

MEETING SUMMARY

APRIL 3, 1998

Present: Sen. Edith Prague (Co-Chair), Rep. Vicki Nardello, Jeff Walters, Dr. Edward Kamens, Dr. Helen Smits (HRI), Kim Weiner for Janice Perkins (MDHP), Dr. John Ray, Ellen Andrews, Judith Solomon, Marie Roberto, Steve Netkin, Peter Johnson, Dorian Long for Gary Blau (DCF), Paul DeLio, David Parrella, James Gaito, Lisa Sementilli-Dann, Cynthia Matthews, Dr. Leonard Banco, Bob Gribbon, Dr. Wilfred Reguero.

Also present: James Linnane, Rose Ciarcia (DSS), Lynn LaPent (Benova), Rick Jacobson, Dr. Larry Deutch & Robyn Hoffman (CHNCT), Mary Alice Lee and Mariette McCourt (Council staff).

DSS Report

Title XXI Status

The State plan for Title XXI was submitted to HCFA January 21, 1998 after legislature approval January 7, 1998. The HCFA submission began the 90-day clock for federal approval of the program. On March 18, 1998 DSS received questions from HCFA about the submitted plan that formally stopped the clock of the federal approval process. The Department responded to HCFA on March 30, restarting the federal approval time period, which extended the process 12 days beyond the 90-day period. DSS now anticipates HCFA approval in late April or early May, although the Department commented that HCFA has submitted more than one set of questions to other states, unlike other HCFA review processes. Handouts of the HCFA questions and the Department's responses were distributed to Council members and questions may be forth coming at the May meeting, after the Council reviews the materials.

Oxford Transition in the Medicaid Program

Health plans participating in the default rotation all increased their membership by 10 to 30%, absorbing the 33,312 Oxford members. PHS received 19% of the members, perhaps because of the plan's prominence in the southwest part of the state and the commercial nature of the plan, similar to Oxford. HealthRight questioned Benova about that plan's lower percentage share of new members. Benova, the state's enrollment broker, stated that the random plan assignment was by family unit, therefore differing family numbers may account for this lower percentage.

Benova Report

The historic mandatory choice rate remained stable at 84% despite the inclusion of the Oxford defaults for April. The April mandatory choice rate was 77%, with a default rate of 23%. The enrollment broker noted that of the Oxford defaults, 4500 were not reachable due to invalid/missing telephone numbers. The April net enrollment report revealed 9428 total default enrollments, with Blue Care, the State's eastern default provider, receiving 34%, Preferred One 23%, HRI 21% and CHNCT 21% of these

default enrollments. Seventy-two of the Behavioral Health Special Needs population were enrolled in new plans, as were 83% of High Risk pregnancy, 73% of HIV and 70% of Substance Abuse/Methadone Treatment clients. Benova worked with the new plans and Oxford to facilitate reports on these special population needs. Oxford exemptions totaled 26 of the total March exemptions. There were 15 (58%) exemption denials, submitted because the physician did not accept Medicaid. While pregnant women, including third trimester women, must apply for an exemption, Benova stated that most plans allow for out-of-network third trimester care. HealthRight CEO Dr. Helen Smits applauded Benova's efforts to facilitate the transfer of the Oxford membership in an efficient manner, with minimal confusion. Benova reported adding extra staff to handle the enrollment process. They received 2.7 times the client calls in March compared to February, answering 93% of the calls within 60 seconds. The call abandonment rate was 1.9% in March. The Council commended Benova for its productive efforts in creating a fairly smooth transition of Oxford members to the other existing Medicaid plans.

HCFA 416 Report

James Linnane (DSS) reviewed the annual state Medicaid HealthTrack report to the federal government, submitted April 1. The report covers unduplicated plan EPSDT data submissions from October 1996 to September 30, 1997. While the state is below the 1995 goal of 80% participation, a comparison of 1995 data that was predominately fee-for service (FFS) to 1997 data that was predominately managed care, shows an improvement. The participation ratio increased, overall, from 42% during 1995 FFS to 54% under managed care and the screening ratio increased from 50% to 61% in 1997. Improvement was attributed to improved health plan outreach and DSS, CPRO and plan work on coding issues.

All but Dental Care showed improvement. The overall participation ratio remained unchanged at a low 43%; however there was a 5% decrease in rates for children aged 6 years to 20 years. Sen. Prague commented that non-payment for services and lower reimbursement rates under managed care may be discouraging dental participation in the CT Access program. DSS reported that the CT Dental Society has met with the Department regarding dental participation. Health plans assisted in mailing letters to Ct dentists, describing program improvements and encouraging participation. According to DSS these letters have generated some interest among dentists.

