

MEETING SUMMARY
JANUARY 30, 1998

Present: Sen. Toni Harp (Chair), Sen. Prague (Co-Chair), Rep. Vicki Nardello, David Parrella and James Gaito (DSS), Marie Roberto (DPH), Dr. Wilfred Reguero, Dr. Leonard Banco, Paul DiLeo (DMHAS), Robert Gribbon (Office of Comptroller), Cynthia Matthews, Judith Solomon (CHC), Lisa Sementilli-Dann, Dr. Edward Kamens, Dr. Helen Smits (HRI), Sylvia Kelly (YPH for Pat Baker, Oxford), Ellen Andrews, Paula Armbruster.

Also present: Judy Bell (CPRO), Mary Alice Lee (CHC), James Linnane, Sue Simmit and Rose Ciarello (DSS), Mariette McCourt (Council staff).

DSS REPORTS

TFA Exit Interview

Sue Simmit from the Eligibility Division in DSS described the DSS policy regarding the 21-month Temporary Family Assistance (TFA) exit interview process and the consequences of the failure to attend the exit interview:

*Families with an employed adult who do not attend the exit interview will remain eligible for Medicaid coverage for 24 months as long as they remain in the state and have a child in the home under 19 years of age.

*Families with no employed adult who **attend** the Exit Interview may apply for an extension of TFA, and remain eligible for Medicaid and Food Stamps, based on the eligibility re-determination.

*Families with no employed adult that **fail to attend** their scheduled Exit Interview lose their Food Stamps and Medicaid.

At the last council meeting, Sen. Harp expressed concern that children may be without Medicaid coverage if the parent fails to attend the interview and that outreach efforts to these individuals, while difficult, must be enhanced.

DSS re-evaluated their first month Exit Interview data of 1000 clients and found that 180 clients, rather than the initial documented 299 clients, did not attend the interview. DSS reported providing additional efforts to contact the missing clients. Changes in the language of the Exit Interview notice mailed to families have been made in an attempt to clarify the procedure, brochures are being developed for client education and eligibility workers are continuing to be trained about TFA eligibility issues, safety net availability and client education needs. The Council requested that the training handbook used be available to the Council and suggested that clients receive information about accessing health insurance if they become uninsured in the future. DSS agreed to do this. Further discussion about outreach to this population will be included in the March Council meeting update on the HUSKY outreach plans.

Managed Care Plans' Deficiency Corrections

James Linnane reviewed the health plans' deficiency corrections, and individual plan status concerning their compliance with the correction process. Mr. Linnane explained that the CPRO audit, performed in the summer of 1997, identified the plan deficiencies that are grouped into three categories:

*Documentation that involved undocumented policies. Overall there were 38 (these represent 31% of the total deficiencies) deficiencies, with 5 remaining outstanding.

*Policy, which addressed lack of written policy for member services, for which two-thirds of the 38 deficiencies (representing 31% of the total) have been corrected.

*Process and procedure deficiencies represented 37% of all deficiencies (45), of which 18 have been corrected and 27 (60%) remain outstanding. This category includes member handbook information deficiencies that remain outstanding because plans are waiting to formalize the printing of their drafts until May 1 when the new contracts will be signed and appropriate policy changes can be made predicated on the content of the contracts. Documentation of a unified grievance process that is in compliance with the DSS process was a consistent deficiency across plans. The Department has clearly indicated that compliance with the DSS grievance standard is expected of all plans. Yale Preferred Health had the greatest number of deficiencies (35) related to the absorption of two Medicaid plans into their plan and have corrected all the deficiencies. HealthRight and Kaiser have the most outstanding corrections (9) with HealthRight having corrected only one deficiency at the time of the DSS report.

In response to Sen. Prague's question regarding plan policy variability, James Linnane stated that there should be no variation among plans for covered services mandated by the federal Medicaid program. There can be variation among plans regarding operational issues (IE authorization/pre-authorization time periods).

