Connecticut
Medicaid Managed Care Council
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Meeting Summary: November 19, 2004

(Next Meeting: Friday December 10, 2004 @ 9:30 AM in LOB RM 1D)

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Rep. David McCluskey, Rose Ciarcia (DSS), Thomas Deasy (Comptroller Office), Dr. Ardel Wilson, (DPH), Robyn Hoffman, Doreen Elnitsky, Dr. Edward Kamens, Janice Perkins, Linda Pierce (MCO rep), Dr. Alex Geertsma, Barbara Parks Wolf (OPM), Ellen Andrews, Marge Eickler, Laura Siembab (DMHAS), Jeffrey Walters.
Also Present: Hilary Silver, Dr. Mark Schaefer (DSS), William Diamond (ACS), Deb Poerio (SBHC), Mary Alice Lee, Mark Scapellati (CHNCT), Gail DiGoia (Anthem BCFP), David Smith & David Wilcox, MD (PONE), Jody Rowell (Child Guidance Clinics), Christine Bianchi, M. McCourt (Council staff).

Department of Social Services

Saga Update

· Provider panel continues to expand (*addendum*: *data as of Dec. 1, 2004)*, with 570 PCPs (70 credentialing in process), 1598 Specialists (236 credentialing in process). These represent a 121% & 422% increase respectively since 8/1/04.
· SAGA transportation coverage is for emergencies; non-emergency transportation (NEMT) is limited to clients undergoing dialysis, chemotherapy, and oncology treatments.
· Network provider restrictions were in effect October 1, 2004. Requests for Out-of-Network authorization must be submitted prior to service provision with decisions made on a case-by-case basis based on the following criteria:

- No participating PCP within a 20-mile radius
- No participating specialist within comparable Medicaid fee-for-service availability.
- Highly specialized care required that cannot be provided in the plan.
- One-day authorization for urgent situations.
- Change in PCP/provider would be injurious to the health status of the member.

Dental Restructuring Update

· The restructuring includes HUSKY A child/adult & HUSKY B members; the target date is 2/1/05.
· Administrative processes such as uniform credentialing criteria/forms, prior authorization criteria/forms would be simplified under the 2 Dental Benefit Managers (DBM).
· Client enrollment assignments to a DBM would begin 12/04, with an opt-out period 1/05.
· Multiple entry points for dental: two DBMs, DBP & Doral, HUSKY line 1-877-CT-HUSKY, which will replace dental subcontractor phone number on MCO member card, Medicaid CONNECT card can be used for dental services.

· The Automated Eligibility Verification System (AEVS) response will include verification of DBM enrollment. The DSS is considering expanding AEVS to include HUSKY B.
· The Dental Administrative & Clinical committees have been formed, with the first meeting scheduled tentatively for 12/8/04.

Council Questions:
ü *Can the DBM provider network list be available in January?* Both DBMs will actively recruit providers into their network panels, updating the list with ACS. Medicaid dental providers must notify the DBM 90 days in advance if they no longer wish to continue Medicaid program participation. May take longer than the 2/1/05 start date to create a 'hard copy' of the network provider panels. Both DBMs will be required to have a web site, which will include network providers, as well as member phone access to the DBM. THERE WILL BE NO LOCK-IN FOR THE PROGRAM.
ü *Will there be a change in AEVS access?* No, AEVS will continue to be managed by the DSS contracted EDS. The AEVS contains information on the client's Medicaid eligibility, the member's MCO and DBM, other insurer.
ü *How does DSS plan to respond to the public comments about the proposed waiver/State Plan amendments & how will those comments impact the proposed dental restructuring?* The DSS has drafted responses to the comments that will be sent with the amendments to the legislative Committees of Cognizance. Most comments addressed operational issues rather than the actual waiver/State Plan amendments. These may be addressed in the DSS/DBM contracts.
ü *The 'dental home' concept is important; however this may have an adverse reimbursement impact for non-dental home providers.* The DSS is aware that some dental providers may not offer the full array of services of a dental home. While the DSS supports this model, providers outside the dental home will be reimbursed. There will be no lock-in for the dental home. This has the potential for duplicative services, although the dental encounter data submitted to Mercer will track this.

