

MEETING SUMMARY
MARCH 6, 1998

Present: Sen. Prague (Acting Chair), Rep. Vicki Nardello, Jeff Walter, Marie Roberto (DPH), Lisa Semetilli-Dann, Cynthia Matthews, Ellen Andrews, John Simsarian for Gary Blau, Robert Gribbons, Judith Solomon, Edward Kamens, David Parrella and James Gaito (DSS), Steve Netkin, Dorian Long for Gary Blau (DCF), Peter Johnson for Marie Casalino (DCF), Pat Baker, Sherry Manetta for Dr. Helen Smits, Marilyn Cormack, Laraine Milazzo, Paula Armbruster.

Also present: Barbara Casey (CPRO), Mary Alice Lee (CHC), James Linnane and Rose Ciarcia (DSS) and Mariette McCourt (Council staff).

DSS Report

Update on the Business Cost Proposal

David Parrella provided the Council with an update of the cost proposal process as well as changes in the Medicaid program necessitated by the Oxford decision to leave the program on March 31, 1998. Both issues prompted a serious discussion by the Council regarding the potential crisis the CT Access program might endure over the coming months.

The publication of the intent to renew the 1915B waiver was initially published in the CT Law Journal on 12/9/97. This publication included the proposed continuous eligibility and health plan lock-in proposals as well as retrospective estimates of savings and program projected cost effectiveness, which includes the preliminary Upper Payment Limits (UPL). According to DSS, the UPL, based on historical fee-for-service costs, is configured to better match payment dollars to cost experience within a capitated payment system. In the November and December, 1997 Council meetings, health plan concerns about the feasibility of providing services within the proposed UPL were raised. The proposed UPL, configured by the State's consulting actuarial firm, represented an approximate 10% reduction from those rates of 1995 that were 95% of the FFS rates.

Over the past two months, DSS has discussed the cost proposal with the managed care organizations (MCO's). The plans have continued to convey their concerns about the UPL that was reconfigured from \$145 to \$148.30, approximately 90% of the FFS rates. Since health plans are questioning the actuarial basis for the reduction of the UPL (from 1997-98 limits), DSS will revisit the actuarial assumptions with the new State actuarial contractor the week of 3/9/98. The Department has withdrawn the current cost proposal. If the actuarial consultant advises changes in the UPL, this will require re-publication of the business cost proposal, perhaps late in March, followed by a presentation of the 1915B Waiver to the committees of cognizance in April. The amendment of the state plan granting 12 month continuous eligibility to all children and the Waiver application granting a 12 month plan lock-in will be submitted to HCFA for approval for the

implementation of the HUSKY part A and B by July 1, 1998.

Following this discussion, DSS presented the financial health plan report of Medicaid Revenue and expenses for the First through the Third quarters of 1997. According to plans' unaudited reports, the mean loss was 5%, with only Kaiser, MD and HealthChoice reporting a plus margin percent. While the mean plan revenue increased (\$281,651,023), the mean net income loss for medical and administrative expenses increased, exceeding the revenue by \$14,907,152. On average, the reported PMPM expenses exceeded the revenue by \$7.63PMPM.

The Council raised questions about these reports, highlighting the lack of uniformity in delineating reported administrative expenses (IE inclusion of transportation, case management, and outreach) and the self-reporting nature of the reports. Rep. Nardello noted that these financial reports were unaudited. Yearly audited reports are submitted by June 1; however these reports are on a health plan's entire book of business, not the Medicaid book of business. DSS stated that the latter is not required by current contract. Rep. Nardello asked if the contract specifications could be modified to include a separate Medicaid audit. DSS replied that this could come from a Council recommendation. Rep. Nardello stated that the state needs to know this information. Sen. Prague stated there is a need to look at the complete cost of the Medicaid program, with an itemized cost analysis of what is actually being spent in the program.

DSS agreed to determine if an annual audited separate Medicaid book of business could be obtained. DSS will report back to the Council in April on the feasibility of this.

Medicaid Program Changes

DSS stated that the Oxford health plan would withdraw from the CT Access program on March 31, 1998. Both Oxford and Pro Behavior Health, the behavior health care-out, have sent letters to Oxford members in an attempt to help members choose other plans. The Department has also notified Oxford members about this change by letter.