Husky Implementation Update

David Parrella reported that the Title XXI proposal has been submitted to HCFA for approval and the Department has sent out notification for the formation of three work groups to address data and policy implementation issues. The Children's Health Council will participate in these groups whose efforts will ensure the effective implementation of the single point of entry (SPE) system within HUSKY. Development of a single application form for HUSKY A and B that is shorter and easier to use is a key aspect of the success of a seamless system. DSS will review suggested HCFA guidelines as work proceeds toward a transition to a two-page application form.

Benova has signed a letter of commitment to work with DSS to begin the development of an eligibility system for both programs. DSS will provide the Council with written information on the development of a combined outreach program before the March meeting.

1915B Waiver Application

DSS is continuing to work with HCFA to develop a standard lock-in and eligibility period regardless of covered group. These issues are new for both HCFA and the state and both are attempting to address concerns about the different lock-in periods per eligibility category. Rose Ciacaro provided a clear overview of the somewhat confusing elements:

*Presumptive eligibility: DSS will authorize qualified entities to grant presumptive eligibility for those who qualify for Medicaid. This would allow a child to receive care even though an application for Medicaid has not been made. It will end on the last day of the month following the presumptive determination if an application to HUSKY A hasn't been filed. It will continue, if an application has been filed, until the eligibility

determination has been made.

*Continuous eligibility, based on the Balanced Budget Act (BBA), applies only to children aged <19 years, determined eligible for Medicaid. The eligibility period of 12 month will not be lost due to increased income; loss of eligibility occurs if the child becomes 19 years old or no longer resides in CT.

*Guaranteed eligibility applies to adults and children enrolled with a managed care plan; however DSS states that in practice it refers to adults. Guaranteed eligibility cannot exceed a 6 month period and once determined, would continue in spite of eligibility changes, for the remainder of the 6 month period (deemed eligible period). Coverage occurs only for services available through managed care; carved out services (SBHC and Birth to Three) are excluded.

*Lock-in refers to the period of time a Medicaid enrollee remains enrolled in a particular health plan. There is a 90-day free-look period and the lock-in period is for 12 months. Consumers can dis-enroll from a plan during the lock-in period for good cause as determined by DSS.

DSS was asked what changes would be needed to give 12-month eligibility to adults. The Department stated there are no federal provisions for continuous eligibility for those > 19 years of age. Expanding adult eligibility would require a federal change, amending the 1915B waiver or the BBA. The Department will discuss these issues again as the 1915B waiver moves closer to submission.

Medicaid Business Cost Proposal

James Gaito reviewed the Upper Payment Limit (UPL) status. The UPL is an expression of the amount of dollars that would have been spent under the fee-for-service (FFS) and has been revised since the original projected UPL was released. The current UPL is \$149.85 PMPM for the contract period 10/97 to 3/98. DSS explained that the originally projected UPL was lowered (\$145.60 PMPM) because of changes in the trend line and the reduction of base costs. The current revised UPL for 4/98 –3/99 is \$148.30.

Changes in UPL are related to various program factors:

Plans are not responsible for State children's psychiatric inpatient care and money for reimbursement to Federally Qualified Health Clinics was removed from the base program costs. The rate system is based on a risk adjustment for specific eligibility categories; more money was added to the base to adjust for increased costs for categories such as newborn care, the category that had the greatest impact on the revised UPL.

Additional money may be available to plans related to the Governor's support of the removal of the premium tax (1.75%) paid by MCO's for contract renewal, for which the state received \$4.5 million last year for Medicaid.

The new Medicaid cost proposal is based on a state-wide eligibility risk adjustment, rather than the previous county adjustment; hence the PMPM rates may change, for some plans, in relation to the concentration of children and their eligibility.

Health plan concerns regarding the \$145.60 UPL led DSS to review the projected UPL and further adjustments were made, resulting in a revised UPL of \$148.30 PMPM. When asked if the numbers may be further adjusted, DSS responded that the 'hard' ceiling for bidding is the UPL, while the 'soft' ceiling is the end point negotiated with the state and plans.

