

MEETING SUMMARY
September 24, 1999

Present: Senator Toni N. Harp (Chair), Rep. Vickie Nardello, Marie Roberto (DPH), David Parrella and James Gaito (DSS), Dr. Wilfred Reguero, Ellen Andrews, Lorraine Milazzo, Judith Solomon, Marilyn Cormack, Jeffery Walter, Robert Gribbon (Office of Comptroller), Lisa Sementilli-Dann, Dorian Long for Deputy Commissioner Gilman (DCF), Janice Perkins (MCO organization), Dr. Edward Kamens.

Also present: James Linnane, Jan Versenic (DSS), Sheila Allen Bell (Benova), Debra Russo (Qualidigm), Mary Alice Lee, Mariette McCourt (staff to Council).

Department of Social Services Report

Medicaid Managed Care Y2K Readiness Status

David Parrella reported that the Health Care Finance Administration (HCFA) has reviewed states' Y2K readiness for the Medicaid program. The assessment report indicated that Connecticut has a low risk of failure in the Medicaid Management Information system (MMIS), low risk for the Medicaid enrollment system (Benova) and a medium risk for failure of the eligibility system. The Department disagrees with the latter assessment. Jan Versenic (Y2K Coordinator, DSS) described the State's Y2K readiness, stating that the Medicaid system in DSS is at low risk of failure. HCFA based the EMS "medium" risk of failure rating on three findings:

The State plan to outsource the Data Center operations would create the potential for an unstable system in January 2000. The Department response: HCFA was advised on July 13, 1999 that contract negotiations were terminated with EDS, but this was not incorporated in the HCFA report issued August 1999.

No Level III testing performed (test the system by resetting the system clock to 2000). The Department responded that there has been extensive testing beginning in 1993 in preparation for the Welfare to Work Project, which was concluded January through June 1999. Follow-up testing will of 24 remaining scenarios will be completed in October 1999. There is only one known Y2K problem that involves an online date display field rather than a data processing problem. DSS MIS staff will be working 1/1/00 and 1/2/00 as needed to monitor and correct EMS application problems prior to the start of business 1/3/00.

End-to-end testing was not performed with all critical business partners. The Department responded that the most critical, high-risk components (automated eligibility verification and pharmacy Point of Sale processing) were tested without problem in April/May 1999. Lower risk provider check file processing will be tested 10/99. Managed Care files were built Y2K compliant. Test files with 2000 century dates were transmitted to Benova in August 1999. Managed Care Plans will be creating test data from existing managed care files to test their input processes.

The State has developed contingency plans that include interim provider payments

during the first three months of 2000 for Fee-for-service (FFS) in the event there are problems with providers' internal billing system. The Department of Insurance (DOI) has reviewed State commercial HMO's Y2K readiness and DSS will accept this review of the three Medicaid MCO plans with a commercial line of business. Mercer will use the same DOI instrument to assess CHNCT, as this Medicaid-only plan is not a licensed HMO and was not required to participate in the DOI evaluation.

Senator Harp thanked the Department for the Y2K update, recognizing the extensive efforts the Department has made in preventing foreseeable Y2K problems. The Department was requested to provide a MCO Y2K readiness update in the November Council meeting.

Kaiser Exit

Mr. Parrella stated that October 31, 1999 is the last day of Kaiser 's active participation in the HUSKY program. The Department and the Attorneys General Office have worked with Kaiser in developing a transitional agreement for a smooth transition of members to other plans.

The Department sent notices to members 9/1/99 and Benova is working with Kaiser to move members to another MCO. There were 3931 Kaiser members on September 1, 1999. Kaiser membership has been reduced by 1000 as of 9/22/99.

Kaiser has identified and communicated to Benova Kaiser members who are pregnant or medically fragile and their health providers. Benova will use this information when enrolling members in a new plan that includes their provider. Kaiser will be working with the new plan to coordinate care for these members and ensure continuity of care.

