

MEETING SUMMARY DECEMBER 10, 1999

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella and James Gaito (DSS), Dorian Long for Gary Blau (DCF), Steve Netkin and David Guttchen (OPM), Marie Roberto (DPH), Janice Perkins (PHS), Pat Carolan (BeneCare), Dr. Wilfred Reguero, Dr. Edward Kamen, Rev. Bonita Grubbs, Lisa Sementilli-Dann, Judith Solomon, Lorraine Milazzo, Jeffery Walter.

Also present: James Linnane and Rose Ciarcia (DSS), Debra Russo (Qualidigm), Paula Armbruster, Cheri Quickmire (Christian Community Action), Mary Alice Lee, Sylvia Kelly, Glenn Wright (P-1), Sarah Calatayud (CHNCT), Bonnie Sodaberg (ABC), Mariette McCourt (Council staff).

DSS Report

HUSKY Enrollment: Plan A and B

The number of applications received for HUSKY A and B since July 1, 1998 to December 1, 1999 totaled 16,036. Of these 9,892 were referred to DSS for HUSKY A eligibility. (On average, Benova receives 1000 applications per month). HUSKY A eligible numbers tend to be between 3000 to 3500 more clients per month than who are enrolled in managed care plans. These numbers reflect the lag time between eligibility determination and the family's plan choice and enrollment in a plan. As of December 1, 1999 171,782 children under the age 19 years are enrolled in HUSKY A. In the last month 907 members were enrolled in HUSKY A.

Since July 1998 there were 4,459 members enrolled in HUSKY B with 5100 determined eligible for B. There was an increase of 274 eligible and 135 enrolled in HUSKY B over the last month.

Discussion about HUSKY enrollment numbers resulted in the **Council request for further information from DSS for the January meeting on the following:**

- Break out of applications by premium bands in HUSKY B. While there always is a lag time between eligibility determination and enrollment in HUSKY A or B because of the time it takes families to choose a plan, there may be a greater lag time in HUSKY B, band 3 (>300%FPL). Enrollees need to be classified by eligibility bands, are required to choose a plan and then pay the 1st month premium before enrollment is completed. Benova follows up on incomplete applications with 3 phone calls and a mail reminder. Rose Ciarcia (DSS) reminded the Council that there is no default enrollment in HUSKY B as there is in HUSKY A because HUSKY B is based on choice, not entitlement and premium payments are required in band 3 before enrollment is completed.
- List of the co-pay amounts in HUSKY B and the different premium rates (for those in

band 3) per plan. Ms. Ciarcia stated that DSS negotiated capitation rates for HUSKY B with the individual MCO's; separate rates were negotiated between DSS and each plan for band 3.

- The basis for the determination of different MCO premium rates in HUSKY B, band 3.

Senator Harp requested the Department provide information on the follow up of families leaving welfare and their continuation of medical coverage. The Department was to track closed cases, identify the families' medical coverage status and link those without coverage to outreach entities to inform the families of possible medical coverage. **The Department will report on this in January. Senator Harp stated that this information is important to track within the Council on a month-by-month basis.**

Behavioral Health Claims Resolution

James Gaito reported that there have been good results with the claims resolution process for two sets of disputed claims:

- Methadone claims: over \$2.3 million in disputed claims were submitted from 14 agencies. Most of the disputed claims were resolved with only one agency using the DSS mediation process for resolution of \$35,000 in claims. The Department is currently working with the MCO's and organization to verify the validity of these claims (i.e. clean claims).
- Behavioral Health providers submitted disputed claims totaling \$1.16 million. The MCO's and providers have worked through the process, resolving \$1million of the outstanding claims. There remains \$135,000 in dispute by 3 agencies and about half this volume may be referred to the mediation process.

Sen. Harp thanked Mr. Gaito for he and his staff's efforts, and CT Community Providers Association (CCPA) along with the providers and MCO's work in resolving this important problem of unpaid claims. The Senator expects that the resolution process will include problem-solving strategies and recommendations, developed by the MCO's and providers, to prevent a reoccurrence of such significant amounts of disputed claims in the future.