HEDIS Specifications: Overview
In response to the Council request, Hilary Silver (DSS) provided a brief review of the Health Plan Employer Data & Information Set (HEDIS) that include national standards for some performance measures. These standards allow comparisons of performance across insurers and other states. The disadvantages to using HEDIS specifications for some Medicaid data include:
· Specifications do not meet federal reporting requirements and HUSKY program need (i.e. annual reports VS six-month reports, misfit of ages).
· HEDIS measures include data for continuously enrolled members in a health plan. This would discount about 30% of Medicaid member's health care utilization, as members can change MCOs monthly and may have changes in Medicaid eligibility during a year.
· HEDIS does not have specifications for some types of care (i.e. Emergency Dept use).

Some of the HUSKY utilization reports are based on HEDIS definitions including inpatient care, postpartum care and Mental Health/Chemical Dependency services. The HUSKY MCOs will be reporting on the HEDIS measure for Appropriate Medications for Asthma for children & adults (at the Council request) as part of their Performance Improvement Project in 2005.

Council comments:

ü The Asthma HEDIS specs may be difficult to apply to HUSKY in that the standard includes MCO eligibility for two years and the criteria for asthma severity may be skewed by multiple prescriptions for lost inhalers, provision of multiple scripts for home/school/after school care site. Important to have interactive billing data, including pharmacy data, outpatient visits and ED/hospitalization follow-up PCP visits.

The DSS will be working more closely with the MCOs on future data reporting, analyzing the reports together, including the 'meaning' of the data variances and identification of MCO corrective action steps prior to presentation of the six-month or annual reports at the Medicaid Council. Rep. Nardello stated this a very positive step in using the data to improve the program as well as assess the impact of change made by the DSS, MCOs or providers.

MCO Case Management Reports for 2Q04

· Approximately 2000 CM cases, after adding the Health Net correction of 431 BH CM cases, were reported for this quarter. Client participation in CM is voluntary. Provider CM in BH may not have been included in each MCO report.

· Approximately 47% (730) CM referrals came from the PCP/provider, while 37% originate from the MCO Utilization Management MCO unit.

· Rep. Nardello requested the DSS consider:

o Identifying CM benchmarks from other states,

o More clearly define CM services

o Identify the number of members that decline the services in relations to those identified as meeting the health plan's criteria.

The DSS will be working with the MCOs to develop more consistent criteria, identify individuals that meet the CM criteria compared to the number of members that voluntarily participate.

Behavioral Health Restructuring Update

Dr. Mark Schaefer (DSS) reviewed the BH carve-out status that will include the HUSKY A child/adults, HUSKY B members and DCF Voluntary service clients (DSS fee-for-services adults and SAGA BH clients are NOT included in the DSS/DCF BH partnership):

· The ASO procurement is going forward, with a resubmission of the bidder RFP in late September, bidders response deadline was in late October. The ASO selection should be completed in December.

· The start date of the BH carve-out is not defined, other than an open date between April-July 2005. This is in part related to the ASO bidder responses that include a proposed implementation plan (i.e. roll out program incrementally versus implement to the total population).

· The DSS and the HUSKY MCOs have been meeting about coordinating the BH ASO functions with the MCOs responsibilities that include medical/BH service integration, pharmacy, Medicaid transportation and quality measurement of the MCO responsibilities.

Council Questions/Comments

ü *What agencies now constitute the BH Partnership?* The partnership involves the Department of Social Services and Department of Children & Families (DSS/DCF). Other agencies will participate as appropriate for their client involvement in the BH restructuring (i.e.

Dept of Mental Retardation, Dept. of Mental Health & Addiction Services (DMHAS), which are involved with transitioning youth, HUSKY A adult providers).

ü *There is national support for Primary Care (PCP) and BH collaboration. How will this be addressed in the carve-out?* Dr. Schaefer stated that the system being created would support the broader role of PCP in BH, if the PCP chooses to do this, as well as assisting the PCP in early BH screens and appropriate referrals to BH specialty services. Dr. Geertsma emphasized the importance of medical pediatrics, developmental pediatrics and child mental health & psychiatry collaboration to define guidelines and reimbursement codes for PCP services in the clinical maintenance of patients with mental health diagnoses in medical primary care. Dr. Schaefer agreed that the medical/mental health co-morbidity issues are crucial to the program and expect that the BH Oversight Committee will include a work group to address this.

Medicaid Council BH Oversight Committee Update

Jeffrey Walter, Co-Chair of the reconfigured BH subcommittee provided an overview of the 'new' Oversight Committee. Senator Chris Murphy, as Co-Chair of the Oversight Committee and Sen. Harp, Chair of the Medicaid Council, reviewed and approved nominations to the core Oversight Committee. The nomination categories were based on proposed 2004 legislation for a Behavioral Health Council, similar to the Medicaid Council, but with broader duties of:

o Rate review & recommendations to the legislative Committees of Cognizance.

o Participation in the development of utilization standards and clinical management criteria,

o Ensuring the smooth transition of the changes in the delivery service model for both clients and practitioners,

o Ensuring that processes are in place for medical/BH service integration.