The new contract contains provisions that provide an incentive for defecting plans to ensure continuity of care, and fulfillment of administrative responsibilities, including encounter data submission, through a \$100,000 with hold from the last capitation payment.

Council discussion raised the following issues:

Provider credentialing by new plans: Anthem Blue Care (ABC) is in the process of credentialing Kaiser providers from the Hartford Center. Janice Perkins (PHS) stated that new provider credentialing takes several months, depending upon the timeliness of the provider's response in submitting the information. Rep. Nardello asked if the credentialing process could be uniform among the Medicaid plans, as was done with the dental process. Mr. Gaito (DSS) stated there are basic credentialing standards in the contract; however MCO's have the option to institute more rigorous standards, especially if the plan is enrolling the provider in both the Medicaid and commercial network. Rep. Nardello stated that since there are DSS and NCQA credentialing standards that plans adhere to, the Department was requested to consider, for the future, a uniform credentialing process. This would expedite the process, reduce administrative costs and provide member care continuity with their health providers, in the event of future plan transitions. Janice Perkins will look into the feasibility of PHS accepting a uniform provider credentialing process.

Impact of Kaiser exit on program network capacity: Program capacity is based on plan capacity, with a ceiling of 1200members/primary care provider. Mr. Gaito stated there is capacity in all counties, providing members with choice as mandated in the 1915b waiver. Individual plan enrollment has been frozen in some counties, largely because of inadequacy of the dental network. Ellen Andrews reported that approximately 12 parents attended a focus group in the Windam/Tolland counties and reported difficulties accessing providers other than dentists. **Mr. Parrella stated that DSS would review the program capacity methodology and current capacity status at the October meeting.**

Ability of the program to sustain other health plan loses: While PCP's in plan networks that have left the program have been successfully brought into existing MCO networks, there would be a capacity problem with the loss of other plans. In the event of the development of inadequate provider networks to serve the whole state through comprehensive contracting, alternative models need to be considered. Other states have implemented a mixed model of managed care and Primary Care Case Management (PCCM). The latter is a non-capitated network with care management and gate-keeping performed by the health provider.

Dr. Reguero commented that the constraints of Medicaid funding, program fiscal goals and the impact of the Balance Budget Act (BBA) on hospitals have the potential to seriously effect care. Mr. Parrella stated that the effects of the BBA on Medicare worsen Medicaid problems. National trends reveal that HMO's have left public programs, including Medicaid, because of fiscal issues. While Mr. Parrella has no immediate sense of a major MCO defection in CT, the Department is very concerned about this. The current 1915(b) waiver rate setting is based on the Upper payment Limit (UPL) that is predicated on the 1995 FFS rates. The managed care UPL is projected forward from this FFS base rate, configured on what the State would have been spending if there were no change in the system from FFS. The problems with the current rate setting, based on FFS include:

- An antiquated fee database upon which the current UPL is based.

- Dramatic program changes since 1995 that include changes in the percentage of cash/non-cash participants related to Welfare reform and a change in the HUSKY case mix related to extensive outreach efforts.

- Increased program oversight that has resulted in a significant financial investment to improve the program. There was little oversight and performance measurement under FFS.

- Increased access, utilization, quality and accountability in the managed care program has resulted in costly administrative burdens and spending.

The UPL creates a ceiling for the absorption of increased program costs. The UPL is a federal regulation that constrains capitation rates to be no greater than a state's existing FFS payments for comparable populations. Thus states may wish to pay higher reimbursement rates but are limited by their prior spending levels (see enclosed May/June 1999 Health Affairs article: Medicaid Managed Care Payment Rates in 1998).

