

Connecticut Medicaid Managed Care Council

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April 12, 2002

Attendance: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella, Rose Ciarcia (DSS), David Guttchen (OPM), Gary Blau (DCF), Thomas Deasy (Comptrollers Office), Barbara Geller for Paul DiLeo (DMHAS), Marie Roberto (DPH), Ellen Andrews, Irene Jay Liu, Dr. Wilfred Reguero, Dr. Edward Kamens, Janice Perkins, Patrick Carolyn (MCO), Jeffrey Walter, Judith Solomon.

Also in Attendance: William Diamond (Concera, formerly Benova), Charlene Casamento, Julie Bisi, Martha Okafor (DSS), Sylvia Kelly (CHNCT), Deborah Hine (ABCFP), Jody Rowel (Child Guidance Clinics), Jesse White Frese (FQHC), Mary Alice Lee (CHC), M. McCourt (Council staff).

Department of Social Services Report

Federal 1915 (b) Waiver & Medicaid Managed Care Program Update

The Department has signed a two-year renewal with the Centers for Medicare & Medicaid (CMS) for the HUSKY A (1915{b}) waiver. During the first year of the waiver (7/1/02-6/30/03) there are no expected changes other than cost neutrality calculations related to budget issues. The Department has contracted with the Children's Health Council for an independent quality assessment for care delivered to Children with Special Health Care Needs (CSHCN) in the HUSKY A program. Based on the Balance Budget Act of 1997, states that include CSHCN in their managed care (MC) program must apply for a federal waiver. If CSHCN are not included in the MC program, the program could be under the Medicaid State Plan.

A waiver amendment is necessary for the second year of the waiver, commencing July 1, 2003, for the planned carve-out of dental and behavioral health services from the managed care program.

- Dental carve-out will include all dental services for HUSKY A & B and fee-for-service (FFS). There is consideration of linking these dental services to the State Employee Health Plan (Achieve Project). An RFP is being drafted for procurement of an administrative organization (ASO) for the proposed dental carve-out.
- The Behavioral Health carve-out, based on the partnership of DSS, DCF and DMHAS, will include behavioral health services for children and adults in HUSKY A & B, Plus BH program, DCF voluntary services and adults in Medicaid FFS, including the SAGA population. An RFP for the ASO is being developed.

In addition to the proposed waiver amendment, the Department has developed a CT HUSKY

information packet, which will be distributed in the Spring to managed care companies, to elicit interest in the HUSKY MC procurement process for July 2003 contract period.

Legislative initiatives currently in the Appropriation Committee budget include expanding adult HUSKY to 185%, moving this population to the HUSKY B, band 2 (Governor's budget), for which the premiums and co pays have been lowered (Appropriation budget). There are also appropriations for DSS to develop an employee-sponsored insurance subsidy for families < 185%FPL. Adoption of these legislative changes will impact the future HUSKY program.

Council comments focused on public input into the development of the carve-out programs:

- Rep. Nardello recommended Council and other stakeholder input for configuration of both the dental and behavioral health carve-out. The Department recognizes the need for public comment and agreed to work with the Council subcommittees and the full Council on a regular basis, discussing the proposed program changes and RFP direction. The Department cannot share the actual draft as this prior knowledge would discount potential applicants.
 - Jeffrey Walter, chair of the BH Subcommittee, stated this was discussed at the last subcommittee meeting, with a recommendation that ongoing discussion among BH stakeholders (advocates, providers, MCO's, State agencies) would identify barriers that, left unsolved, may result in a "firestorm" during the next legislative session.
 - The Public Health subcommittee will work with DSS on the dental carve-out.
 - Marie Roberto requested formal DPH representation in the dental carve-out process; DSS welcomes their formal representation on the development of the RFP.

