Connecticut
Medicaid Managed Care Council
Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307
www.cga.state.ct.us/ph/medicaid

MEETING SUMMARY
MAY 8, 1998

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Dr. Edward Kamens, Dr. Helen Smits, Marilyn Cormack, Jeffery Walter, Ellen Andrews, Bob Gribbon, Judith Solomon, Dr. Wilfred Reguero, Marie Roberto, Steve Netkin, Peter Johnson, Paul DiLeo, Janice C. Perkins, David Parrella, James Gaito, Lisa Sementilli-Dann, Paula Armbruster.
Also present: Barbara Casey (CPRO), Mary Alice Lee (CHC), James Linnane, Rose Ciarcia, David Dearborn (DSS), Debbie Hopkinson (Benova) and Mariette McCourt (Council staff).
Senator Harp opened the meeting by welcoming Janice Perkins from MD Health Plan as a newly appointed insurance representative to the Council and Dr. Peter Johnson from DCF. Sen. Harp announced that Dr. Wilfred Reguero is the 1998 recipient of the Common Cause Public Service Achievement Award. Common Cause bestows this award on individuals whom, by the force of imagination, initiative and perseverance, have made an outstanding contribution to the public interest. The Council congratulated Dr. Reguero with a standing ovation. Sen. Harp stated that the Council is honored to have Dr. Reguero as a member of the full Council as well as Co-chair of several Council subcommittees.

DSS Report

Business Cost Proposal / Contract Process

The Department reviewed cost proposal elements that are structural changes reflecting health plans concerns. The UPL, calculated by Lewin and reviewed by Mercer, the state's current actuarial consultant, will probably not change, according to DSS. Rather, changes described in the April meeting, will be incorporated to address health plan concerns of unpredictable high cost services, such as maternity/newborn, high outlier costs absorbed by plans, rate cell structure complexity, transient program and plan membership and quality care financial incentives (***see handout 'MCO rate Meeting')***. Funding for "kick" payments for maternal and newborn will come from deductions in the PMPM rates paid to each plan. Stop loss funding will come from a PMPM withhold that will be kept in reserve and paid to plans when the service is provided. The annual quality incentive costs (approximately $3.8 million) were added by the Administration to the program costs.
Council members raised the following issues in the ensuing discussion about the structural changes in the cost proposal:

Incentive payments to plans: DSS had stated that the measures have not yet been identified but will probably include EPSDT performance goals and quantifiable administrative measures. Council members recommended that DSS work with the QA subcommittee to identify incentive indicators and allow Council comments before the items are finalized.

Shared outlier risk: DSS stated that only a few cases (6) have exceeded $250 thousand; **Marie Roberto (DPH) requested that DSS provide the Council with the high cost diagnoses and the services used in these cases. DSS agreed to share this at the next Council meeting.**

Append K, State/MCO risk-sharing and Riverview child disenrollment ended: questions concerning the implementation of these changes revealed the still-unsolved underlying issue of the lack of an organized treatment approach that includes appropriate post-acute placement sites for DCF children with chronic, severe psychiatric illness. The current plan is to determine the number of inpatient days for which the MCO is at full risk. The number of days will not be based on medical necessity for acute care; rather the point at which the State will share inpatient costs while post-acute placement is obtained. It is expected that fiscal incentives will encourage MCO's to develop and/or reimburse creative step-down care alternatives. DSS and DCF will discuss the process of building incentives for appropriate levels of care. Riverview children will now longer be disenrolled form managed care because of the cost of two funding streams encountered when the child is re-enrolled in Medicaid managed care (see April summary). **DSS will describe the stop-loss plan in more detail at the June meeting.**

Out-stationed DSS eligibility workers at MCO sites at MCO expense: DSS stated that this would be modeled on the current hospital eligibility programs in that DSS staff is available at institutions for determinations/re-determinations. Dr Smits (HRI) suggested that optimal use of this staff would be to rotate them among health care sites rather than at MCO offices.

Further work on the cost proposal is needed, according to DSS, that involves identification of meaningful and measurable indicators, clarification of the inpatient psychiatric stop-loss implementation and re-determination of the PMPM MCO rates that account for these structural changes and separate cost reimbursements. The completed proposal will be then released to the MCO's, the committees of cognizance and HCFA for approval. **The Council will receive a status report on the cost proposal process at the June meeting.**

Follow-up of Council Issues

DSS reported on the Council items raised in the April meeting that included:

*A list of dental providers within each Medicaid Health plan was provided by DSS as well as a table depicting changes in dental participation in fee-for-service (FFS) and Medicaid managed care. A discussion ensued in which it became clear that while efforts to enroll more dentists in Medicaid managed care has been successful, the number of services performed are actually less than FFS. There has been a reduction in dental screens under managed care as compared to FFS. The Department observed that MCO's are paying dentists at least 90% of the FFS rates or close to the commercial rates. These observations challenge the assumption that increasing the number of dentists and providing adequate reimbursement for services will increase the availability of services. DSS stated that new MCO contracts could include incentives to increase dental use, based on a dental prevention performance standard of a specified participation ratio.

