should be at about 85%. Higher ratios suggest significant financial losses (i.e. Oxford reported 100% medical LR as well as the highest overall loss ratio). Lower medical ratios suggest more income compared to health service expenditures. While ABC had a lower ratio, the different types of business lines might influence this. HRI, a Medicaid-only plan, had a medical LR of 79% and an administrative LR of 20%.

Council members asked about the HEDIS item 'days in unpaid claims', observing that ABC had the highest number (149). The following information was provided:

The data reflects a comparison of claims coming in, money going out rather than individual claims. It reflects the company's liability compared to spending.

ABC data is based on the full line of business, not HUSKY A that is about one-third of the ABC business.

The unpaid claims are adjudicated claims: there is no data on clean vs. unclean claims in the system.

State law mandates managed care timely clean claims payment within 45 days.

The HUSKY A contract defines 'clean' claims as well as mandates claims payment in 45 days. A HUSKY separate line of business report for 1999 will be reported in 2000.

HCFA 416 Report

Participation	Under 1	1-5 Years	6-14 Years	15-20 Years	Overall
1994	61%	40%	40%	21%	41%
1995	62%	41%	40%	23%	42%
1996	63%	41%	41%	23%	42%
1997	74%	52%	54%	33%	54%
1998	80%	56%	63%	43%	60%

Screening	Under 1	1-5 Years	6-14 Years	15-20 Years	Overall
1994	51%	56%	43%	23%	49%
1995	52%	57%	43%	25%	50%
1996	49%	58%	46%	27%	50%
1997	57%	71%	58%	38%	61%
1998	68%	78%	68%	49%	69%

James Linnane reported on the EPSDT data submitted annually to HCFA. **CT was the only state that submitted this report on time to HCFA.** This is also the first time encounter data, sent to Qualidigm and CHC, has been directly used for the report. Mr. Linnane stated that the quality of the data submitted by the health plans is improving and is more dependable, due to the significant collaborative efforts of Qualidigm, health plans and MEDSTAT to improve data quality. While the EPSDT ratios are not at 80%, a goal to have been achieved in 1995, there is at least a 50% increase in EPSDT rates compared to 1994 FSS rates. The new contract, in place as of 2/1/99, sets the goal for an 80% ratio, with financial incentives paid to plans that exceed this and financial sanctions applied to those plans that report ratios under 80%. These will be applied to data reported after July 1999; currently 'shadow sanctions' (non-financial) will be applied to plans below the 80% ratio. The following summarizes the EPSDT data:

Improvement in EPSDT ratios, especially for adolescents, was attributed to:

- Including CPT codes in the reporting.

- Significant outreach efforts by the plans, CHC, community-based organizations such as Healthy Start and other programs such as Head Start and the WIC program.

The inclusion of school-based health clinics as providers within the Medicaid managed care system (mandatory contracting of MCO's with SBHC) results in the encounter data capturing EPSDT service delivery in the SBHC system.

Benova Report on the HealthRight Transition

Voluntary enrollment numbers in the remaining eligible HUSKY health plans was presented:

HRI 1/99 4/6/99 4/9/99

HUSKY A 34,195 7,392 6,900

HUSKY B 511 97

Transition of High Risk HRI Clients (behavioral health, third trimester pregnancy, complex medical needs clients) Benova will manually match clients to a health plan that includes their health provider in the new plan network):

1/99 4/6/99

HUSKY A 1730 397

BH 53

Maternity 74

Medically complex 270

HUSKY B 14 4

BH 1

Medically complex 3

Overall HUSKY B numbers: applications to Benova only as of 6/1/98:

Total number enrolled in a health plan: **3279**

Total applications approved: **3509**

Applications referred to DSS for HUSKY A eligibility: **9680**

HUSKY B Plus enrollees: Medical-15, BH-5. (DSS-projected numbers for the PLUS programs was 3% in each program).

MD/PHS Merger, Vendor Changes

Janice Perkins reported that PHS Passport Plus and MDHP Healthy Options have become one plan as of April 1, 1999. **The name of the new plan is PHS Healthy Options.** The only vendor change for previous MDHP members is the dental vendor change from Benacare to Dental Benefit Providers (DBP). Previous PHS members will experience two vendor changes: PRO Behavioral Health for behavioral health, rather than CMG and Block Vision instead of Davis Vision for vision. The hospital network will expand to include all hospitals and the newly formed plan has contracted with CHC, Inc., a community health center. Ms. Perkins stated that members will have an enhanced network of providers under the merged plans.

The Council raised the following issues:

While the PHS database allows both social security (SS) number and the Medicaid number to be used, Rep. Nardello questioned if only the SS number is used for billing. This becomes especially burdensome for SBHC where only the Medicaid number is readily available. Ms. Perkins will report back to the Council regarding this.

Subcontractor vendor monitoring by the main plan has been a weakness in the HUSKY program over the past three years. Rep. Nardello stated that this must be addressed by all plans in the HUSKY program. Ms. Perkins stated that PHS is very aware of this. Contract provisions mandate this and the Qualidigm audit will be evaluating this. In addition, PHS has a delegation

oversight committee that meets monthly, monitoring the subcontractors, auditing charts, and checking the credentialing process. Monitoring is based on NCQA standards and contractual requirements. PHS is aware that delegated services must adhere to the same standards as the main plan.

Communication process with health providers, main plan and subcontractor, especially related to service authorization was questioned. This has been of particular concern in behavioral health services. Sen. Prague asked what recourse a provider has if service is denied by the subcontractor, yet the provider believes care should be provided or continued. The Department stated that the appeals process is client driven, not provider driven and that the Notice of Action (see March summary) gives the client 10 days to appeal a plan decision that denies, terminates or changes the level of care. During the appeal process, the plan must continue services until the appeal process is completed. The client can also apply for a fair hearing with the Department while filing an appeal. Clients are identified as the head of household (if the client is a child); if the child is a DCF client, both the DCF worker and the family/guardian are identified as the client. The Department is working with health plans in developing uniform NOA and fair hearing forms for clients.