Quarterly Data Review

James Linnane presented an overview of key areas that included:

1) Behavioral health: The total number of enrollees receiving both mental health and substance abuse services remains at 4.5 to 5% of the population. The Department is looking more closely at BH encounter data in preparing the behavioral health report for the General Assembly (due in February 2000). This review of encounter data of BH services for Medicaid children from April 1, 1998 through March 31, 1999 has revealed problems with data reporting that contributes to the unexplained fluctuations seen in the quarterly reports. For example, inpatient services are looked at by provider type, revenue codes and CPT codes. It has been found that MCO's use various revenue codes and some plans are using 'homegrown' codes in the claims data. Unlike EPSDT, where more uniform codes are now used, BH codes may differ by plan, making it difficult to assess utilization patterns within the HUSKY program. Changes in the penetration rates are inconsistent among plans across quarters; thus DSS has not requested an explanation of decreases or increases in utilization from the MCO's. **Mr. Linnane agreed to look at the Compass data, which reports on HEDIS indicators for commercial plans and discuss this information with the Council in January.** While commercial BH benefits have been more limited than Medicaid, Mr. Linnane stated it might be useful to compare this data with the HUSKY data. Jeffery Walter, Co-Chair of the Behavioral Health subcommittee, requested DSS report to the BH subcommittee on the data being developed for the legislative report. **Mr.**

Linnane stated he would refer the request to the task force involved with developing the report and report back to the Council.

2) EPSDT utilization: Kaiser achieved over 80% in screens, but there are some declines among other plans that require attention. The following issues were raised:

- A discussion is needed about the feasibility of consistently achieving the 80% screening ratio and the need to establish interim performance goals within each plan rather than the 80% ratio that has thus far been consistently out of reach of the MCO's. Since there are variables that effect quarterly ratios, the Council agreed to evaluate the April HCFA 416 report in relation to the previous years performance and have a discussion of establishing more realistic interim goals at that time.
- Evaluation of the quality of the Medicaid program should compliment the DPH initiatives defined in the State Health Plan. For example, unintentional injuries are the #1 cause of mortality/morbidity for children and age-appropriate smoking cessation interventions have positive long-term health effects ranging from reducing passive smoke effects on young children to decreasing adolescent smoking rates. EPSDT anticipatory guidance protocols address these health issues at specific age intervals. Sen. Harp requested that DPH, DSS and the Quality Assurance subcommittee work together to bring recommendations to the Council that take into consideration DPH initiatives. The Qualidigm EPSDT special project will assess the comprehensiveness of EPSDT screens through chart review of age-specific EPSDT content that includes anticipatory guidance. This report will be available in early 2000.
- Strategies to improve EPSDT performance must include MCO's, providers and consumers (see July 99 Council summary). The Children's Health Council has broadened its efforts beyond their initial work with MCO's (which continues) to training school readiness local councils that are now legislatively responsible for ensuring EPSDT screens are performed and distributing EPSDT information to providers.
- CT has demonstrated good performance in two components of EPSDT; immunization and lead screening rates. CT Medicaid immunization rates (77%) exceed national commercial plan rates (61%) as well as CT commercial rates (66%). A preliminary report of 6 CT cities' lead screening data suggests that Medicaid screening rates greatly exceed those reported in the GAO report of lead screens in the Medicaid population. A report on this study initiated by DPH will be forthcoming in early 2000.

3) Dental Utilization: Utilization is now being reported as a ratio of children that received dental services as compared to the number of children in a plan in a quarter. The ratio should be 50%, assuming a child has 2 visits a year and the data is reported on a quarterly basis. For the second quarter of 1999, 16% of children aged 3-20 years received preventive dental services and 10% received treatment. These total averages were skewed by significantly higher rates reported by PHS for this quarter that do not match the data submitted on dental services per 1000 member months. Janice Perkins (PHS) reported that upon receipt of the quarterly report from DSS, the MCO asked their dental subcontractor, DBP, to review the data and resubmit corrected data to DSS the week of 12/17/99. There was an error in reporting.