Mr. Parrella stated that Connecticut has the highest Medicaid capitation rates in the country. (According to the Health Affairs article, the State's adjusted monthly rate is \$182.52, compared to the national average of \$179.78). In addition, Connecticut has a statutory spending cap that further limits program spending. These two create the State's parameters within which to balance reimbursement rates and the cost effectiveness of the program. Mr. Parrella stated that a Washington Task Force is attempting to develop alternatives for rate setting other than the UPL; however he doubts this issue will be resolved prior to the elections in the year 2000.

The BBA provisions have reduced Medicare reimbursement to hospitals, long term care facilities and home care, and reduced Graduate Medical Education reimbursement, all of which impact on Medicaid. As these Medicare cuts are implemented, providers will look to the State to fill the resource gap. The State will be faced with major policy and budgetary considerations in the coming year. Dr. Kamen stated that as reimbursement is reduced and provider overhead increases, the pressure on the individual provider is increased. This results in less time spent with patients. Managed care remains focused on retrospective process models of care rather than prospective outcomes

measurement. Further discussion of fiscal issues, program quality and configuration will continue in future meetings.

Overview of the HUSKY Quality and Contract Provision Monitoring

Mr. Parella presented an overview of the HUSKY program Quality Assurance that included the entities involved and their responsibilities (**see attached DSS document**).

Quality Assurance and Improvement oversight is broadly addressed by three entities: the Department of Social Services, the Children's Health Council and the Medicaid Managed Care Council.

The Department exercises direct responsibility for the quality of the HUSKY program through:

Collaborative arrangements with the Department of Public Health (DPH) that include tracking blood lead levels and data sharing, matching for lead screens, programs in Maternal Child Health, WIC, SBHC and Health Start and immunization tracking through CIRTS.

The actuarial consultant (Mercer) that performs financial audits and rate setting configurations for the Department.

The Enrollment Broker (Benova) that provides the Single Point of Entry into the HUSKY A and B programs, tracks enrollment, generates monthly reports and provides outreach to potential applicants.

The Department's three internal divisions, Quality Assurance Division, Contract Administration and Health Care Finance Division address program quality and improvement. The latter division has responsibilities for contract monitoring (James Gaito), Reports and Analysis of plan performance (James Linnane), Customer Assistance and Policy & Program Direction (David Parrella).

Qualidigm, an External Quality Assurance Organization, is contracted by DSS to perform operational audits of plan performance, data validation, and clinical quality improvement studies. MEDSTAT is the Qualidigm subcontractor for the encounter data management.

The Managed Care Organizations have quality assurance responsibilities that include internal quality monitoring and improvement, encounter data reports, provider credentialing and network provider performance.

The Children's Health Council provides advocacy and oversight of children's health through monitoring access to care, special studies and reports. The Children's Health Project, under the CHC, subcontracts with Maximus for tracking EPSDT services through the encounter data and provides outreach services, and the Children's Health Infoline (CHIL) for customer service.

The Medicaid Managed Care Council is a legislative oversight council that provides the only vehicle for legislative and public input, in an advisory capacity to DSS, for the development and ongoing implementation of the program. The Council's main mandate is to advise DSS on program issues that arise in the Council and the five subcommittees, which address specific areas, including quality assurance, behavioral health, consumer access, women's health and public health issues.

The DSS and the Attorney's General staff organized the spreadsheet (see attached) that summarizes contract compliance monitoring of the new contract provisions. The Department had made the decision fully supported by the Medicaid Council, to include the BBA provision of sanctions and financial incentives to ensure MCO performance levels. There are three levels of sanctions with consequences applied after three strikes (A level sanction) or upon evidence of a more serious contract violation (B and C level sanctions). Financial incentives are awarded in four performance areas: EPSDT, Dental,

Behavioral Health and Consumer Satisfaction. The latter incentive is based on a survey of the general population and families with special health needs. One of the behavioral health incentives involves an outcomes-based study, the first in the HUSKY program, performed with Alan Kazdin, chair of the Yale Psychology Department. Administrative funding has been secured through Eva Bunnell with OPM and a private foundation. The Council Chair as well as members of the Council applauded the efforts of the Department to aggressively pursue overall program improvement through contract provisions with the managed care organizations and the Department's quality assurance entities. Senator Harp stated that we have come a long way in obtaining needed quality measurement. She commended the Department for all their persistent efforts and for listening to the Council concerns and following through with the implementation of Council recommendations. The Senator stated she looks forward to the results of the Behavioral Health outcomes study. Janice Perkins stated she is encouraging New Jersey to follow Connecticut's lead by including incentives in their program, as the incentives are a great motivator in improving performance.