While the appeals process is client driven, Dr. Requero questioned the carriers' relationship with health providers in their network to deal with differences of opinions related to care management. Steve Ruth, Executive Director of PRO Behavioral Health, PHS subcontractor, explained that licensed plan staff and providers discuss issues regarding levels of care and care management, trying to come to agreement before the appeals process/fair hearing process is initiated. Mr. Ruth stated that the third level appeal is infrequently used and the fair hearing process hasn't been initiated over the past four years. Mr. Ruth attributes this to the success, at the internal complaint level, of provider/plan discussion and agreement on care management. The subcontractor and PHS meet twice monthly to review complaints and sentinel events on the subcontractor level.

The average length of the appeal process is 30 days, according to Mr. Ruth; however there are several levels of appeals with time lines. PRO BH would be happy to provide the Council with more specific appeal information that has been created to meet the new contractual standards. Both the behavioral health and quality assurance subcommittees have discussed these issues with plans and providers over the past year. Recently, the BH subcommittee requested the Department confirm the appointment of administrators in each main plan, as stipulated by the new contract. This administrative position is responsible for plan BH oversight, ensuring integration of physical and mental health care and linkage to care resources that may be outside the managed care system. The subcommittee will request that the administrators attend meetings to explain their function within each plan.

Dedicated HUSKY member service staff and adequate bilingual staffing availability was questioned. Ms. Perkins stated that there is HUSKY dedicated bilingual staff in member services and outreach staff. Ms. Solomon stated she understood that DBP did not have bilingual staff. Ms. Perkins will report back to the Council on this.

Sen. Harp questioned if PHS tracks new providers and network capacity of vendors. Ms. Perkins stated that PHS matches MCO data with the vendors to ensure the vendor data regarding clients and providers are the same. PHS closely monitors the capacity of their provider network, including the vendors, as this affects enrollment caps. The Department also regularly monitors each plan's network capacity.

Sen. Harp thanked PHS and PRO BH for their participation in the discussion and looks

forward to PHS response to specific items at the May meeting.

Subcommittee Reports

Quality Assurance: the subcommittee chairs discussed recommendations to the Department that would consolidate the communication process involving Council oversight of quality assurance projects. The recommendations recognize the Department as the responsible agent for HUSKY program quality and the entities currently involved in quality measurement of the program. These recommendations have been presented to the Department in the spirit of collaboration in ensuring the continuing improvement of the quality of the HUSKY program.

The Subcommittee also raised the issue of the need for a uniform data system among the departments involved in HUSKY (IE DCF, DSS, DPH). The subcommittee recommended that other states that have achieved this be invited to describe their systems to the Council. Sen. Harp suggested that Marc Ryan, Secretary of OPM, be invited to a Council meeting after the session to discuss what the State is currently doing to address this issue as well as contemplated future efforts to improve data sharing and communication among agencies.

Behavioral Health: SBHC contracts for behavioral health services have been delayed because of communication deficits between plans and SBHC about the scope of services provided by SBHC. The Departments of Social Services and Public Health have, at James Gaito suggestion, brought together the entities to have a forum to discuss contract barriers. The content of this meeting will be brought to the next DSS/MCO meeting in April.

The importance of outcomes measurement across levels of care has been a reoccurring theme in the subcommittee. The committee has:

A working group developed an outcomes study tied to contractual behavioral health incentives with consultation from Allan Kazdin, Ph.D, Chair of the Psychology Dept, Yale University. The study uses the OTR form developed in 1998 by subcommittee participants. Mr. Ryan (OPM) has confirmed that funding will be available for the study in July 1999.

The committee will follow through on developing outcomes measurement of behavioral health services throughout the levels of care for children and adults in the HUSKY program.

The committee agreed to address the issue of gaps in the continuum of care as they relate to the Special Needs children (formerly Appendix K). There has been an initial attempt to develop an inpatient database that assesses acute/subacute care that could be reported on a quarterly basis.

An important component to addressing gaps in the continuum of care is resource mapping that would compile the services available for behavioral health within the HUSKY program as well as outside HUSKY.

Public Health: The subcommittee will be meeting with the Consumer Access subcommittee to address issues within the SBHC delivery system along with DPH and DSS.

Consumer Access: continuing to work with DSS on the development of focus groups; a date for one group has been set for April 28. Representative from the Department of Corrections and Board of Parole met with the subcommittee to develop strategies to assist inmates and parolees in accessing the HUSKY program. The subcommittee continues to work with DSS on the HUSKY application revision.

Other Items

Rep. Nardello stated that information presented by the Department to the Council has been very helpful and has led to cooperative efforts to improve the HUSKY program.

While the process has been painful at times, both the Council and DSS have worked together to resolve problems. While the Council has addressed HUSKY B outreach effort, there has been no discussion as yet of what data the Department will be collecting on HUSKY B and how that will interface with HUSKY A. Mr. Parrella stated that HUSKY B is under Title XXI guidelines in the State Plan, whereas HUSKY A adheres to Title XIX guidelines. Data reporting guideline to HCFA is different for each program. The Department will present a summary of the data reporting for HUSKY B, comparing it to HUSKY A reporting requirements at the June Council meeting.

The next Council meeting will be Friday May 14 at 10 AM in LOB RM 1D. The subcommittee chairs will meet with Sen. Harp at 9:15 AM, prior to the Council meeting in LOB RM 3000.

