

Connecticut
Medicaid Managed Care Council
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Meeting Summary
February 15, 2002

Present: Senator Toni N. Harp (Chair), Rep. Vickie Nardello, David Parrella & Rose Ciarcia (DSS), Thomas Deasey (Office of Comptroller), Marie Roberto (DPH), Naida Arcenas for Gary Blau (DCF), Judith Solomon, Dr Edward Kames, Ellen Andrews, Phyllis Rotella, Lisa Sementilli-Dann, Janice Perkins (Health Net).

Also Present: Jack Huber, Paula Doyle (Qualidigm), Martha Okofor & Hilary Silver (DSS), Deborah Hine (ABCFP), Sylvia Kelly (CHNCT), Tejas Patel (FirstChoice, Preferred One), Jessie White Frese' (FQHC's), Chet Brodnicki (Child Guidance Clinics), Mariette McCourt (Council staff).

HUSKY Operational Audit: Jack Huber, Qualidigm

(See attached Qualidigm presentation)

Jack Huber is the Medicaid Auditor for Qualidigm, the External Quality Review Organization (EQRO), whose contract with DSS covers children, services and health plans participating in the HUSKY A and HUSKY B program. The contract compliance audits of the HUSKY A program have been conducted by Qualidigm since 1997. This audit covers the DSS/MCO contract period from July 2000 through June 2001, measuring the HUSKY A MCOs compliance with the current program contract and determining whether the MCOs operations and practices are adequate to support delivery of all covered services to HUSKY A enrollees. The audit assesses two principle areas: core functions that pertain the basic infrastructure of a MCO, and Medicaid -specific functions defined by federal guidelines and the HUSKY A contract. The latter are represented by criteria within the access/ service availability and member services categories.

The audit results for 2001 demonstrate exemplary MCO performance as all MCOs achieved a cumulative score of 85% or above, with significant improvements in specific areas compared to the 2000 audit (no Preferred One 2000 audit, as plan was sold in 10/00). Each yearly audit is accompanied by MCO deficiency-reduction plans. Improvements in the 2001 audit were tied to MCO corrective actions and internal changes.

Significant improvement was noted in **MCO subcontractor oversight, UM management & documentation** (particular gains in MCO documentation of discharge planning and connection to community services were noted), and the **credentialing & review process**. Health Net made significant improvement in this area, achieving a score of 100% in this audit compared to 42% in 2000. **All four MCOs scored at or near 100% in these 5 categories.** The administrative deficiency differences between the larger multiple-product plans and Medicaid only plans seen in the 2000 audit are no longer evidenced in the 2001 audit.

The categories that need continued efforts are:

- Quality Management: CHNCT and PHS demonstrate most improvement in this area. ABCFP achieved 100%. Qualidigm concluded that data analysis is not integrated to measure clinical outcomes.

- Member services: Preferred One and PHS achieved 100% in this category. Cultural sensitivity and translation services are audited in this category. Mr. Huber will provide information on these items. CHNCT score decreased slightly in this category; Qualidigm made three recommendations for improvement that included developing a log to track annual grievance forms to providers, verify network mailings and delegate grievance tracking within MCO staff.
- Service Access has 2 components: responsiveness to timely appointments & handling new member needs. Specific services such as EPSDT ratios, which are under 80% across all plans, are addressed in this category. Ratios under 80% are attributed to difficulties in member outreach, % of members' missed appointments and changes in the adolescent periodicity schedule (more screens were added).
- Grievance Review: CHNCT, PHS and Preferred One scored 100% in this category: ABCFP showed little change from 2000, although the plan achieved the 85% score.

The following 2001 audit recommendations were made:

- Documentation Deficiencies:
 - Modification to the Notice of Action Letter process: 1 MCO
 - Creation of a service Log to track grievance forms annually delivered to provider offices: 1 MCO.
- Policy/Contractual Deficiencies
 - Initiatives to improve EPSDT participation & screening rates: all 4 MCOs.
 - Strategies to improve clinical management programs: all 4 MCOs.
- Process/Procedural Deficiencies
 - One new quality improvement/preventive health study required from each of the 4 MCO subcontractors.
 - Amend quality work plan to include benchmarking for clinical & service measurement, vendor performance and CQI projects: one MCO.

Mr. Huber stated that in preparation for the 2002 audits, Husky A criteria will be reviewed, adding, expanding or maintaining categories and reevaluating the weighting scheme. A HUSKY B audit review categories will be created. Mr. Huber is developing a comparative study of the impact of the audits on the 4 MCOs, reviewing the past three year audits.