The BH Oversight Committee will organize several work groups of interested stakeholders to address these issues. Legislation for a Behavioral Health Council will be proposed in the 2005 session.

The Child Guidance representative commented it is important to have outstanding Accounts Receivables (ARs) resolved and processes in place for payment of the remaining run-out BH claims before the BH carve-out system is implemented.

ü Sen. Harp stated 2001 legislation had the DSS require the HUSKY MCOs include provisions in their dental & BH contracts ensuring that their subcontractors have a financial with hold in place to cover outstanding claims. Rose Ciarcia (DSS) stated the MCOs are responsible for the managed care subcontractor performance that includes claims payments.

ü It was suggested that the BH Oversight Committee address this, establishing timelines and encouraging provider timely submission of claims and ARs.

Managed Care Plans: Discussion of Performance Variances/Corrective Action Plans

The DSS presented HUSKY A utilization reports at the October 15 Medicaid Council meeting. Sen. Harp noted there was considerable variance among health plans on several indicators. The Senator requested the health plans come to the November 19, 2004 meeting prepared to discuss their individual variances, including positive trends, and indicate corrective actions for lower performance areas as appropriate. A grid summarizes the variances was sent to DSS & MCOs after the 10/04 meeting:

Data elements	Anthem	CHNCT	Health Net	Preferred One
Inpatient days/discharges		Higher than mean of 4 MCOs, on both		
ED Visits		> mean for three 6-month reporting periods		> Than the mean for one reporting period 4Q03-1Q04
BH Services				Lowest rate 4%, mean about 9+%
MCH: Missing data	ü	*? Not a problem_ what works?*	ü	ü
Enrolled in 1st trimester		*++ > Mean –What works?*	*++ > Mean What works?*	
Preventive visits			*++ Above mean-comment?*	
Mammograms Even if tests within 2 years, % are low	ü	ü	ü	ü REALLY low rates: < ½ of the other MCOs
Cervical Ca Screens			*++ Highest % past 2 years*	< 30% - lowest of the 4 plans.

The following highlights the presentations (*copies of the MCOs handouts can be obtained in the Public Health Committee, LOB RM 3000):*

Preventive Care

Mammography (all health plans)

Anthem BCFP (30-31% annual screen rate):

· There are differences between the HEDIS reporting standards and DSS reporting standards.

o HEDIS report covers women aged 50-69, DSS women aged 40 and over,

o HEDIS reporting period is a mammogram in past two years, DSS requires annual reports.

o Using HEDIS criteria, Anthem's Medicaid HEDIS rate is 64%.

o Using the DSS criteria, Anthem averages 30% mammography rate/year.

· Action Plan includes outreach call to members and phone reminders & post card reminders to members that have not had a mammogram in the past 24 months. Anthem also reminds members of the importance of yearly PAP smears.

CHNCT (28-30% annual screen rate)

· Plan has seen a decrease in rates in all of 2003, which may be partially related to a decrease in the # of females over 40 years enrolled in the plan.

· Action Plan: further investigate the reasons for the decrease, have added overdue mammogram reminder mailings, outreach calls to member who has not had the screen in the past year, then will make an appointment for the members, and have added "Welcome Call" questions about the new members last annual exam. The Outreach worker will then assist the new member in making an appointment.

Health Net (28- 32% annual screen rate)

Member mammography & cervical cancer screens tracking/Outreach:

· Identify members eligible for screening 15 months in advance of birthday date.

· Send reminder post card if no claim in the system & query system prior to birthday for claim, if none, reminder again sent.

· Education to providers via fast fax, in the provider manual, newsletter, and member handbooks.

FirstChoice/Preferred One – PONE (12-13% annual screen rate)

· Rechecked the data, found that inappropriate members were included in the denominator.

· Upon recalculation, found a 20% annual screening rate, which is still lowest % of the 4 plans.

· Corrective action for December 2004 includes outreach to targeted population, chart audit for the report period to determine if there is under reporting of screens.

Cervical cancer screens

PONE (25-28%, mean = 41-42%)

· PONE rechecked data and reported a >35% rate in 2003.

