



Council on Medical Assistance Program Oversight

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Sen. Toni Harp Sen. Terry Gerratana Summary for January 11, 2013 at 9:30 AM in LOB Room 1E

Attendance: Senator Toni Harp Chair, Steve Mackinnon, Carol Trapp, Julia Evans Starr, Deborah Poerio, Mary Alice Lee, Tracy Wodatch, Vicki Veltri, Katherine Yacavone, M. Alex Geertsma, Sheila Amdur, Jesse White Frese, Renee Coleman-Mitchell, Beth Cheney APRN, Jeff Walter, Rep. Michelle Cook. Rep. Betsy Ritter, Senator Terry Gerratana, Senator Joe Markley, Jennifer Hutchinson, Sylvia Kelly, Debra Gould, Uma Ganesan, Mark Heuschkel, Chris Lavigne, Pat Cronin, Rob Zavoski, Kate McEvoy

Sen. Toni Harp began the meeting began at 9:30 AM in LOB Room 1E.
There were introductions of the committee members.

Kate McEvoy discussed the meeting's agenda. Primary Care Rate Increases

- **Primary Care Rate Increases**
- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding)
- Final federal rule issued November 2, 2012
- services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine
- certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment
- higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician
- the Department anticipates that it will take until at least July 1, 2013 to make all of the necessary changes to implement the rate increase, retroactive to January 1, 2013

■ **Payment Reform - Background**

In conjunction with the other health care reform strategies outlined in the November and December meetings of MAPOC, the Department is also embarking on a project to update and modernize its payment methodologies. Overall, the Department seeks to move toward **value-based purchasing**.

The Centers for Medicare and Medicaid Services (CMS) define **value-based purchasing** as a method that provides for:

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers. Many elements are required in order to successfully implement a **value-based purchasing strategy**, including selection of performance measures and implementation of a means of sharing information with providers. A necessary first step for the Department,

however, is updating its current payment mechanisms so that they are consistent with other major payers (Medicare, private payers).

- Two key elements of updating and modernizing payment mechanisms include:
 - reforming the means of making hospital payments
 - conversion of medical codes from ICD-9 to ICD-10
- **Hospital payment reform** will:
 - align payments to the services that are provided
 - incent efficiency
 - enhance predictability and transparency of method
 - accommodate value-based payment mechanisms (pay-for-performance P4P, shared savings, episode bundling)
 - better align with methods used by private payers
 - Hospital Payment Reform (cont.)
- Hospital payment reform will involve two elements:
 - conversion of inpatient method from the current Target Payment/Discharge approach to use of Diagnosis Related Groups (DRGs)
 - conversion of the outpatient method from the current mix of fixed fees and cost-to-charge ratios to Ambulatory Payment Classifications (APC)
 - Hospital Payment Reform (cont.)

Inpatient payment should be converted from the current Target Payment/Discharge approach to use of Diagnosis Related Groups (DRGs) because:

- targets are based on 2007 data that is outmoded
- payment is premised on average acuity, and may be undercompensating the actual costs of care
- settlement is required almost two years subsequent to payment
- Hospital Payment Reform (cont.)

DRGs (a prospective payment based on age, principle and secondary diagnoses and in some cases surgical procedure performed) will:

- permit the Medicaid to establish “base rates” and “relative weights” for intensity of service; and
- outlier payments to accommodate higher acuity
- Hospital Payment Reform (cont.)

Outpatient payment should be converted from the current mix of fixed fees and cost-to-charge ratios to Ambulatory Payment Classifications (APC) because:

- the current method is based on Medicare Cost Reports that are perennially dated; and
- APCs (a prospective payment based on service(s) provided) will permit the Medicaid to establish “base rates” and “relative weights” for intensity of service
- Conversion of Medical Codes

Effective October 1, 2014, all providers that are HIPAA –covered entities will be required to convert from the current ICD-9 medical code set to the updated ICD-10 set. This change involves both modifications to code groupings (taxonomy) and doubling of the number of codes, representing a much higher degree of specificity.

ICD refers to the International Classification of Diseases, Tenth Revision, Procedure Coding System.

■ **Example:**

ICD-9 provided a code for a burn.

ICD-10 provides a series of codes for burns based on where the burn is located on the body and its degree of seriousness, among other factors.

- These codes are currently used by the Department in:
 - Medicaid Management Information System (MMIS) processing, including how we configure:
 - coverage rules
 - reimbursement rules
 - prior authorizations
 - Data Warehouse
 - queries
 - reports
- Payment Reform – Next Steps

Following reform of hospital payments and conversion of medical codes, the Department will evaluate use of payment mechanisms including pay-for-performance (P4P), episodes of care and shared savings.
- Confirmation re Primary Care Rate Increases
- Hospital Payment Reform Overview
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Report
- Eligibility Reports
- CMS 416 Report
- Annual Medicaid report based on the Federal Fiscal Year
- Redefined for the 2010 reporting year
- Changes include:
 - a redefinition of the eligible population
 - include CHIP members if the program is a Medicaid expansion program (not applicable to CT)
 - include services for only those children enrolled at least 90 continuous days
 - expanded dental measures
- Screening Ratio- The extent to which children received an initial or periodic screen per the state's periodicity schedule, prorated by the proportion of the year they were Medicaid eligible.
- Participation Ratio- The extent to which children received any initial or periodic screening service during the year.
- Children who received any Dental Services- The number of children who received at least one dental service by or under the supervision of a dentist.
- Children who Received Preventive Dental Service- The number of children who received at least one preventive dental service by/under supervision of a dentist.
- Children who Received Dental Treatment- The number of children receiving at least one treatment service by or under the supervision of a dentist.