- Ellen Andrews asked about preliminary information regarding performance incentives, configuration of financial risk. The Department commented:
 - Expect the BH carve-out program to be statewide. The report on the BH partnership (DSS, DCF & DMHAS) should be available on the DSS website in 1-2 weeks.
 - Dental program may be statewide or regional, similar to the non-emergency transportation services.
 - Risk model has not been determined: may involve only the ASO that will have performance measures. Reserving a pool of funds for provider performance incentives has not been discussed at this point.
 - A process for transitional unpaid claims will be part of the RFP process. The Department policy has always been that authorized services should be promptly paid; contractual arrangements between the MCO and subcontractor work against the policy implementation at times

HUSKY HCFA 416 & MCO Quarterly Report

Julie Bisi, lead planning analyst, HUSKY division reviewed the two reports.

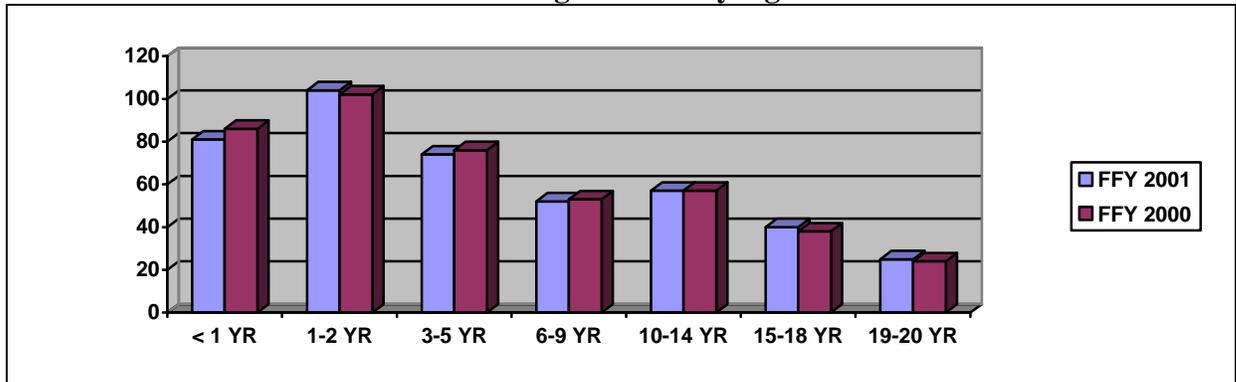
The HCFA 416 report is the annual EPSDT report covering the federal fiscal year (October-September) that includes Medicaid enrollment numbers, EPSDT screening & participation ratios, dental services and lead screens. The latter number will be revised upon receipt of the DPH data on lead screens for Medicaid beneficiaries for FY2001. The following table summarizes the last three years reports:

Three year Summary of HCFA 416 Reports

	FY2001	FY 2000	FY 1999
Total eligible (<21 yr) for EPSDT (MC & FFS)	244,083	220,546	222,146
Screen Ratio	69.28%	70.34%	69.15%
Participation Ratio	54.2 %	56.8 %	51.36 %
# Eligibles with ANY dental service	67,826	68,630	61,224
Total # Lead screens	6,845*	31,772	30,268

*To be revised after DSS/DPH data match is completed.

