

September 5, 1997

MINUTES

Members Present: Senator Toni Harp (Chair), Senator Edith Prague (Vice-Chair), Representative Anne McDonald, Representative Vickie Nardello, Jim Gaito, David Parella, Sue Graham, Cynthia Matthews, Eva Bunnell, Marilyn Mellon-Cormack, Judy Solomon, Marie Roberto, Jeff Walter and Pat Baker.

Also Present: Rose Ciarcia, Jim Linnane, Dr. Edward Kaimens, Steve Netkin, Paul DiLeo, Judy Bell and Barbara Casey.

DSS Report

Jim Gaito reported on new financial reports from plans indicating that medical loss ratios increased for the first two quarters of 1997, meaning that plans are spending more money on medical services. Some plans are now registering a loss of over \$6 per member per month; during the first two quarters of 1996 plans registered a profit of \$1.19 per member per month. The inclusion of DCF children in the plan was offered as a possible explanation for the drop in profits.

Jeff Walter questioned whether this reduction in profits will cause cut backs in care for clients. Jim Linnane noted that plans will have to change the way they do business to save money. Judy Solomon asked if there were significant differences between plans; Jim Linnane answered that most plans are near the average. Sue Graham asked if linking capitation rates to eligibility categories will address this problem. David Parella noted that risk adjusting capitation rates will not increase the overall pool of money available in the program but will ensure that funding more accurately reflects the costs of enrolled individuals. He noted that the bids for the three-month contract extension reflected the increase in utilization rates. He felt that the program has been operating for two years and members are becoming comfortable with the system, allowing them to better access services.

Jim Linnane described the addition to capitation rates of pass-through funding for FQHCs. These payments will begin October 1. The rates vary depending on how much the plans' rely on services provided by FQHCs and reflect the difference between fees paid by plans and the amount paid by DSS under cost-based reimbursement. The rates are based on information provided by the plans.

Marie Roberto asked about the format of plans' financial reports to DSS. Jim Linnane noted that financial information comes directly to DSS from plans; it is not reported first to the Dept. of Insurance. He noted that DSS uses the same forms as DOI and is consistent in reporting requirements as far as possible. However there are different requirements for Medicaid Managed Care plans and not all plans are licensed by DOI. Rep. Nardello asked if interpretation is involved in the definition of administrative and medical costs in developing the medical loss ratio. Jim Linnane stated that there may be differences between the plans' interpretations; DSS continues to work with the plans on

this.

David Parella reported on the status of the waiver renewal and the bidding process. He stated that DSS is still waiting to hear from HCFA on the application for an extension of the current waiver; they expect an answer soon. DSS has received letters of intent for the new (January 1) contracts from all the current plans and no others. DSS has sent all bidders responses to 185 questions on the RFP from the bidder's conference. Negotiations have concluded on the contract extensions and they are awaiting signatures.

Rep. Nardello asked if DSS still intends to seek a renewal of the 1915(b) waiver, in light of federal changes allowing the operation of Medicaid Managed Care without a waiver. David Parella noted that DSS intends to apply for a waiver renewal as usual. He noted that there were sweeping changes in the program in the new balanced budget bill, but that CT still needs a waiver to include children with special needs and DCF children in managed care. Eva Bunnell asked if DSS will consider a waiver for other special needs populations still not included in managed care with separate risk-adjusted capitation rates, e.g., SSI kids. David Parella noted that in CT, SSI is not a separate eligibility group and it would be hard to identify those children and pull their experience out of the data as it is configured now.

Senator Harp asked whether DSS intends to go forward with the contract amendments October 1 despite the fact that there is not yet approval of the waiver extension from HCFA. David Parella reported that DSS anticipates getting permission from HCFA to continue the program. When the description of the state plan amendment process is available, DSS will determine if they need to reevaluate plans to renew the waiver.

Pat Baker asked DSS about the impact of DSH cuts on CT. David Parella answered that DSH are federal funds to CT to offset hospital care for uninsured patients. DSH payments make up 12% of CT's Medicaid federal funds; CT is one of the highest DSH states in the country. In the new budget, CT's DSH allotment was cut by \$4 million in 1998 with further reductions in subsequent years. The budget also imposed limitations on payments that states can claim for DSH reimbursement which will affect CT. However he noted that DSH payments are not part of Medicaid Managed Care in CT as they are in some states.