Questions, Comments and Discussion

- Uma Ganesan discussed the work plan for the primary care rate increases. CMS has made a lot of changes and modifications of the medical aspect.
- The Rate increases will be implemented in July 2013. DSS has a work plan in place. The Affordable Care Act Regulation is in place. Kate made comments about the PCP Rate bump is welcome because it is consistent with the integration of supports. Funding is means of enabling in achieving access. PCMH initiative launched January 1, 2012 through enhanced reimbursement and technical assistance. There is a large number of practitioners participating. One element of the deficient mitigation package. Eliminates supplemental payments to FQHC. Big challenge. Providers are being compensated from

different sources. FQHC are paid. There is no change in the eligibility for the technical assistance and reviewing the criteria. Is there another way of accrediting J-CO. Technical assistance and financial assistance for other providers? 851. 117 Sites and 17 Practices. 112 Practices and 407 sites in Glide Path. These negotiation was in the implementer bill even though

- Sheila Admur asked if the federal government will cover the Primary Care Rate Increase and will permanently cover that. Comments about putting in a whole system for the network of providers. She made comments about if PCP Rate Increase is not going to be permanent how the state is going to do over time.
- Office of Policy and Management is looking at it in terms of the out years. The value in the out coming years.
- Kate McEvoy made comments about how primary preventative care can put towards the outcomes we want. The increase gives people the opportunities to put out that rate.
- Ellen Andrews said Medicaid rates are very high in the State of CT.
- Kate McEvoy- Kaiser Commissioner Report. When you partialize that across the provider groups.
 - Obstetrical rate- 150-185 % of Medicare
 - Radiological- 100% of Medicare
 - Pediatrics- 50% of Medicare today.
- Katherine Yacavone made comments about how the FQHC was taken aback by this decision. FQHCs have worked very hard. This decision does create significant impediments for health care. Comments about the Medicaid visit rate. Health Center is still reimbursed for that visits. There is still some misunderstanding for the rate structure and go above and beyond what is required of the Medicaid program. It is difficult now. The FQHCs need to continue to have a dialogue on the department. She made comments about how the state can't continue to cut the service providers who are most vulnerable
- Mary Alice Lee made comments about how this agreement cut the PCMH in result of the negotiation in the implementer bill. She inquired how legislators were notified.
- Sen. Harp made comments about how the decision was made. The decision came from leadership of the General Assembly two weeks prior to the vote trying to reach a number. The Governor's recessions were almost 5 %. The General Assembly called together the leaders. The proposal came to the executive branch. The Appropriations and Finance Committees negotiated the final package. From the senate democratic side, none of the things were things we wanted to do. The Negotiation was done by the leadership. The cuts were known and understood during the time of negotiation. The FQHC-Perspective payment and cost based reimbursement is a different system and a challenge.
- Alex Geerstma MD asked a pediatric rate question and Medicare coverage.
- Katherine Yacavone made comments about how the FQHCs can put together information will be able to share cost-based rate and perspective based rates.
- There were comments made about Payment Reform Back Ground. There was discussion about how will we bring forward and modernize the payment systems. Control the rate of growth in spending. Reward best Practices and the measures is important. They will be working with Mercer.
- Mark Heuschkel and Chris Levigne present on hospital payment reform. How this change in code set changes. The Codes provides more measurement. Conversion effort is more complex. Discussion about which services can be done for certain members.
- Working with Directly with Providers.

- St. Francis has exploring episodic payments. Using the Duals demonstration.
- Jeff Walter commented on figuring out a way to insulate the process from Annual Budgetary Processes.
- Sheila Admur comments about Mental Health Issues are important to consider and the importance to stabilize the person. How this fits this into the concern. Suggested having Bill Halsey to come in and discuss Mental Health.
- Debra Gould asked about the ICD Codes
- Katherine Yacavone asked about a notice and guidance on how to bill for those services.
- Mark there will be an Education Plan. Need to access further to understand the impacts across the system and across the services.
- Sen. Harp: Is October 1, 2014 a realistic date for CT. Are we going to be there?
- Mark responded with we have no choice and do our best to make it.
- Sen. Harp Made comments about the duals demonstration. Need to have the ability to access Medicaid.
- CMS 416 Report- Report from CT Dental Association. Improved access to dental care for children. Pat Cronin- Annual report for 2010 Fiscal Year. Major changes affected thee eligibility. Who is providing the dental service?
- Screening Ratio- CMS Formula Expected well-child visits for the year.
- Participation Ratio- More confidence on numbers.
- Children who received any dental services. Growth in most treatment.
- Sen. Harp commented on National Averages a way to understand what these numbers mean.
- Debra Gould asked When was the change of two times a year to one time a year



Microsoft PowerPoint
97-2003 Presentation

1. ***Enrollment Reports-***

The presentation is attached.