HCFA 416 EPSDT Screening Ratio % by Age FFY 00-01



Quarterly MCO EPSDT Ratio: 2Q01 & 3Q01

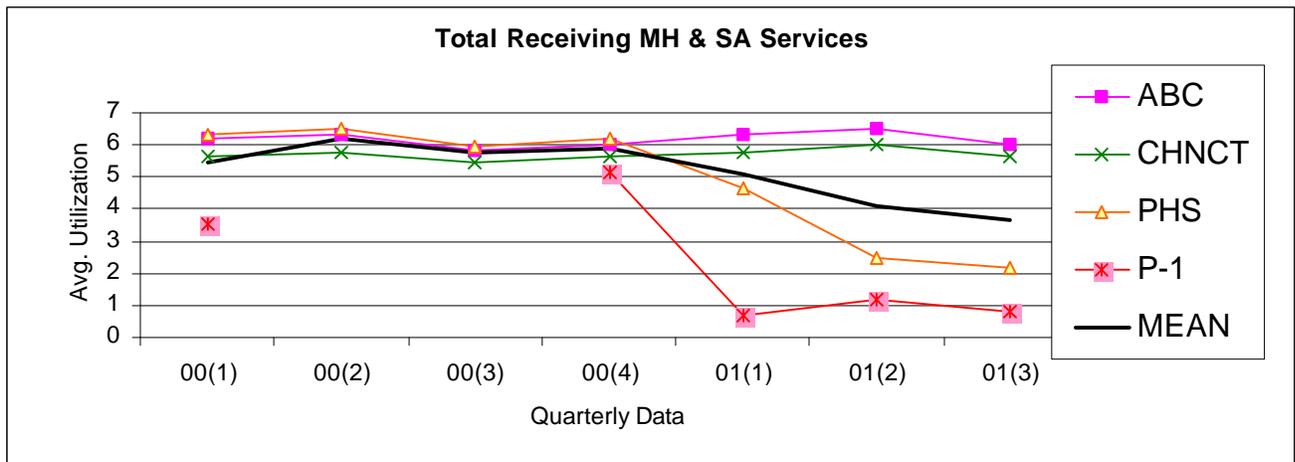
Quarter	ABCFP	CHNCT	Health Net	Preferred One	Total weighted Average
2Q01 % Screens	69%	71%	64%	60%	67%
2Q01 % Participation	64%	65%	62%	61%	63%
3Q01% Screens	84%	75%	79%	177%	88%
3Q01 % Participation	79%	72%	71%	107%	77%

Observations from data:

- HCFA 416 data is edited by Mercer (as is the HUSKY data provided to the Children’s Health Council).
 - Both the screening and participation three-year trend reflect low utilization patterns of members >14 years, and the highest utilization for the 1-2 year olds. The slight increase in the 10-14 age group may reflect mandatory school physicals. Encounter data errors may be identified through the Mercer edit process.
 - The Department was asked about the percentage of positive lead screens. The Department of Public Health will report to the Council on this.
- The 2nd & 3rd quarter encounter data that health plans self-report reveal the typical increase in screens in the 3rd quarter, related to school physicals. What is most notable is the significant increase in Preferred One ratios in the third quarter: DSS stated the plan confirmed the accuracy of the numbers. Adolescent ratios were reported as over 200%. These high levels would, if included in the Mercer data submissions, elevate the overall HCFA EPSDT rates.

Other encounter data highlights:

- Behavioral Health data represents all BH services to HUSKY members (adults & children). There is a decline in the mean number of services provided in the 2001 quarters compared to 2000: Preferred One data for the 2nd & 3rd quarters 2000 was missing and the 2001 data shows a decline in utilization. ABCFP and CHNCT show consistent utilization patterns over the 7 quarters.



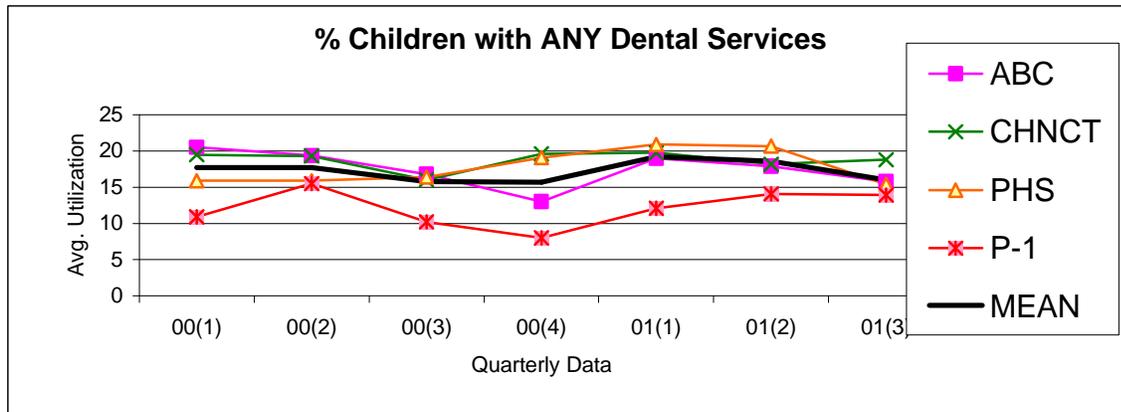
(Data source: MCO quarterly reports. P-1 data missing for 2&3 quarters 2000).