Senator Harp asked about DSS' plans for other opportunities under the balanced budget bill. David Parella described plans to expand children's health insurance under a new section of the Social Security Act, Title XXI. \$36 million is available to CT each year for the next three years to expand insurance coverage to children up to 235% of the Federal Poverty Level (CT now covers most children up to 185% of the Federal Poverty Level). The state must match those federal dollars as in Medicaid, but with an enhanced match rate of only 35% (in the current Medicaid program CT must match federal dollars at a 50% rate). DSS and OPM have been studying CT's options, including where to get the required state match which could potentially be \$19 million, and whether CT can claim the enhanced match for the Medicaid expansion that passed the General Assembly this year. Under Title XXI, CT has to make fundamental choices including whether to use the Medicaid program for the expansion or create a new program. Mr. Parella will be in Washington next week to learn more about the possibilities. He noted that the administration is moving very rapidly in its planning for the program. Senator Prague asked if legislation would be necessary to implement an expansion of children's health insurance. Mr. Parella expected that it would.

Mr. Parella stated that DSS is working on the issue of six months guaranteed eligibility for Medicaid Managed Care.

Jim Gaito reported on access to nurse midwifery services. DSS has clarified its policy to require each plan to offer those services. He noted however, that nurse-midwifery services do not fall into the same category as family planning services; clients are free to choose any provider for family planning services regardless of whether they are in a plan's network. He stated that in July, there were 48 nurse-midwives participating in Medicaid Managed Care, 44 as members of plan networks and four under fee-for-service.

Jim Gaito also reported on formulary policy changes. DSS does not prohibit plans from using formularies to limit prescription medications. When assessing the substitution of generic drugs, DSS requires that the drug be of the same efficacy as the brand name drug. He acknowledged that DSS had received a letter of complaint sent to Rep. Nardello by an emergency physician at St. Mary's Hospital, concerning a change in Blue Care Family Plan's formulary. He noted that Blue Care consulted an expert panel to develop the formulary and made provisions that some drugs will not be substituted. Blue Care allows for physician override when necessary and reasonable. Upon review, DSS felt that the Blue Care formulary process was reasonable. In response to a question from Rep. Nardello, DSS stated that they will continue to monitor the situation.

Judy Solomon noted that drug formulary issues are a common theme in calls to the Child Health INFOLINE. She suggested that DSS make sure that health plans are making the forms and the override process clear to providers. Senator Harp suggested that there may be a disconnect between health plans' stated policies and implementation of those policies. She asked that DSS urge plans to improve communication with line staff.

Enrollment Broker Report

Paul DiLeo of Benova described the latest statistics for plan changes. He stated that as of August 1997, CT Access had a 90.7 % choice rate and for defaults the choice rate is 83.7%. There are currently 213,000 people enrolled in the program. He believes that CT's choice rate is one of the highest in the country.

The most frequent reason given by clients for switching plans has changed from primary care provider not participating in the plan to hospital or clinic not participating. The other top reasons are unhappy with plan, dental provider not participating or "other." He noted that the number of plan changes is decreasing.

Senator Prague asked if when a client calls to enroll, Benova attempts to match them with a plan that includes their preferred hospital or clinic. Rose Ciarcia answered that DSS monitors networks to ensure that all plans have adequate access to hospital care in each area.

Aetna's enrollment has dropped from 3800 to 2300 during July and August. DSS sent letters to all Aetna members; Benova is calling those who do not respond. To date, there are approximately 605 heads of households still enrolled in Aetna who need to choose another plan.

Marie Roberto asked if the fact that hospital or clinic not in plan is now the biggest reason for switching indicates a reduction in access to care overall. She asked if Benova can go back to those clients and determine if the problem is access to primary or acute care. Paul DiLeo said they could discuss that with DSS.