Members must choose another health plan; those that do not will be defaulted into one of the remaining health plans. The plans involved in the default assignment will be determined by DSS, based on plan capacity within a geographic area. **The Department will have determined those plans that can accept default assignment by the week of 3/16 and will communicate this to the Council, in writing.**

The Oxford exit has an impact on the program in that the capacity of the system will be challenged and continuity of care will be interrupted. The former addresses the issue of provider network adequacy, in that Oxford required all providers in their system to participate in the Medicaid program. Thus providers who hadn't previously participated in the system did so as Oxford providers and may not continue in the program through another plan. DSS stated that the loss of a plan results in decreased program capacity to serve the eligible and meet the multiplicity of health needs for this large population. When the system capacity has been exceeded, the FFS system would be resumed; however the program is not at this point as yet.

Oxford was a major provider and DSS acknowledged that the system could not sustain several more plan losses without eroding the Medicaid managed care system.

Continuity of care issues related to the Oxford exit were also raised, specifically in relation to Behavior Health services. It had been brought to Council members attention that Pro Behavioral Health had indicated to members in writing that authorized outpatient mental health services would need to be re-evaluated as of March 31;

however inpatient authorizations would be honored for the duration of that authorization. Clients may also have to change provider if that provider is not in the newly chosen plan's network. Oxford reported they understood their obligation, in that high risk clients such as pregnant women are eligible for an exemption to remain with their provider but that Oxford responsibility for Behavior Health outpatient authorizations ends March 31. DSS stated that the policy of continuation of services at the time of a plan change has the needed protections in place in that services would continue until the new plan re-evaluated the treatment plan. The Department is meeting with Oxford and Pro BH next week (3/9) and **will inform the Council of the outcome of this meeting.** Benova, the enrollment broker has been asked to describe the exemption process to clients when they enroll in a new plan. DSS reported that additional staff has been added to Benova during March to meet the increased demand necessitated by the plan change.

Update on Husky Plan: Outreach Implementation

The Department will evaluate the RFP applications for part B in Mat, 1998. The task force has been working on the new 4 page single point of entry (SPE) application. The new application, available in May, will be in regional DSS offices, hospitals, FQHC's and other sites throughout the community. Rep. Nardello observed that schools are an excellent outreach site but would require funding to do this. DSS stated that outreach funding is available (\$800,000); the process of apportionment among schools needs to be determined. A proxy for economic need, such as percentage of a school's participation in the lunch program, could be used in determining outreach-funding distribution. School based health clinics could capture the number of uninsured children, targeting this population as part of outreach efforts.

The Department described the potential population of HUSKY children, in response to Cynthia Matthew's question. Approximately 53,000 children in households <185%FPL have never applied for Medicaid. There are 37,000 uninsured children at various economic thresholds, with 14,000 in households above 300%FPL. The Department expects that over the next 2-3 years, the eligible population (90,000) will apply through the SPE system.

Quarterly Data Review.

HealthTrack

James Linnane highlighted aspects of the quarterly data, noting that the upward trend in the HealthTrack ratio is heartening. There remain, however, discrepancies in screen and participation reports between the encounter data and the aggregate data (this was discussed at the January Council meeting). Data provided by the CHC often revealed lower EPSDT screen encounters, approximately one-third less, than the aggregate data reported to DSS by plans.

The Council expressed concern about consistent plan under-performance using the median percentages of the HealthTrack screen aggregate data. The Council requested CHNCT to come to the April Council meeting to explain the plan's persistently low EPSDT screen reports. DSS observed that CHN has had reporting issues related to conversion of their historical encounter reports using FFS codes to the DSS-defined codes for EPSDT services. CPRO and MEDSTAT have been working with CHN to correct data reporting deficiencies through the Data Validation project. CHC noted that CHN's percentage of visits thought to be miscoded were very small. Correction of miscoding would not bring CHN up to other plans' EPSDT screen and participation levels.

Behavior Health

Behavior Health ambulatory care utilization decreased this last quarter among nine of the ten plans for reasons that are unclear. This may reflect a seasonal factor. Differences among behavior health data categorized by HEDIS, provider and diagnosis suggest that perhaps behavior services are now provided outside the traditional provider system. DSS noted that behavior health assessment is a murky area and the Department is trying to clarify the issues regarding service access and quality through:

Participating, along with the chairs of the Behavior Health and Quality Assurance subcommittees, DCF, CPRO, Sen. Harp and Professor Kazdin, Chair of the Yale Psychology Dept., in a study of behavior health services delivered in the New Haven area by child guidance clinics,

CPRO Appendix K study that involves discharge of DCF-committed inpatients

Facilitating meetings with the MCO's and child guidance providers that address administrative policies and clinical authorization issues.