The dental issue of unpaid claims raised questions about state law regulation of reimbursement delays and 'clean' claims. DSS was asked if the program's RFP includes a lag time for claim payments as well as a contract definition of 'clean claims'. DSS responded that there is a definition of 'clean' claims in the contract and there is a contractual time limit of 45 days lag in claim payment but that eligibility issues and third party coverage may create problems in processing claims. While the Department has intervened with specific plans and providers regarding outstanding claim payments, DSS has not applied sanctions to any plan for not adhering to the 45-day reimbursement time period. In light of the exit of several plans from the program, the payment of outstanding receivables is of concern. Dr. Reguero observed that there are reports of problems among Oxford providers obtaining reimbursement since the plan left the program. DSS was asked if they have a report from Oxford about outstanding liabilities. The Department reported they have not asked Oxford for such a report. **The**

Council recommended that DSS request this information from Oxford and communicate this to Sen. Harp, as the Department must ensure that health plans respond to these costs even though they drop out of the program. The Department agreed to this. In addition, DSS will provide the Council with the definition of clean claims, the contractual time frame for claim reimbursement as well as a list of Dentist by health plan for the May meeting.

Business Cost Proposal

The state's new actuarial consultant, William Mercer, has reviewed the Upper Payment Limit (UPL) proposed by Lewin Associates. The average rate of \$147 PMPM, based on age, sex distribution, will probably not change much, according to DSS. Given that the rates may not change, the Department is considering incorporating features that respond to health plan financial concerns. Two approaches described by the Department are:

Provide birth/delivery payments outside the capitation system (thus lowering the rates), as maternity costs are unpredictable and payment per pregnancy may be a more reasonable approach,

Develop a stop-loss system to reduce health plan risk for individual health care costs over \$100,000, with DSS reimbursing health care providers for costs in excess of this amount. While all Medicaid plans have private reinsurance per contract, the reduction of the plan's risk in high cost cases is an attempt to lower unpredictable risks for health plans.

Simplify the rate cell structure for both DCF children and the overall program without changing the actual rates for DCF children.

The Department expects to make final decisions about the cost proposal the week of 4/6/98, after which DSS will share the proposal with the plans and entertain negotiations for the contract period July 1, 1998. The implementation time frame for HUSKY A and B remains July 1, 1998. The plans that will continue to participate in HUSKY A will be known by June 1, 1998.

Medicaid Expenditures for the AFDC Population

As requested by the Council, DSS provided a summary of the Medical Assistance Expenditures for FY 1996 –97.

The following table shows costs highlighted by DSS (see handout for complete #'s)

	SFY 1996	SFY 1997	% Change 96-97
ManagedCare Inpt	\$ 123.5 million	\$ 57.2 million	-38%
MC Capitation	131	357.2	172%
AFDC Total	269.9	297.8	
DCF Total	30.7	28.1	
ManagedCare Total	480.9	523.3	9%
Grand Tot:Medicaid	2.3 billion	2.4 billion	4%

The Department emphasized that these numbers represent spending; Medicaid savings are not included. It is also helpful to recall that SFY 97 included the 1995 voluntary enrollment process and costs reflect significant fee-for-service (FFS) claims. In addition, DCF enrollment was delayed; hence only \$200,000 was spent for DCF managed care capitation in 1996. SFY 1997 revealed the impact of a more 'mature' Program with a 38% decrease in inpatient hospitalization under managed care. Capitation spending tripled; total DCF costs decreased as did the DCF FFS costs. Overall, Medicaid

managed care spending increased 9% while total program costs that include 'other Medicaid' (other than AFDC, DCF) increased 4%, over the 1996-97 SFY period. The Department explained that the costs represent two streams of payment as the reimbursement systems changed from FFS to Managed Care; prior FFS claims and concurrent FFS claims continue during the Medicaid eligibility and HMO enrollment lag period, represented by the first three quarters on the Mercer graph. These PMPM costs are represented in an upper payment limit (UPL) for the total FFS risk, whereas the UPL for HMO risk is based on the fourth quarter, which is the HMO responsibility. DSS stated that this two-stream cost phenomenon is in any environment in which the payment system changes from FFS to managed care. As managed care enrollment reaches capacity, one would expect to see savings during the enrollment lag period. This decline may not occur for awhile in Connecticut because of the two year Medicaid extension associated with CT's welfare reform. Further, the state estimates that the HUSKY single point of entry will reach Connecticut's 50,000 eligible, yet currently unenrolled children resulting in an increase in the Medicaid population over the next several years. Rep. Nardello observed that the Medicaid managed care goal of reducing costs may not have been achieved; perhaps a single payer source was the better system, considering the turmoil created by the implementation of the managed care program. Judith Solomon commented that eligibility changes and improved outreach through the HUSKY program would shift the risk to the managed care system rather than the FFS system. **The Council requested information about the eligibility LOS for the TANF population, in particular women.** DSS stated that the current eligibility period for children is about 7 months; **the Department will provide the requested information.**

