

MEETING SUMMARY NOVEMBER 7, 1997

Present: Sen. Toni Harp (Chair), Rep. Anne McDonald, Sen. George Gunther, Rep. Vicki Nardello, Marilyn McMellon-Cormack, Laraine Milazzo, Judith Solomon, Steve Netkin, Dr. Wilfred Reguero, John Simsarian, Jim Gaito, David Parella, Jeff Walter, Pat Baker, Lisa Sementilli-Dann, Marie Roberto; also Paula Armbruster, Dr. Ulder Tillman, Barbara Casey, Jim Linnane and Mariette McCourt (Council staff).

DSS Oversight of MCO Work Plan Response

The Department has developed a procedure to monitor MCO performance, provide feedback to the plan and allow the Department to review the MCO feedback to the Department regarding deficiencies and correction plans. This process will be complete by Dec. 31, 1997. A matrix with plan comments and a time frame for compliance to correct deficiencies will be shared with the Council.

DSS Discussion of Quarterly MCO Utilization Data

Jim Linnane reviewed the utilization data from plans, focusing on the following areas:

1) Percent of Low Birth Weights (LBW), <2500 Gm: In Ct. Access populations, this remains higher than in the general population. The percentage of women receiving over 80% of recommended prenatal visits(in plans) increased 6.8% during the first quarter of 1997; however the percent receiving care in the first trimester decreased by 5.8%. Over 70% of plan participants received on-time post-partum care.

Dr. Reguero stated that LBW have been studied for forty years without clear indications of the effect of interventions and there is a need for funds to be allocated for a critical analysis of the role of genetics in LBW. DSS replied that while genetics may be a factor, it is helpful to know inputs to birth outcomes such as prenatal care which are part of the reporting requirements of the Hedis system.

2) Health Track (EPSDT) Medicaid data: overall access for the second quarter 1997 was 62% compared to FFS access in 1995 of 50%. Access rates appear to be fairly stable over the previous quarters, yet consistently under the 80% goal. DSS suggested that the improved access for in those aged 15-20 years may reflect the improved relationship between the MCO and SBHC.

3) Emergency care utilization (comparing FFS with MCOs): as measured in # of visits per 1000 members per month, MCO use is 30/1000MM as compared to FFS of > 70/1000MM. This reduction may reflect institutional changes in redirecting inappropriate ER visits to primary care, yet raises the question of whether clients in need of medical care access care elsewhere. DSS responded that the percentage accessing primary care is higher than FFS as shown by EPSDT data.

4) Inpatient care: FFS number of inpatient days were 60/1000MM compared to CT Access coverage of 30/1000MM. This data includes Behavioral Health in acute hospital settings. These numbers do not reflect the quality of care and DSS agreed to look at readmission rates as one indicator of quality.

5) Subcontractors in Medicaid Managed Care: Sixty percent of the Ct Access population accessing Behavioral Health are in subcontractor plans, with 26% enrolled in Pro Behavioral Health. Six of eight plans use either Benocare or DBP for dental carveouts. DSS is working with plans to clarify data collection procedures and rectify deficiencies.

6) Behavioral Health: DSS reports that the penetration rate is similar to FFS as measured by provider or diagnosis; however Hedis data has a more restrictive definition and lower rates. Judith Solomon noted that Info Line data reveals of limited access at every level of service and carve out procedural barriers maybe becoming access barriers. Dr. Reguero questioned if the \$28/PMPM is adequate: are we certain MCOs are providing service similar to FFS? DSS replied that present data shows lower expenditures by plans as compared to FFS, with decreased inpatient care as well as outpatient care with similar penetration data. Since one would expect an inverse relationship between inpatient/outpatient expenditures, it is unclear why this is not occurring. DSS suggested that lower outpatient charges, changes in intensity of level of care, such as using more outpatient visits than partial hospitalization programs, may explain this. Clearly, behavioral health utilization must be more closely scrutinized to identify gaps in services and the effect of changes in level of care within the managed care system. DSS is working with task forces, Medicaid Managed Care subcommittees, health plans and their subcontractors and CPRO to answer questions about service access and the quality of mental health services.

Marie Roberto questioned how DSS uses the data considering the variations across plans and variations of individual plan data with the mean data. DSS reviews data with plans, identifies reasons for differences which may include data collection problems as well as service delivery and expects plans to address deficiencies.

Retrospective/Prospective Cost Report

DSS reported a \$30 million projected medical cost savings since the change to Medicaid managed care: this is based on the projected costs if FFS had continued as the payment system. Savings were not realized until the second year of the program in part because of the administrative start-up costs. Over the next year DSS expects some administrative costs to decrease (IE Benova Enrollment costs, Lewin Group actuarial consulting) while other will remain stable (IE Children's Health Council which performs

a dual role of oversight and outreach to Ct Access groups and CPRO which has contracted with the state for external quality assurance programs until Oct. 1998). Overall, DSS expects administrative costs to decrease as the state moves into the maintenance phase of the program. Contract renewals negotiations are in order with Benova and CPRO during 1998.

Medical cost savings were less in the first year because of the speed-up of enrollments and inclusion of pregnant women and DCF children. The greatest savings based on projected FFS costs, were seen in the full risk plans where 40% of the costs are inpatient services; savings in partially capitated plans were smaller because of the limited range of services (these plans exclude inpatient risks). The designated provider plans (Oxford and Blue Care) discount to the state provided a \$2 million savings. Senator Harp and Dr. Regeuro questioned what the actual spending rates have been. DSS indicated that there were increased expenditures as compared to budgeted amounts and inflation and utilization rates have been contributing to increased spending. Senator Harp requested the Department to share the paper on savings with the Council at the next meeting.