DSS reminded the Council that the revised UPL is a bidding guide for plans. Different eligibility categories carry different UPL. For example, non-DCF categories carry an UPL of \$82 PMPM whereas DCF children, aged 6-14 years have an UPL of \$276. DSS

noted that the Department is working with DCF in determining how the contracting process will reflect the philosophy that payment differentials reflect different contracting obligations. Cost savings are based on decreasing the percentage of the UPL on which plans base their bid. DSS expects that bids will not be greater than 90% of the UPL, although health plans can bid at 90 to 95% of the projected UPL that is determined by DSS. Contract negotiations will not occur until the UPL rate setting is finalized.

Local Health Department meeting 1/6/98

James Gaito reported that Dr. Tillman, representing local health departments, DSS and Marie Roberto from the DPH met to clarify the issues presented at the December Council meeting and plan to meet again to address these issues:

Accuracy/completeness of communicable disease reporting. In an effort to enlist MCO help in problem resolution, Dr. Tillman will present the list of communicable diseases and the reporting mechanism to the monthly MCO/DSS meeting, which will include the health plan medical directors.

WIC coordination issues: DPH, DSS and Dr. Tillman agree that the current system deals adequately with this problem.

MCO's and local health departments need to develop a working relationship.

MCO's and providers need to ensure that lead screening and follow-up measures are performed.

Mental Health Meeting

DSS met first with Child Guidance clinics and DCF to address common issues involving managed care, followed by a meeting with MCO's, DCF and child guidance clinics on January 27, 1998. James Gaito described the meeting as a frank, full discussion of the issues that included: 1) common definitions of service areas, such as play therapy, extended day treatment, case management, 2) how case management relates to the medical setting, 3) authorization/denial of care, 4) claims processing and timeliness of provider payments. The group reached agreement to: 1) have clinics meet with their MCO's and Behavioral Health subcontractors to discuss issues specific to each clinic, 2) finalize the list of issues and prioritize for the meeting 3/3/98 and 3) organize sub-groups to develop strategies to resolve the problems. DSS reported that good ideas were expressed at the meeting. One issue that was raised was the need to focus on the coordination of care for the most needy children who are high resource users. This may ultimately create a broader involvement with agencies in coming together to address this issue. DSS will report on the progress of this group.

CPRO REPORT

Judy Bell provided an update on the Data Validation Project, which is divided into two phases. The purpose of the project is to develop an encounter database that is useful to everyone. It has required a great deal of work and detailed attention from CPRO, DSS, MEDSTAT and health plans. Ct is the first state to validate data and standardize the process and data collected.

Phase I involved initial discussions with those who use or will use the data followed by the development of the analytic guide, on-site reviews of individual plan data elements and collection processes. Plans were graded for data collection/reporting capabilities, with overall adequacy in data collection processes but concerns about data quality, completeness of data were taken back to the plans.

Critical and non-critical elements were developed that have become the basis of data now collected. The critical elements were divided into five claims categories: inpatient services, outpatient services, prescription drug, vision and dental services. DSS will use

a subset of these indicators in evaluating plan performance during the next contract period.

CPRO began formal data validation of data submitted by health plans during July and August 1997, in October 1997. Plans were provided feedback regarding data deficiencies with a February 11 meeting scheduled for plans to obtain an overview of the data evaluation project. Face-to-face meetings with plans, MEDSTAT and CPRO to review deficiencies and develop data correction strategies will follow this meeting. Phase II will involve validation of medical records against the electronic encounter database. The project will measure actual service delivery, rather than quality outcomes. Validation of the data is necessary before quality issues can be measures. The study design will initially focus on inpatient care, and project completion is scheduled for 9/30/98.

CHC REPORT ON EPSDT DATA

Mary Alice Lee presented an overview of EPSDT on-time visit rates, a longitudinal study of access to EPSDT services and special studies. There are several EPSDT monitoring reports for the Medicaid population that are available:

- *DSS submits an annual report to HCFA on EPSDT data

- *Health plans submit quarterly EPSDT screening and participation rates

- *Health plans submit an annual Health Prevention report in April that includes reports on continuously enrolled children aged 3-6 years and 12-20 years, who have had one EPSDT service during the calendar year.