CHNCT Report

Rick Jacobson, Robin Hoffman and Dr. Larry Deutch from CHCT summarized the plan's efforts to correct the low EPSDT participation/screen ratio. CHN reported that the plan was well below the median screen ratio in the second quarter 1997 (46%). While there was an increase in the third quarter to 64%, CHN remained below the median 76% screen ratio. Factors affecting the ratio were: incomplete encounter submissions from practitioners, related to changing incentives associated with capitation payments rather than FFS claim reimbursement, coding inaccuracies related to the transition from the FQHC single service code to DSS Medicaid codes and the level of actual screen services provided. CHN has tracked individual FQHC's performance, observing that there is a wide variation in individual clinic reporting, ranging from 4% to 79%. The plan reported that this is a data issue rather than a service provision problem as their chart reviews of low performing sites demonstrated full comprehensive screens were provided but inaccurately coded.

CHNCT outlined the plan's efforts to improve both the data reporting problems and member participation in preventive care.

Member focus: EPSDT coordinator provides bilingual screen notices to families, coordinates outreach with DCF staff and follow-up for missed screens with 7 outreach workers. A pilot project using a telephone reminder system is being used in the eastern part of the state.

Provider focus (includes FQHC, SBHC, offices): presentations have been made to the Board of Directors and provider sites on the appropriate reporting codes and clinical features of the exam. The plan is considering a simplification of the reporting forms to improve provider-reporting compliance and have given practitioners uniform code 'prompts' to enhance accurate procedure coding.

Dental screens: plan verification of dental assessments through chart review and site visits, aggressive recruitment of dentists, with CHC having perhaps the largest number of dentists in a health plan network and member oral care education.

The Children's Health Project has reported, in the past, a 40% difference in CHN encounter data vs. aggregate data submissions. CHNCT stated that the plan's evaluation of data records show that 90% of 'missing screens' were actually done.

According to CHNCT, the differences may be attributed to:

*Practitioner code use (IE continued use of the FQHC code rather than DSS -determined codes)

*Compliance measurement differences between DSS codes and CHC EPSDT -specific codes.

Lag times associated with data collection

The Council thanked CHNCT for their presentation and recommended they continue to work closely with CHC, to continue to document actual preventive health care delivery and engage their practitioners in participation of uniform EPSDT code use.

Outstanding receivables update

James Gaito reported that DSS and CT Community Providers Association (CCPA) have facilitated discussions with health plans and providers in efforts to resolve the problem of unpaid claims. DSS has set an 8- week time period for resolution, recognizing the difficulties of reviewing long-standing claims. A third meeting of plans and providers will be held mid- May. The Department will then audit the remaining unpaid claims and a payment settlement will be decided upon by DSS. CCPA requests that the new contracts contain an incentive/penalty provision for claim payment within a specified lag time. The Association indicated that other Behavioral Health providers have requested the Association's assistance in resolving their outstanding receivable issues. Jeff Walter commented that receivable issues often involve coding problems as health providers struggle with the transition to managed care. He appreciates the health plan's accommodation of the clean claim issue.

Subcommittee Reports

Quality Assurance: Health plans informed the subcommittee about their grievance process, illuminating process variability among plans as well as internal efforts to resolve complaints prior to reaching the grievance level. The committee will continue to review the process and the Department's ongoing efforts to unify the grievance/fair hearing process, presenting recommendations at the next Council meeting.

Public Health Subcommittee: the subcommittee has been working on the DPH Safety Net Provider Survey and will formulate recommendations, based on the survey, for the next Council meeting. In addition, issues regarding SBHC/MCO contracts were reviewed and several plans are invited to the next meeting to update the subcommittee on contract progress and behavioral health utilization.

The Council expressed appreciation for the Department's forthrightness and availability in addressing issues of concern for the Medicaid program.

The next Council meeting is:

Friday May 1, 1998 at 9:30 AM in LOB RM 1D.

Please come prepared to comment on and vote to accept and/or amend the quarterly report included for your review with this meeting summary.