4) Emergency visits: The data is difficult to interpret as changes in billing practices at some hospitals have had a major effect on the data without reflecting plan interventions. It is important to obtain valid data regarding ED use, in particular non-emergent utilization, which may reflect consumers' use of/access to their Primary Care providers and the flexibility of PCP hours. Financial barriers to developing a more flexible ambulatory care infrastructure for primary care may arise from the impact of certain Balanced Budget Act provisions. Both the health plans and

DSS will attempt to clarify ED data, both emergent and non-emergent use, with the hospitals.

5) Prenatal Care: The incidence of low birth weight (LBW) infants (9.7%) is slightly higher than the general population (7.3%). Marie Roberto (DPH) stated that HRSA is changing the parameters of the Maternal Child Health Title V grant reports to include information about LBW and the consequences of prenatal interventions for both Medicaid and non-Medicaid Title V clients. Both DPH and DSS have been investigating the feasibility of linking the Medicaid database with the DPH birth data, which will be needed to comply with the changes in data reporting.

Anthem Bluecare reported the highest percentage of women receiving care in the first trimester (83.6%). The quarterly percentage of women enrolled in MCO in the 1st trimester has ranged from 38% to 48% since 1997. The percentage of women receiving care in the first trimester is based on less than half of the births in HUKSY A. There does not appear to be a relationship to 1st trimester care and incidence of LBW rates in the data among plans. This may be due, in part, to the low and varied numbers of births per plan (making comparisons between plans not meaningful), as well as differences in population characteristics and geographic location of members among plans.

Plan	% of women receiving care in 1st trimester	% Total LBW
Bluecare	83.6%	9.3%
CHNCT	64.3%	9.9%
Kaiser	60.9%	4.2%
PHS	63.4%	7.9%
Preferred One	63.1%	12.3%
Mean	67.1%	8.72%

6) Immunization rates of 2-year olds, 1998: As noted above, Medicaid immunization rates exceed commercial rates. Marie Roberto expressed concern that missing data in the Immunization Registry (CIRT) is of concern to DPH and questioned how the plans can work with providers to improve reporting. Data omissions suggest either the data is not reported or some children are not being immunized. Comments reflected the following issues regarding data reporting:

- While the MCO may track immunizations through evaluation and management codes, immunizations are free; hence no claim is submitted to the MCO, making it impossible for the MCO to track the actual immunization record from their claims data.
- ALL PROVIDERS are to report immunizations to the Registry; there were no exclusions for reporting in the legislation that created the Registry. Some providers may not be aware of the requirement to report all immunizations to the Registry. Terminals for the electronic submission of immunization data are beginning to be placed in

provider offices; over time this will be done throughout the state.

Health Plan Y2K Readiness

Mr. Gaito reported that the Department of Insurance reviewed the Medicaid MCO Y2K readiness for those plans that have a commercial line of business. Mercer used the same criteria to review CHNCT, the only Medicaid-only plan. The reports should be released within the week; however DSS does not anticipate any problems. The Department has been working with Benova and the MCO's to test the eligibility system. No problems have been identified.

Dental Expenditures, CY 1998

As requested by the Council, DSS presented a report submitted by the MCO's of dental expenditures in the Medicaid program for CY 1998. The following information was provided:

- Total spending under FFS in 1995: \$13.2 million.
- Total spending under MC for CY 1998: \$15.7 million (does not include administrative costs).
- Percentage spent by service type in 1998:
 - Evaluation: 19%
 - Preventive services: 19%
 - Other services: 62%
- Average PMPM rates per service (rate paid the subcontractor by the main plan):
 - Evaluation: MCO ranged from \$.69 to \$1.82 with average rate of \$1.34 PMPM.
 - Preventive: ranged from \$1.20 to \$1.48 with average rate of \$1.37 PMPM.
 - Other services: ranged from \$3.19 to \$5.22 with average rate of \$4.42 PMPM.
 - Total dental care: ranged from \$5.92 to \$7.91 with average rate of \$7.13 PMPM.
 - Total dental care PMPM rate under FFS: \$5.51 PMPM.

Dental spending under managed care (1998) increased by approximately \$2.5 million (16%) as compared to FFS spending. The overall MCO global capitation rate is \$179.78: the dental rates paid to the subcontractors represent .03% to .04% of this global rate. The actual rates paid the dental provider by the subcontractor are proprietary.