- They have been revisiting the additional reports and changed the format of presentation.
- Steve McKinnon went over the enrollment reports.
- There was a 956 or a 0.2% decrease in HUSKY A enrollments over the previous month.
- There was a 363 or a 0.4% decrease in HUSKY C enrollments over the previous month.
- There was a 508 or a 0.6% increase in HUSKY D enrollments over the previous month.
- There was a 173 or a 8.3% increase in Limited Scope enrollments over the previous month.
- There was a 270 or a 1.9% increase in HUSKY B enrollments over the previous month.
- There was an decrease of 5 or 2% in HUSKY Plus enrollment over the previous month.
- There was a 52 or 0.9% decrease in Charter Oak enrollments over the previous month.
- There were 105 or 24.2% decrease in the number of children disenrolled due to failure to pay premiums.
- There was a 33 or 5% decrease in the number of individuals disenrolled for failure to pay premiums.
- There was a 61 or 31.6% decrease in CT PCIP Applicants over the previous month.
- There was 17 or 2.9% increase in CT PCIP enrollment over the previous month.
- There was a 26 or 9.1% increase in CT PCIP Applications pending more than 1 month.

- There was a 25 or 5.7% decrease in HUSKY B applications denied or closed over the previous month.
- There was a 121 or a 6% decrease in HUSKY B/Charter Oak applications denied or closed over the previous month.
- There were 70 or a 6.8% increase in Charter Oak applications denied or closed over the previous month.
- There was a 44 or 19.5% decrease in the number of renewal applications Closed for not reapplying from previous month.
- Decrease in those that have been denied for closed.
- Vicki Veltri commented on having a better process for letting people know about their renewals and application. There were questions about PCIP.
- Question about limited benefit.
- 3 groups that fall into the limited benefit plan. Family Planning Services, TB.
- Rep. Ritter- Get more information with the Charter Oak because of some constituents. The problem - There only on charter oak because they really need the health insurance. Continued discussion.
- Steve- This has been very strong by applicants.
- Conversation about: Combine
- Mary Alice Lee: Slide 2- How many those are children are under 19.
- Uma: Trying to get the report run. Ratio- Husky A.
- High Disenrollment Rate- Was there a suspension in lock out in January?
- January Last year- Suspend or extend the grace period.
- Katherine Yacavone discussed the back-log. Is there any update?
- Commissioner Bremby will come to the February Meeting.
- The hiring is well in process towards eligibility work. 3 Features of the ConneCT will be in production this month. The Three features are voice, Prescreening, My Account. Map out the time table
- Beth Cheney asked how long does it take the person to do the application process and what is the reason for denial.
- Steve commented about how the Applications do require follow-up. The staff works with applicants and review through that process. Reasons for delay are denial.
- Mary Alice Lee made a comment about New Enrollment. 76,000 people are expected to come into the program. The Findings indicate there are problems keeping them insured. The CMS awarded 23 States bonuses of increasing enrollment for children in Medicaid. This is on top of a 5 million bonus from last year. Success in our outreach.

Committee Reports

- Quality Improvement-** Debbie Poerio discussed the status of the Quality Improvement Committee. The QI Committee is redefining the attribution process to define where service gaps are and the gaps in the system were. They are working in systems now. The Child Adolescent Taskforce is working on development screening and identifying the need and looking at numbers. Working with the department. Adult continuing work on PCP who are treating depression. How much many medical providers are treating.
- Consumer Access-** Christine Bianchi gave a report about what the Consumer Access Committee. The Consumer Access Committee is working with the coordination of care. Looking at the policies with Transportation. There is consumer representation. The

Committee is working for those consumers. The Committees are working around those access services around Medicaid.

- c. **Care Management PCMH**- State Rep. Cook gave a committee report on the Care Management Committee. The committee will meet every other month. The committees have been discussing respects of the Department and PCP. There has been discussion about the certain type of title or certification and on-going topic within the Higher Education Department.
- d. **Complex Care** - Sheila Admur gave a report on the updates of the Complex Care Committee. Sheila discussed the importance of the questions being brought up in the committee. Who can be the lead in the health neighborhood? There will be a Behavioral health partner. Can the state agency receive any of the payments for providers? Application has been submitted on May 31, 2012. National Scrutiny in that MedPac. Is this a demonstration if you're enrolling a large number of dual Eligibles? Discussed the Protections for dual Eligibles. Election. CMS is reserving identifying a pool of funds 95 Million dollars and submit additional details in operating plans in April. There is a TA Call Scheduled. They will be forwarding details on that process.

Sen. Harp ended the meeting at 11:45 AM.

Next Meeting will be held on February 8, 2013 at 9:30 AM in LOB Room 1E