Other Issues

Rep. Nardello requested the Department provide an update on the school outreach contracts and activities that have evolved in HUSKY outreach to school children. The Department will do this in October.

Senator Harp commented that September 30 is CT's deadline for the use of federal TANF Medicaid administrative funds, appropriated for outreach associated with the Welfare/Medicaid de-linking. The Senator asked DSS if these resources have been accessed. Mr. Parrella stated he would have more information in October. The Department is considering the possibility of putting the federal matching monies in a receivable account to allow a roll-over of funds for future outreach. Congress will hopefully extend the availability of the money for another 12 months.

Marie Roberto questioned if DSS has taken a position with the Medicaid managed care companies in implementing smoking cessation programs. Mr. Parrella replied that while the legislature passed a bill providing the Commissioner with the opportunity to consider smoking cessation as a covered Medicaid service, the Department has not yet decided to change the State Plan. If the State Plan includes this as a covered service, then the MCO's would be obligated to do so by contract.

Dr. Reguero stated that transportation for medical services remain a problem, in particular long wait times to return from appointments. Mr. Parrella requested specific information regarding this for a discussion at a future meeting. Dr. Reguero stated he would collect information on the client and the provider for a future Council meeting.

Benova Report

Sheila Allen Bell, Director of CT Benova, introduced Ruthann Wilmes who is replacing Lynne LaPenta as Operations Manager.

Ms. Bell reported on the HUSKY B enrollment status as of 9/21/99:

Total HUSKY B children enrolled: 4112

Total approved: 6130

Number of children referred for HUSKY A review: 15,595

At the start of the HUSKY B program, the projected number of uninsured children was 35,000 according to DSS.

Ms. Bell stated that those approved and not enrolled in HUSKY B (2018) may not have sent in complete information or are "locked-out" if the family fails to pay their premiums.

Of these, approximately 1700 are approved, and 155 children are in 'lockout'. The 6130 approved number is cumulative since the beginning of the program and include the 150 children moved from B to A when the federal poverty level changed in April 1999.

Benova completed a lockout survey in September and found that of the 70 families (155 children), 20 had obtained other insurance, 5 received HUSKY A, 4 could not afford the payment, although their financial situation had not changed. Of those who indicated a financial change, 7 agreed to send new income verification. One client was reinstated during redetermination, 5 reported a payment discrepancy with the health plan.

Benova completed a redetermination survey of HUSKY B families and found that :

Of the 88 families (172 children) that did not reapply, 26 families were sent an application were later referred or approved.

Six families obtained other insurance.

One family was not satisfied with the program

Benova was unable to contact 54 families after three phone attempts (61%).

Of the 37 families (75 children) with incomplete documentation at redetermination, 20 were sent verification and were later referred or approved.

Five families did not understand what verifications were needed and 9 families indicated they would send in verification.

Benova was unable to contact only three of the 37 families after three attempts.

Benova will continue to do outreach to families not yet enrolled, but approved and are working on strategies to measure the effectiveness of outreach efforts. A HUSKY mass mailing in the Hartford Courant over three weekends, sponsored by the Mohegan Sun, has resulted in 22 calls to Benova and 64 coupons requesting more information about HUSKY. Benova was asked to review the impact of the mailing in the October meeting. Benova is also compiling data on the distribution of HUSKY B enrollment by county and premium band by race. Preliminary data reveals a disproportionately low number of minority enrollees.