Maternal Child Health (Anthem, CHNCT, Health Net)

Anthem stated that;

· Exclusion of "unknowns" = no prenatal visits from the data resulted in 70% members received 1st trimester care and an increase in those receiving 80% of the PNC visits.

· Postpartum care (21-56 day timeframe), 6% had visits prior to 21st day and 15% had visits after the 56th day. Excluding "unknowns" and adding in PP visits outside the 21-56 day period, the adjusted postpartum visit rate would be 86% rather the data report of 34%.

· "Missing" data action steps include monthly letters to providers beginning 12/04, continue follow up phone calls, work with medical management to identify providers non-compliant with data reporting.

CHNCT: consistently has a higher than average member participation in maternal child services. The plan attributes this to their Outreach staff that contact newly delivered mothers regarding postpartum and newborn infant visits.

Health Net has also met the overall rates or exceeded the average in MCH services. The plan attributes this to:

· Diligent data collection on about 700 births/quarter, including over 200 hours of staff time in a manual process of collecting information from providers offices.

· In 1/1/05, the plan will launch a new prenatal care program of aggressive outreach to member/providers, enroll members in *Pregnancy Matters* program and implement an education campaign

Inpatient Stays (CHNCT):
CHNCT had the highest days per 1000 Member Months (52, mean 35).
· Upon CHNCT's review of the data, inpatient days averaged 38.3 days per 1000MM rather than 52; the discharges per 1000MMM were 10.7 rather than the 14.5. Reasons for the variances include 10-12 % of all newborns admissions are preemies, which increase newborn (sick) days.
· Action: Review of internal criteria for inpatient stays support that the admissions and lengths of stay are appropriate; however CHNCT will investigate the discrepancies in the DSS report, continue to monitor sick newborn rates and CHNCT has budgeted for a perinatologist consultant to work with the MCO regarding high premature birth rates in 2005.

Emergency Room visits per 1000 MM (CHNCT, PONE)
CHNCT: Observations:
· Overall use of ED and urgent care centers rising. Hospitals are expanding both their EDs and urgent care centers and aggressively advertising the availability of these services in ED settings. More facilities such as hospital satellite ED and urgent care centers are billing ED codes.
· Increased use of EDs for non-emergent care. CHNCT has a higher concentration of membership in inner cities, within walking distance to EDs, members change PCPs, and there is increasing fragmentation of care between PCP and specialists.
· CHNCT Actions: continue to report members' high ED use to their network physicians, contact members post ED visit to identify if assistance with PCP needed. CHNCT will implement a new pilot, offering incentives to an identified health center to increase staffing and off-hours services.

PONE (higher than average ED rates October 03-March 04)
· One facility has an extensive urgent care center, with an exclusive relationship with PONE. Services provided by this facility account for 30% (618) of all December 2003 ED utilization visits, which were 938 visits; this high rate was attributed to the severe flu season one year ago.
· The value of the numbers reported was unclear, dissimilar to the data reports and PONE was asked to review and explain at the Dec. meeting.

Behavioral Health Services (PONE)
PONE reports on BH utilization (4%) was well under the other MCOs and average rates (about 9%). The MCO reviewed and revised their data for the 10/03-3/04 period, resulting in > 9.5%. . Codes were omitted from the BH subcontractor report that led to the significantly low percentage reported.

Council discussion:
ü Regarding PONE, Sen. Harp noted there has been an ongoing 'data problem' as well as significant differences in recalculated data. Expect the health plan to briefly describe heir systematic resolution of the problem in December.
ü Missing/insufficient MCH data has been an ongoing problem, despite significant time spent

by both MCOs and practitioners in providing Prenatal & postpartum data. The DPH birth certificate data contains elements required in the DSS/MCO report. A suggestion, supported by the Chair, was that DSS take the lead in organizing a meeting with DSS/DPH and the MCOs to identify possible data sharing. The DSS agreed to this.

ü ED utilization has been increasing in HUSKY, although rates are lower than under Medicaid FFS. Based on the Council discussion, Sen. Harp outlined two areas of concern:

o Unable to break down ED data by emergent, urgent and non-urgent visits, which provide more information about ED use.

o Policy issue of hospitals expanding urgent care centers, marketing them in a way that may emphasize this source of care over use of the Primary care system.

Commented that the urgent care centers may be expanding as an umbrella for the increasing number of uninsured.

The HUSKY enrollment report was distributed; however discussion was deferred to the December meeting.

Next meeting of the Medicaid Managed Care Council is December 10 at 9:30 in LOB RM 1D.