- Emergency room utilization, measured as visits per 1000 member months, has risen in comparison to 1999 and 2000 quarters. The gradual increase began in 1Q00, peaked during the 1Q01 and has decreased by the 3Q01. The health plans have noted the change in utilization, but have not yet been able to identify factors contributing to this pattern.

The ED services are costly and declining rates in the past have been attributed to improved Primary Care access and less reliance on ED's as a source of non-emergent care.

Quarter	99(4)	00(1)	00(2)	00(3)	00(4)	01(1)	01(2)	01(3)
Visits	44.9	49.7	49.5	49.7	49.0	53.7	51.5	50.7

- Dental Services: Slight downward trend in service utilization over the last two quarters.



*The maximum dental utilization per quarter is 50%

MCO/Subcontractor Claims Report

Charlene Casamento reported on the new quarterly report of claims processed by the health plans and their subcontractors. The report included a claims inventory in dollars and volume, claims turn around time and number of claims paid in excess of 45 days. The subcontractor reports covered those with risk-based contracts for pharmacy, dental, vision and mental health. The intent of these reports was to allow the Department to identify problem areas in timely claims payments before a crisis developed.

Results for the 4th quarter 2001:

Anthem BCFP

- 87% claims processed electronically. 98.2% of Anthem claims were paid within 45 days. Their pharmacy, dental and vision subcontractors reported 100% of claims paid in 45 days.
- Total unpaid claims as of 12/31/01: 13,349, with 70.5% (9,407) < 31 days old.

CHNCT

- The plan was undergoing a system conversion, so no electronic claims were accepted in 4Q01: 90% of claims were paid within 45 days, 100% of Pharmacy, dental, mental claims and 99% of vision claims were paid within 45 days.
- Total unpaid claims as of 12/31/01: 1,118, with 57% (640) 31-45 days, 35% (389) 46-60 days old. The system conversion is complete and improvement is expected in the next report.

Health Net

- 99% of claims were paid within 45 days, 100% of dental, chiropractic and vision were paid within 45 days, 91% of mental health claims and 72% of skilled nursing services were paid within 45 days. The latter should show improvement now that the vendor has completed a claims enhancement process.
- 82.9% of claims inventory as of 12/21/01 are <31 days old. Total unpaid claims: 9,620.

FirstChoiceCT/Preferred One

- 8% of claims were received electronically, expect electronic claims to increase over the next two quarters. 88% of the plan's claims were paid within 45 days, 100% of pharmacy and dental, 96% of mental health claims were paid within 45 days.
- There are 7,633 claims unpaid as of 12/31/01. 80.2% of claims are <31 days old.

The Department response to Council questions:

- Claims prior to HUSKY enrollment are retroactive for 3 months and paid under fee-for-service Medicaid.
- The report looks at processed claims; 'unclean', rejected claims are not assessed in this report. Providers remain concerned about their experience with the % of rejected claims and resubmissions.
- The HUSKY health plans have adopted the claims criteria for HUSKY claims that they developed with the Department of Insurance. The Council previously had requested DSS determine if this could be done.

Children's Health Council: Health Care Disparities in HUSKY A

Mary Alice Lee reviewed their FFY 1999 data that showed that African American children were less likely than White or Hispanic children to receive well-child care, have a usual source of care or receive ambulatory care. This group was also less likely to receive dental care and was more often hospitalized for ambulatory-sensitive conditions such as asthma (see report on site www.childrenhealthcouncil.org). The CHC has worked with DSS and an advisory work group composed of representatives from DSS, health plans, DPH, the CT Academy of Pediatrics, and others to develop follow-up studies of health disparities in HUSKY A that include:

- Analyze enrollment & encounter data for FFY 2000 & 2001 to assess utilization rates. Status: in progress.
- Conducted parent focus groups, focusing on care access, the basis of which will be used to formulate a longitudinal survey of families in Bridgeport, Hartford, New Haven and Willimantic.
- Longitudinal survey of newly enrolled children to determine the impact of HUSKY is in progress with funding by CT Health Foundation.
- Convene a roundtable discussion with community leader in the Summer or Fall of 2002.
- Next steps: design an action plan, based on the survey results, to eliminate barriers to care, increase preventive care use, improve health outcomes.