[The Millbank Memorial Fund issued a report from the Reforming States Group (RSG) on Pediatric Dental Care in CHIP and Medicaid entitled "Paying for What Kids Need, Getting Value for State Payments" (1999). The report proposed a new approach to state financing policy of dental care that included a program with diagnostic, preventive and restorative dental care components. The authors stated that "based on utilization patterns in California, the resulting estimate for direct cost of services under the RSG program was determined to be \$14PMPM; \$16-\$17PMPM with administrative costs included".] The PMPM rates paid CT dental subcontractors by the main health plans ranged from \$7.91 PMPM to \$5.92 for total dental care in 1998.

A look at 1998 total dental care PMPM rates with the 1998 quarterly reports of dental services per 1000 member months show that those plans (ABC, Kaiser and MD) with rates over \$7 PMPM exceeded the mean number of services provided by all the plans in each quarter. However subcontractor rates are only one variable that may affect dental access. Provider availability, transportation, and family understanding of the importance of routine dental care also influence dental access. Inadequate dental provider network capacity, based on FFS capacity rates, has resulted in frozen enrollments for Bluecare in Hartford County, CHNCT in Middlesex and New London counties and PHS in

Fairfield, Tolland and Windham counties (see November 1999 Council summary). The Millbank study highlights the challenge states are faced with (including CT) to provide an adequate and an efficient level of dental care within the constraints of inadequate provider networks in some areas of the state, limited funding and allocation of these funds for dental care, and consumer perceptions of the importance of regular preventive dental care in the health of their child.

Quarterly Dental Services per 1000 Member Months 1998

Plan	Total Dental care PMPM rate: 1998	98(1)	98(2)	98(3)	98(4)
ABC	\$7.91	249	245	246	255
CHNCT	\$6.54	176	174	281	212
Kaiser	\$7.55	No report	193	241	223
MD	\$7.13	233	223	241	228
PHS	\$6.49	172	234	177	163
Preferred One	\$5.92	221	193	206	164
Mean	\$7.13	210	210	232	208
PMPM>\$7Mean # of services		241	220	243	235
PMPM<\$7mean # of services		190	200	221	180

Other

Sen. Harp stated that a statewide physician management group reported that plan changes among enrollees in the Medicaid program is of great concern. Currently, members may change plans within 30 days. Benova enrollment reports show that of the 886 members that have changed plans in a month, 56% changed because the PCP and or hospital/clinic was not in their plan.

The Department is interested in identifying the problems related to plan enrollment and PCP participation in the network that result in plan changes, prior to plan lock-in implementation. The Department had stated in the past that plan lock-in would be implemented in the new contract phase. Mr. Parrella replied that, due to Y2K preparations, plan lock-in would most likely be implemented at the time of the new eligibility changes related to the HUSKY A parent expansion in July 2000. **Mr. Parrella stated that the Department would do an analysis of an enrollment sample to identify the causes for plan changes related to PCP/hospital issues and report to**

the Council in three months. Mr. Parrella suggested that future contracts with DSS and the MCO's could include development of a quality indicator that monitors the number of providers that leave a plan, with the goal of having low numbers of PCP change per plan.

Subcommittee Reports

Quality Assurance: This subcommittee and the Women's Health subcommittee met jointly to review women's breast and cervical cancer screen rates that have been consistently low in the HUSKY program. Dr. Anu Gupta reviewed a study of the MCO characteristics and professional guidelines for cancer screens. HUSKY guidelines are inconsistent with these guidelines making it difficult to more realistically evaluate services and compare HUSKY data to national benchmarks. Primary care visits are associated with higher screen rates, according to a review of the encounter data by the CCHP. The Department is considering looking at primary care visits by gender. The Women's Health subcommittee will undertake follow-up of women's preventive cancer screens.

Behavioral Health: The working group of providers, agency and MCO's continues to meet to address operational issues. The BH outcomes study is being finalized and is expected to begin in 2000.

Consumer Access: A proposal to DSS regarding early identification of Special Needs children in the HUSKY A and B programs has been reviewed and will be presented to the Council in January.

The next Medicaid Managed Care Council meeting is on Friday January 14, 2000 at 10 AM in LOB RM 1D.

Happy New Year!