In response to related questions, DSS stated that clients could be enrolled in FFS Medicaid only. There are about 220,000 participants in Medicaid managed care, 120,000 in FFS that include adult dual eligibles, and a very small percentage of children (IE those in the Katie Becket Waiver are excluded from Medicaid managed care) and 10,000 general assistance medical participants. Dentists in FFS probably serve adults while those in Medicaid managed care serve children and their parents.

Dentists can limit the number of Medicaid participants in their practice. Rep. Nardello asked if there are differences among plans in allowing these limitations; it would be helpful to know what MCO policies are regarding this. Sen. Harp commented that the provision of dental services within the Medicaid managed care program now needs to evolve toward the goal of increasing service availability.

*DSS distributed the Medical Services Policy that defines clean claims used in FFS. Subsequent to the issues raised by CCPA in the Methadone/Substance Abuse outstanding receivable resolution process, the Department will:

identify the critical elements of clean claims that will be included in the new contracts

include the Department of Insurance requirement that claims be paid within 45 days of receipt in the new MCO contracts.

*In response to questions at the April meeting, DSS provided the Council with a summary table of Medicaid family coverage groups' length of eligibility from 10/1/96 through 9/30/97. Measuring Medicaid length of stay (LOS) is difficult because of the frequency of movement in and out of the program. The HCFA report describes eligibility months/year, an overall view Medicaid LOS. Overall, 65% of the 290,000 Medicaid participants were continuously eligible for 12 months and 70% of the Adult Cash Assistance participants retained eligibility for one year. Subgroups showed shorter participation rates, perhaps related to changing income levels, differing birth dates within the report time frame or limitations of postpartum participation beyond 60 days. Ellen Andrews suggested that it would be helpful to track family eligibility changes throughout the different categories to develop a better picture of Medicaid participation and average LOS. This is not done at present.

*The Department has requested Oxford health plan to submit a report by the end of May on accounts receivable by provider type and Oxford's plan to resolve any outstanding claims issues. **Sen. Harp has received a copy of this request and DSS will provide the Council with information at the June meeting**.

Husky Program Outreach Plans

David Dearborn provided an overview of the Husky outreach plans that will involve community-based organizations, including churches and schools, state agencies and traditional media resources to reach all uninsured children. Linkages with the Info Line, the Children's Health Info Line (CHIL), the Department of Motor Vehicles and possibly the IRS (to target eligible income levels) are part of the Husky outreach process. The application form has been simplified, phone applications will be accepted and Husky kits will be sent to service providers to assist them in the enrollment process. There have been 2000 consumer inquiries via the toll free number 1-877-CTHusky and information is available on the State's Home page WWW. Husky. Com. The Department is also supportive of the Children's Health Council's (CHC) grant application to the Robert Wood Johnson Foundation for an outreach effort that involves community agencies. Council comments reflected appreciation of the Department's efforts in developing a Husky outreach program as well as the following concerns:

Will Husky marketing efforts include adults and adolescents that participate in Husky A? DSS acknowledged that it is a challenge to market both A and B, disassociating any stigma attached to welfare with the program as well as reach the somewhat elusive adolescent group. Outreach plans will be more clearly identified in June when the Department will sponsor an outreach forum for community agency representatives.

What is the enrollment process for Husky A and B? DSS explained that the evaluation process

for the Husky B RFP in now ongoing. Plans wishing to participate in B are some of the plans from Husky A. No plans outside of the Husky A program have applied for the B program. Health providers may choose to be in the A network and/or the B network; there will probably be a provider overlap between the two programs. Benova staff is trained in both A and B policy and will screen applicants as to program eligibility. Benova will send Husky A applications to DSS for eligibility processing; those eligible for Husky B will be processed by Benova and applicants will be helped to choose a plan and Primary Care Provider (PCP). Once DSS determines eligibility for A participants, the information will go back to Benova for plan enrollment and PCP choice, as is the current Medicaid enrollment process. Benova's summary of the Husky implementation clarified some Council questions.

Benova Report on the Husky Implementation Plan

It was announced that Sheila Allen Bell has been appointed the Regional Director of Benova.

Debbie Hopkinson, Projects Manager, Husky Program, reviewed the extensive work Benova has undertaken for the single point of entry (SPE) process for the Husky program. Staff has increased from 20 to 94 and 15 eligibility specialists will be in the DSS field offices. Materials explaining Husky A and B will be available by the end of May and will include program changes of the 90-day free look period for A and 12 month plan lock-in features. Benova, DSS field office staff and community representatives are meeting to develop outreach strategies for both programs. Benova has met with MCO's to update the latest information about provider networks. Applicants to Husky B can begin submitting applications June 1 and plan coverage will begin July 1. Participants whose eligibility changes (from B to A) can call Benova and become enrolled in Husky A at any time.