Benova: Husky Enrollment

William Diamond announced that the Benova name has changed to **Concerra Corporation**; the change does not reflect corporation ownership changes. Calls to the HUSKY Call Center remain higher than previous years, with a peak in January of 24,243 calls. The number of applications

received has also increased considerably throughout 2001 as compared to 2000, with peaks noted during August-November and again in January 2002. There was a three-month (August - October) increase with the media identified as the source of HUSKY information: subsequent to October this number has returned to lower rates as the identified information source. The contact areas rated highest were media, health provider office, DSS and friends.

A 5000 HUSKY A member increase within one month is unprecedented in the history of the Medicaid managed care program. Changes in the economy (*and commercial insurance premium rate increases*) are thought to be driving the enrollment increases.

HUSKY A & B Enrollment March-April 2002

Program	March 2002	April 2002	Change: March-April
HUSKY A (total)	265,212	270,291	5079
Adults only	76,586	77,818	1232
< 19 Yr	188,626	192,473	3847
HUSKY B (<19Yr)	11,972	12,534	562

HUSKY B PLUS Programs Enrollment March of Each Year

PLUS Program	1999	2000	2001	2002
CCMC	3	48	111	96
Yale Physical	14	37	55	90
Yale BH	6	8	10	11

Mr. Diamond discussed the HUSKY presumptive eligibility process and final HUSKY A disposition from October 2000 – March 31, 2002. Designated qualified entities deem a family/child as eligible for HUSKY A, help the family complete a short information form that is then sent to the DSS Central office, where eligibility determination is made. Families do need to complete the formal HUSKY application in order to enroll in HUSKY; however they will receive Medicaid (FFS) reimbursable health care during the 3 month presumptive eligibility period. The following summarizes the data:

- 6,585 individuals were granted presumptive eligibility over the 1.5 year time period.
- 3,572 (54%) were granted HUSKY A eligibility.
 - 283 were found over income
 - 316 applications are pending
 - 440 were already enrolled in HUSKY A
 - 1,974 (30%) of those granted presumptive eligibility did not complete the HUSKY application. These individuals received health care reimbursed by Medicaid, but unfortunately were not able to be enrolled in HUSKY for longer-term health coverage due to an incomplete application process. Both the qualified entities and the DSS Central office work together diligently to help individuals complete the application process.

Department of Public Health: HIPAA Compliance Status

Subsequent to the Department of Information Technology presentation of statewide HIPAA initiatives and the Department of Social Service HIPAA compliance status report in February, Marie Roberto (DPH) provided a brief overview of the DPH status (see attached fact sheet). The Department has appointed a HIPAA Privacy Officer, completed a survey of all personally identifiable health data, and determined that the covered entities that are required to comply with HIPAA Privacy and Security requirements are those activities performed by the State Laboratory. These include newborn screening, microbiology testing, serology, virology and tuberculosis testing.

The Department will next focus on bringing covered programs into compliance, identify and implement good business practices that are appropriate to DPH programs that are not required to comply with HIPAA and provide HIPAA information to health clinic entities that receive funding through DPH. Dr. Roberto will answer questions about the DPH HIPAA compliance process at future Council meetings.

Other

The quarterly report for January-March 2002 was accepted without changes.

The Dental project report from the University of CT Dental School was given to the Council Chair (attached to this report).

The Chair of the Council requested brief information from Preferred One and Health Net regarding the status of unpaid PROBH claims and status of MCO's role in informing their members of approaching enrollment end-dates. These topics were deferred to the May meeting.

The Medicaid Managed Care Council will meet on Friday May 10 at 9:30 AM at the LOB.