The outcome of these efforts will be reported to the subcommittees and the Council. The Department restated the need for Behavior Health outcomes and money spent in this part of the CT Access program. The Department reportedly asked plans, six months ago, for more detailed reporting on spending for Behavior Health services. This depth of reporting has not been implemented; DSS stated that this request could be made again. The Behavior Health subcommittee will be working with DSS, CPRO, plans and committee participants in identifying outcome measures.

Immunization data

Reported immunization rates among continuously enrolled two-year olds have improved from 77.2% to 85% of those whose status was known. The percentage of cases whose status is unknown has declined from 30% to <10%.

Prenatal Care

Again, there is great variation among plans in reporting the percentage of those receiving care in the first trimester. The variability among plans in the number of deliveries influences both the percentage variability and interpretation of the reports. The QA subcommittee will review this data when the fourth quarter is available in June.

Other Services

Dental exams have decreased 20%, from a median of 39 per 1000 MM in the 1996 third quarter to 31 per 1000 MM in 1997. Access to dental services remains a difficult problem within the CT Access program. The Public Health and the Access/EPSTD subcommittee have been addressing this and CHC will present their dental utilization study at the Access meeting on 4/14/98.

Mental Health, Local Health DPT Work Groups

James Gaito reported that the dialogue between the MCO's and child guidance providers continues. Two sub-groups have organized to develop consensus about administrative and clinical coverage issues. The full working group will reconvene in May and a report, when available, will be made to the Behavior Health subcommittee and the Council. Dr. Tillman, representing the state's local health departments, will attend the April MCO/DSS meeting that will include plan Medical Directors.

Communicable disease reporting and lead screens are among the items to be addressed.

Connecticut Community Providers Association (CCPA) Report

Linda Tatarczuch, Director of Health Care Policy for CCPA, an association of specialty providers, presented a report on receivables due Methadone and Substance Abuse (SA) providers from MCO's, based on a May and December, 1997 provider survey. Outstanding receivables prior to May 31, 1997 was \$2,320,294 and \$2,020,800 as of 11/30/97. These amounts are reportedly owed CT Access Methadone and SA providers by carve-out companies and parent health plans.

Provider/MCO relationships were confusing during the first six months of SA client participation in the CT Access program. The providers had limited experience with managed care companies and the MCO's had little knowledge of SA/Methadone treatment modalities. Changing Medicaid eligibility and client plan changes contributed to the difficulties, as did differing treatment authorization forms and providers' limited technical capacity. The resulting financial burdens on the SA facilities from unpaid claims threaten to destabilize services to a vulnerable population whose safety net providers are, themselves, financially vulnerable. Receivables that represent a significant portion of an agency's operating budget could contribute to the failure of that clinic.

Non-reimbursement for services is particularly alarming in light of the fact that the health plans received capitated payments from DSS in advance to provide these behavioral health services. CCPA brought the problem to the attention of DSS and plan liaisons became involved in attempting to resolve the payment problem. While some progress has been made, there remains a sizable amount of receivables not yet resolved with provider service claims. CCPA recognized the Department's efforts to resolve the issue and offered the following recommendation:

*DSS refrain from signing new contracts with the involved plans until the payment issue is resolved,

*Establish penalties for MCO's that fail to pay providers for services rendered within the 45 day lag time deemed reasonable according to the Insurance Department standard.

*Include DSS arbitration, in the new contract process, to manage future reimbursement issues.

The Council urged DSS to continue efforts to resolve the problem by identifying standards for 'clean claims', maintaining MCO adherence to Insurance Dept. standard of payment within 45 days and renewing MCO contracts when there is resolution of the problem. DSS indicated that the Department may have to perform it's own audit to resolve the problem. **DSS will continue to work with providers, CCPA and MCO's to bring about a final resolution and will inform the Council of progress.**

Subcommittee Reports

QA subcommittee: the subcommittee will focus on the following areas, comparing CT data with national data: ED utilization as reported in the quarterly reports, development of a prenatal care framework with which to review quarterly reports, assess cervical and breast cancer prevention access and consider a childhood lead poisoning pilot study to assess the percentage of Medicaid children tested and percentage of those tested with high lead levels. In addition, the subcommittee will invite plans to provide information and participate in a dialogue about grievance procedures, MCO internal QA and health promotion, over the coming months.

Public Health subcommittee: reviewed the DPH Safety Net Provider Survey and will develop recommendations, based on the survey. The survey and recommendations will be presented to the Council at a future meeting.

- The next meeting of the Council will be: **Friday, April 3, 9:30 AM in LOB RM 1D**