Husky A time frames, beginning when the signed application reaches Benova, is the 45 day promptness standard, with turnover of the application to DSS for eligibility determination within two days of receipt. Husky B has a standard promptness of 30 days; however if the application process is complete before the 30 days, enrollment in Husky B must occur within 7 days. Benova will follow-up on all applicants, closing the case only if there is no further response from the participant confirming their intent to enroll. The TFA cash assistance population will not be processed through Benova, rather remain with DSS. Beyond the 2-year Medicaid extension, children aged <19 years at 185% FPL would access Husky A as described. **The new application form will be shared with the Council at the June meeting**.

Children's Health Council Report

Judith Solomon, Executive Director of CHC, gave a brief overview of CHC's activities:

* The CHC is sponsoring a forum on May 22, addressing EPSDT outreach issues and strategies to improve EPSDT visitation.

The CHC has applied to participate in the Robert Wood Johnson grant "Covering Kids" which supports initiatives for getting uninsured children insured through the federally expanded insurance program that formed the basis of the Husky B program as well as the Medicaid program. The grant requires collaboration with state and local coalitions, which CHC has identified. The CHC proposal has three outreach components. The first, "No baby leaves the hospital uninsured", developed in collaboration with the Ct Hospital Association, American Academy of Pediatrics, Ct chapters of the American College of Ob/Gyn (ACOG) and American College of Nurse Midwives ensures that children are enrolled in health insurance before discharge. Ms. Solomon reported that this endeavor would begin before the granting process.

The second initiative, being formed with a consultant and in partnership with the State Department of Education, SBHC, and pre-existing teen groups, would bring adolescents into both the insurance system and the health care system. This is important, as this age group has the lowest EPSDT participation ratio of all age groups. The third initiative involves outreach to families of young uninsured children through childcare sites. In addition to statewide programs, two local pilots will train community providers, parent leaders and clergy to assist families in the enrollment process. These pilots will be in Bridgeport and Stratford and a five-town area in the Manchester, East Hartford area.

Mary Alice Lee reviewed the CHC preventive dental study that was performed to identify factors associated with utilization patterns and provide the basis for policy recommendations regarding dental care access. The study revealed that less than one in three children received preventive dental care during 7/1/96 to 6/30/97 with the lowest rates occurring among Black children, aged 15-19 years residing in Fairfield, New Haven and Tolland counties. Younger non-DCF children living in Hartford County, who remained in one health plan for the year had higher participation rates (although all rates were less than 50%). CHC recommended that collaborative efforts with CHC, DSS, Dental Hygienist and Dental Associations and health plans be established to promote improved dental utilization, perhaps through establishment of a utilization goal to be used in the new contracts and an assessment of what has been successful in utilization of preventive services. Rep. Nardello raised issues that could be further explored, that included identifying where services are being provided (IE clinic or private practice), the service provider (IE hygienist, dentist) and what has been successful (IE Hartford county profile) in dental outreach efforts.

Mary Alice also reported that the Children's Health Project (CCHP) staff had met with CHNCT and both agreed to review re-submitted encounter data to evaluate the plan's screen ratio percentages. The CCHP will once again revisit the EPSDT coding issues, involving DSS in the discussions.

Quarterly Report

The Medicaid Council quarterly report was unanimously accepted by voice vote.

Subcommittee Reports

Quality Assurance: There was a discussion with health plans about the grievance procedure and implementation of the process that may impact the new contract period, with emphasis on the ease of consumer use of the process. Upcoming items include assessment of Emergency Dept. Medicaid utilization based on plans quarterly reports, cervical and breast cancer screening rates, from health plans' annual preventive reports, an update by CPRO on the prenatal project. The subcommittee is willing to work with DSS on development of QA indicators for the new contract period.

Public Health: The subcommittee reviewed SBHC contract barriers with Blue Care and Kaiser health plans and will follow-up on the contract progress at the May meeting. Recommendations from the DPH Safety Net Provider Survey are being formulated by a subgroup of the subcommittee.

Access/EPSDT: The CHC Dental utilization study was reviewed in more depth with DR. Stanton Wolfe (DPH) participating in the discussion about the low preventive dental utilization rates in the Medicaid program. A subcommittee meeting will be scheduled after the CHC Outreach Forum to suggest strategies to improve outreach, especially to children who have had no encounters.

Behavioral Health: There was continued discussion of the development of QA indicators by a subgroup of the committee. Step-down service was discussed and the committee will be interested in the final changes in the new contracts that relate to Appendix K.

Women's Health: Sen. Harp stated that there has been interest in focusing on women's health in the Medicaid program, an area that has not been previously addressed. The Council agreed that a women's health subcommittee should be formed. Dr. Wilfred Reguero and Lisa Sementilli-Dann offered to chair and co-chair the newly formed subcommittee that will address these concerns. An organizational meeting will be held June 10 at 10:30 AM; interested participants can contact M. McCourt, Council staff, regarding this subcommittee.

The next meeting of the Medicaid Managed Care Council is Friday, June 5 at 9:30 AM in LOB RM 1D.