The CHC and the Connecticut Children's Health Project have also developed reports for health plans that assist them in outreach to families under-utilizing EPSDT services.

These reports include:

- * Children due for screens 2 months prior to the due date.

- * Children overdo for screens

- * Children who have had no encounter visit.

In addition to the tracking reports, CHC is monitoring two other aspects of the EPSDT process:

- *EPSDT on-time visit rate which identifies the number of children screened and the timeliness of the screen, allowing variable windows of time according to the age of the child. The first quarterly report of this monitoring revealed that 25% of 30,000 children received on-time visits with a 180-day run-out time period. There seems to be a consistent pattern in which the likelihood of receiving a screen decreases with age.

- *Longitudinal study of EPSDT access determines the number of required EPSDT screens received within a 13-month time for a cohort of children, continuously enrolled for 13 months. Of the 587 children included in the study, only 25% received five or more screens while 13.8% received no screen during the study period.

Data analysis of on-time ESPDT rates and to a lesser extent, the longitudinal study, is limited by missing or incomplete data, discrepancies in EPSDT encounter reports and EPSDT procedure coding. Subsequent to the CHC report and DSS review of new quarterly EPSDT rates, Council members discussed the problems associated with obtaining accurate EPSDT data. Accuracy of the reported data is related, in part, to use of proper CPT-9 codes. Health providers, institutions and health plans are responsible for recording the appropriate code when an EPSDT screen is performed. Some Council members recommended the use of a standard EPSDT reporting form as a means to ensuring uniform reporting of screens. CHC questioned the utility of this as DSS has

identified uniform codes to be used in reporting EPSDT services and the health plans are responsible for ensuring that they are used. DSS stated that contract standards with sanctions must be based on clear performance standards and that the encounter system will be the basis of data reporting by which plan performance will be measured. Timely EPSDT encounters are representative of accessibility of care and reflect the issues of clients' knowledge and appropriate use of the primary care provider system. The problem with EPSDT performance is multifaceted. Issues involve: provider and institution billing practices, variations in health plan outreach efforts, collaboration of community groups with plan outreach programs, EPSDT education of providers other than pediatricians who see adolescents, difficulties in behavior change on the part of the adolescent, and loss of encounter information when clients seek screens/services from safety net providers (IE SBHC, Visiting Nurse, van clinics, etc.). Senator Harp suggested that a conference for providers, presented by plans, DSS, CPRO, CHC and the EPSDT subcommittee, would be helpful in addressing some of these issues.

Subcommittee Reports

Quality Assurance: Mary Alice Lee was introduced as the new co-chair of the committee. The newly formed subcommittee met for the first time January 22, at which DSS provided a comprehensive overview of the encounter data process and CPRO informed the new members of the status of their ongoing projects. Task definition will be addressed at the next meeting.

Behavioral Health: 1) the standardized Methadone reporting form, prepared by a collaborative effort of providers and health plans, with Jill Benson from ProBehavioral Health as the organizing force, was presented to the Council for approval. The Council approved the form with a recommendation that DSS request health plans to use this standard form for treatment authorization and reauthorization. A copy of the file will be given to DSS, for duplication, for health plans use. 2) Behavioral Health plans presented an overview of each plan's grievance procedure. Discussion ensued regarding authorization and the denial process.

Public Health: DPH presented their completed Provider Safety Net Survey, which the committee will continue to review with DPH. The Community Benefits issue will be addressed at the March meeting.

Access/EPSDT: health plans attended the January meeting and reviewed their outreach efforts, strategies that have improved outreach efforts. All plans reported using the CCHP reports to target members not participating in EPSDT services. Issues around EPSDT delivery and data reporting were discussed. The CHC will be addressing these issues as well as the subcommittee.

The next meeting of the Medicaid Managed Care Council will be **Friday March 6, at 9:30 AM in LOB RM 1D.**