Preliminary estimates of trend calculations for full risk capitation plans for 1998-99 is expected to decline from the 1995 10.3% because of decreased LOS, the FQHC cost based reimbursement payment to be paid as a pass through and utilization factors. [Note that the 1.84-3.67% for 1998-99 reflects 80% of the prospective rate changes]. Rep. McDonald questioned if MCO projected costs will be different from commercial HMOs that enjoyed early cost savings and now estimate substantial increases in health care costs by the end of the century. DSS replied that costs are expected to rise and the Department will need to look at new ways to project costs as the FFS data will no longer serve as a basis for trend projections. Asked if increased costs will translate into less service availability secondary to lowered capitation rates, DSS indicated that there will be pressure on capitated rates for savings and this pressure could contribute to decreasing services over the next two years. Pat Baker observed that the current \$6 PMPM loss adds up to a \$15 million loss for plans; the plans cannot continue the program with these losses. Ms. Baker stated that in reality, the capitated rates may not be adequate for service provision.

Hospital rate trends were another source of concern for Council members. DSS stated that over the last three years the TEFRA rates have varied from 2-4%, but the state paid hospitals 3.4%. The Boren Amendment, which mandates that states could not under-reimburse hospitals for Medicaid services has been repealed. While the state will keep the TEFRA percentages in place till Oct 1998, as part of the CHA V. O'Neill agreement, the rate setting after that time is unclear without federal rules and will become an issue in cost projections and actual costs.

The preliminary 1998 Upper Payment Limits (UPL) tables represent 36 eligibility/age/sex combinations with the 0-3 month aged grouping added as a new cell, in which LBW babies in the NICU represent the high costs. DSS noted that the 'K1, K2' cells which represent foster children and some SSI children have a projected UPL 1.5 times the average AFDC population costs. DSS stated that the bottom line of the UPL is

to better match payment dollars in a capitated rate system to cost experience and that the UPL system has the potential to provide plans with adequate money with which to serve the population. The Department expects to have rates finalized shortly, give specifics to plans as part of the business(cost) proposal RFP. The plans will have done their own projections, compare their numbers with the state UPL trend line, and factor this into their bid. DSS emphasized that the UPL are not rates, but rather represent changes in the program over time (IE inclusions of different groups or services). Pat Baker stated that generally plans bid within 80-90% UPL and according to this preliminary data plans would be working with \$134 PMPM, which would be difficult.

Marilyn McMellon-Cormack questioned if costs are being shifted from MCOs to other state services. DSS replied that there have been anecdotal reports but the Department does not think it is happening on a broader scale. The Department has begun a dialogue with state agencies, MCOs and CHC to facilitate referrals and define service and financial boundaries among plans, agencies and funded programs.

Contract Extension Negotiations

DSS stated that the negotiations have not begun. They will begin next month.

Hyde Amendment Impact

Previously, Federal monies could be used in FFS only for abortions deemed medically necessary if the mother's life were in danger or if rape or incest led to pregnancy. Now, if states no longer can pay for medically necessary abortions within capitated rates (shared state and federal funds), the state must separate this from the rates. This will become an administration problem, with funding coming from state resources, not from federally matched resources. DSS stated that the state will continue to pay for medically necessary abortions with or without federal funding.

Benova Plan Changes

In September, the # one reason for plan changes was exclusion of the client's PCP in their chosen plan whereas hospital/clinic choice exclusion from a plan became a less frequent reason for plan change. Benova looked at July 1997 and found that 60% of those that identified the clinic of their choice not in the provider panel, changed plans. Some changes in plans may have been related to client confusion about the clinic as part of the hospital that may have been in their plan.

Public Health Department/MCO Integration

Dr. Ulder Tillman from the Waterbury Health Department discussed the local health departments concern regarding public health integration with MCOs. In particular the problems are identified as: 1) coordination of reporting processes and treatment plan with health departments, MCOs and health care facilities in cases of communicable diseases such as TB; 2) follow up screening of children with elevated baseline lead

levels, as there is considerable variability among plans in covering these services; 3) health provider adherence to state statutes regarding data reporting (IE lead testing, immunizations) and the role of MCOs in promoting this adherence and 4) the integration of federally funded programs into MCOs' structure where physical and laboratory assessments are required for periodic recertification (IE WIC program). DSS stated the Department was unaware of the lead problem, whereas they have intervened when plans deny approval for WIC assessments. The Department would intervene with lead testing follow-up denials. Rep. Nardello requested a written action plan from the health departments to the Council. Sen. Harp requested that DSS and the Department of Health look at surveillance statutes, disseminate these to MCOs and providers as compliance can be plan driven. Jim Gaito will discuss the issues raised by Dr. Tillman with the Dept. Of Health, then bring others together, including the State Medical society to find solutions to the issues raised by local health departments. Sen. Harp thanked Dr. Tillman for bringing these important issues to the attention of the Council which will follow up on resolution of the problems.

Subcommittee Reports

Public Health: Dr. Tillman's presentation covered the subcommittee report.

QA: Sen. Harp stated that CPRO and the subcommittee chair met and will work on Behavioral Health indicators.

Access/EPSTD: Sen. Harp requested the subcommittee look at the HealthTrack numbers, bring plans in to discuss access issues. Judith Solomon and Dr. Reguero will schedule a meeting.

The next **two** meetings of the Medicaid Managed Care Council will be:

FRIDAY DECEMBER 5, 1997 AT 9:30 AM (LOB RM 1D)

FRIDAY JANUARY 9, 1998 AT 9:30 AM