Utilization Data

Jim Linnane described the prenatal care report on low birth weight newborn, immunization status and other utilization data. He noted that the birth weight data uses the standard definition from Medicaid HEDIS and there is a six-month lag in getting the data. The report counts only deliveries to women continuously enrolled in a plan. The total is close to the statewide average. He noted there is some variation in the numbers that may be due to small numbers in some plans. Prenatal care measures are also from HEDIS; he noted that this is a different index than DPH uses. He noted that the numbers are not good; there is a lot of missing data. The rates of women receiving care in the first trimester are very low, 64.3% vs. 88.5% statewide. There is significant variation between plans. Immunization data is from CIRTS, (CT Immunization Registry and Tracking System). He believes that this statewide system of tracking immunizations for all children is unique among states. The data was based on a random sample of plan members chosen by DSS. Unfortunately, plans could not determine the status of 20% of kids. This rate of missing data varies by plan. Of children whose status is known, 75% are fully immunized. The CDC found an 88% rate for the general population. He acknowledged that plans must improve their performance both on reporting and on immunizing members. He reported on EPSDT screening and participation ratios are improving. He noted that the behavioral health penetration rate is improving and compares favorably with FFS experience. He noted that inpatient services have increased which may explain increases in medical loss ratios. He noted that dental and vision utilization are increasing.

Marie Roberto suggested that linking data systems between DPH and DSS could improve the quality of birth weight data. DSS agreed and will work on that with DPH. Senator Harp noted that Blue Care has improved EPSDT performance over time; she appreciated their response to the Council's concerns. She asked DSS how they will address gaps in the data and about the low performance numbers of some plans. Jim Linnane stated that DSS will work with the plans to improve quality.

Marilyn Mellon-Cormack noted that behavioral health penetration rates have not improved significantly over fee for service and are far below the needs of the population. Jim Linnane stated that DSS will look at how services are being delivered. He noted that improved quality does not always follow increased utilization. Ms. Mellon-Cormack asked if there were any behavioral health outcome measures to compare with fee for service; DSS answered that there are none.

Senator Harp asked DSS to describe at the next meeting how they will communicate their expectations to plans and how to raise the level of concern of those who are operating the program.

CPRO Report on the Results of Operational Audits

Judy Bell, operations specialist from CPRO, reported on the operational audits of plans. The purpose of the audit was to assess health plan operations and contract compliance for bench-marking future audits, to compare program-wide performance, to compare plans and gather best practices. Plans were scored in several areas including oversight of subcontractors, access & availability, prevention/promotion, member services, quality management, medical records, credentialing and utilization management. Medicaid-only plans performed better on parameters that are specific to Medicaid, while commercial plans scored better on "core" functions. Most plans scored within acceptable ranges on most parameters. The largest number of unacceptable scores concerned oversight of subcontractors, the parameter that DSS weighted as most important. In response to the

results, CPRO drafted a set of general recommendations for all plans; each plan also received a report specific to their performance. Plans were required to submit a strategy to address the problems to DSS by July 31st.

Recommendations for Medicaid-only plans were to: continue to build operational infrastructure, strengthen core functions, delay any expansion of business until infrastructure is sufficient and bring core services in-house. Recommendations to commercial plans were to improve performance on Medicaid-specific functions -- to bring their commercial standards into compliance with Medicaid requirements, develop staff expertise in social services and in dealing with the Medicaid populations, raise awareness of Medicaid population issues (especially EPSDT and transportation), delay rapid membership growth and increase corporate resources for the Medicaid product. Eva Bunnell asked how long it takes for providers to be credentialed by plans. Judy Bell stated that it varies; the shortest time frame is about four weeks, but it shouldn't take more than two months. CPRO used NCQA standards in measuring performance. Ms. Bell noted that 50% was the score chosen as the minimum acceptable score for this audit; in future audits plans will be held to a higher standard. Susan Graham asked if DSS will sanction plans that do not improve; Ms. Bell stated that the new contracts will have provisions for imposing sanctions.

CPRO agreed to report on patient-focused studies, MEDSTAT's project and database validation at the next meeting. Senator Harp tabled a vote on the Quarterly Report until the next meeting.

The next meeting will be October 3, 1997 in Room 1D.

Senator Harp adjourned the meeting.

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