Council members commended Qualidigm on the audit initiative and the four MCOs for their internal efforts that resulted in improved audit compliance scores. Council questions/comments included:

- ⌘ Is there a differentiation between general health and behavioral health performance within the audit? Mr. Huber stated there are subcontractor categories within the audit that address BH.
- ⌘ Consumer concerns suggest the need to include provider recruitment, the ability of providers to take new patients and timely appointments in more detail. Qualidigm will consider this in the next audit.
- ⌘ How does this audit compare to NCQA commercial plan criteria and measurements, in particular related to quality management? Mr. Huber responded that the past three year review would measure plan performance over time. Future attention will focus on this.
- ⌘ Chart availability was not a problem in this audit, as it was in the EPSDT special project.
- ⌘ What steps can DSS take to reduce the incidence of missing data, either in the quarterly quality reports or the compliance audit? Rose Ciarcia (DSS) stated the new contract has a withhold of the last month of the MCO capitation payment that would be released upon receipt of the data.

Department of Social Services Report

HUSKY Enrollment/Program Capacity

Rose Ciarcia reviewed the February enrollment number and the overall HUSKY A program capacity as well as individual MCO capacity by County. HUSKY A enrollment increased by 918 children and 925 adults in the previous month and HUSKY B enrollment increased by 510 members in the last month.

Assuring access in the HUSKY program is done through measurement of:

- Provider to client ratios for 5 provider types: Primary care for adults & for children, Women's health, mental health and dental (dental hygienists practicing in a Public Health setting count as 0.5 dentist).
- Monthly enrollment information combined with the latest quarter's information on MCO provider panels determines the capacity/ MCO/county (providers in boarder towns out side the state are not included in the capacity ratios).
- PCP Panel Report: MCOs provide quarterly reports to DSS on the number of HUSKY clients in each PCP panel. DSS informs the MCO if the provider has more than 1200 HUSKY clients across all plans; the MCO must then guarantee that these few providers have adequate service access and report this back to DSS or face a potential financial sanction.
- Each MCO shall ensure that members have an age-appropriate PCP and OB-GYN provider within 15 miles and a dentist and BH provider within 20 miles.

The following table summarizes the total program's capacity by County:

County	Fairfield	Hartford	Litchfield	Middlesex	N. H.	N. L	Tolland	Windham	Total
# enrolled	52,803	78,238	9,099	7,417	79,691	18,197	5,325	11,175	261,945
Cap %	58.5	59.5	56.8	49.2	75.9	63.4	42.7	76.6	63.4

Those plans with capacity over 80% in a county include:

- ABCFP: 87.65% in Hartford, 88.7% in New Haven.
- Health Net: 85.1% in Fairfield, 83.4% in Litchfield, 91.9% in New Haven, 95.5% in New London, 95.99% in Tolland and 94.8% in Windham.

The Department stated that while some plans are approaching capacity in several counties, there is capacity in every county in every MCO. Health Net enrollment is no longer frozen in Fairfield County.

HIPAA Compliance Status

At the December Council meeting, the Department of Information Technology provided an informative overall State perspective on the HIPAA compliance process. Subsequent to that presentation, the Department of Social Services was asked to update the Council on the Agency and Managed Care Organization compliance status with the Administrative Simplification portion of the Health Insurance Portability & Accountability Act (HIPAA). This portion of the unfunded federal mandate requires standardization of electronic transmissions of administrative and financial transactions. The compliance deadlines have been under discussion in Washington with possible extensions for transactions and code set standardization to 10/16/03 and no definite date for the security and identifier components. The privacy compliance deadline remains at 4/4/03.

- Medicaid Fee-For-Service (FFS): EDS is working on HIPAA compliance.
 - Assessment of transactions, code sets & security requirements completed.

- Eliminating local codes through fee schedule updates.
- Completed Privacy assessment performed by DoIT
- Begun implementation efforts and begun outreach to providers via newsletters.
- Need to modify systems, application, policies, provider and vendor training, testing and recertification and implementation.
- Medicaid managed care: there are additional transactions for capitation and enrollment transactions.
 - Provider claims will be impacted: all state only procedure codes must be eliminated, there will be a change to American Dental Association Claim Form, elimination of type of service currently used for claim submission & claims payment, add new field and claims details. The Department is unaware of any HIPAA requirement for the SS# as the unique provider number.
- Managed care organizations:
 - Completed assessment and gap analysis of transactions, code sets & privacy requirements, developed implementation schedules and developing trading partner agreements.
 - Need to: modify systems, applications, policies, complete coding, testing and recertification, execute trading partner & business associate agreements and implementation.
- Benova: gap analysis being conducted, selecting translation utility vendor to manage transaction sets that include HUSKY A capitation transactions and HUSKY B enrollment and capitation, have designated a privacy expert. An extension is requested.
- DSS/HUSKY:
 - Gap analysis being conducted. There is high impact on HUSKY A enrollment transactions.
 - DSS is submitting a request for an extension for transaction & code sets, focusing on privacy compliance, as that federal deadline is unmovable.
 - Developing implementation schedule and budget
 - Facilitating coordination between MCO's, Benova and DSS.

The Medicaid Council will meet **April 12, 9: 30 AM in LOB RM 1D.**