Sen. Harp commented that there is a slight decline in the HUSKY A enrollments over the past several months and asked DSS to comment about this at the next meeting. In addition, the Department was asked to comment about the Department's plans for the HUSKY A parent expansion.

Children's Health Council

Judith Solomon reported that the CHC is also struggling with developing effective strategies to identify the impact of outreach efforts in the Robert Wood Johnson grant and the CBO outreach grants. The CHC now has access to a longitudinal database for HUSKY A that allows identification of new children coming into the program since July 1998, as monthly net enrollment figures cannot differentiate those coming into the program and those children exiting the program. From 7/1/98 through 6/30/99 over 40,000 children have come into the HUSKY A program. This number includes newborns and families new to cash assistance and cannot be attributed to outreach.

Ms. Solomon commented that the reduction in the HUSKY A numbers may be associated with the difficulties CT has had with de-linking cash assistance and medical coverage. The department is looking ways to improve this. Families in the 24-month transitional Medicaid program are gradually losing their coverage and may not be going through the redetermination process.

Connecticut is included in a tri-state SCHIP outreach effort sponsored by the Children's Defense Fund, Martha Stewart and K-Mart stores. Health fairs in eight K-Mart stores will

take place in October and Benova, CBO grantees and others will be present to take HUSKY applications.

Mary Alice Lee reported on CHC performance monitoring:

EPSDT on time rates were lower in the 4th quarter of 1998, in part due to changes in the adolescent periodicity schedule.

In a comparison of encounter data and plan aggregate reports, CHNCT had lower encounter submissions than in their reports, which may influence the low EPSDT rates in this quarter. Asthma hospital discharge rates for children showed that Medicaid discharge rates (50%) were disproportionate to the Medicaid state population (1 in 5 children are on Medicaid). Medicaid children also had longer hospital stays than non-Medicaid children.

Council Subcommittee Reports

Behavioral Health: The subcommittee has heard a report from the providers and health plans on the impact of managed care on behavioral health. A task force has been formed to address prioritized concerns of both providers and plans.

Public Health: DSS presented a report on dental participation rates and fee schedules for CT as compared to other states. The Department will work with DPH and providers to develop credentialing criteria and forms in order to implement the 1999 legislation that allows dental hygienists to receive direct Medicaid reimbursement for services within their scope of practice.

Consumer Access: DSS presented the HUSKY B satisfaction survey, the collaborative effort with DSS/DOC/and subcommittee participants to educate York Correctional counselors about HUSKY in an effort to ensure inmates are connected to HUSKY prior to release is ongoing. A report on the focus groups will be forthcoming in October.

Women's Health: Recommendations have been approved by the subcommittee regarding lactation services and support in the Medicaid program and will be presented to the full Council. Future activities include an assessment and measurement of women's access to preventive cancer screens and primary care. The subcommittee will also work with DSS on planning outreach to parents in the HUSKY A expansion program.

Quality Assurance: The subcommittee had identified the importance of evaluating environmental health prevention and treatment in the Medicaid program, specifically lead poisoning and asthma. The collaborative study by DPH, DSS and the Children's health Project assessed lead screens for children aged 12-24 months in the HUSKY program in Hartford. Lead screening rates were very high, over 90%, in sharp contrast to the GAO study that reported rates less than 30%. The study will be replicated for five city's data and reported in October/November. The merged DSS/DPH database provides the opportunity for outcomes measurement for lead management.

Senator Harp thanked all that support the subcommittee process, especially the Department of Social Services, as important work is done in each subcommittee. As the program has grown, activities have increased and could not be addressed solely at the Council level.

The next Council meeting is October 15, 10 AM, at which the quarterly data for the 1st quarter 1999 will be reviewed and the results of the Qualidigm MCO operational audit will be presented.

The November Council meeting will be November 5, 1999.