Connecticut
Medicaid Managed Care Council
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MEETING SUMMARY
JULY 10, 1998

Present: Sen. Toni Harp (Chair), Rep. Vicki Nardello, Paul DiLeo (DMHAS), Steve Netkin (OPM), David Parrella and James Gaito (DSS), Dorian Long for Gary Blau (DCF), Janice Perkins, Dr. Helen Smits, Jeffery Walter, Eva Bunnell, Marie Roberto (DPH), Ellen Andrews, Dr. John Raye, Judith Solomon, Marilyn Cormack, Robert Gribbons (OC),
Also present: Marc Ryan (Dep. Sec, OPM),Barbara Casey and Judy Bell (CPRO), James Linnane (DSS), Paula Armbruster, Mary Alice Lee, Lynn LaPenta (Benova) and Mariette McCourt (Council staff).

DSS Report

Business cost proposal and contract process

Marc Ryan and David Parrella reviewed the Medicaid cost negotiations process that has been completed. All Medicaid plans currently participating in the program will remain in the program. All but MD/PHS are participating in the Husky B program. The Department will be developing the contract content now that the payment rates have been agreed upon, with the start of the new contracts targeted for August 1, 1998. HCFA approval will be sought for the 1915B waiver now that rates have been formalized.

Mr. Ryan stated that the Administration, Deputy Commissioner Starkowski and David Parrella all shared the concern of balancing Medicaid access with maintaining targeted savings in the budget. The 90% UPL that would have contribute to program savings was determined by DSS and the Administration to be unattainable in this contract period, thus the 92.5% UPL was agreed upon. Adopting this will mean that the budgeted amount for Medicaid may be insufficient, depending on the enrollment numbers for the year. The ability to maintain the capacity to serve the 240,000 Medicaid clients is predicated on retaining the present number of plans, according to Mr. Ryan. In the effort to balance cost savings with quality care and access, Mr. Ryan stated that the current rate agreement between the State and the plans places quality in the forefront.

The structural changes discussed at previous Council meetings were difficult to implement in an established program within the time constraints of completing the negotiations and ensuring that all the plans remain in the program. Mr. Ryan stated that the negotiations revealed this difficulty; however further study over the next year or more will be undertaken to assess the feasibility of implementing these creative cost structure changes. For this contract period, the Administration felt that everyone should benefit from the rate increase and the decision was made to continue with the same structures and health plans. The agreed upon rate structure is as follows:

Rate cells remain unchanged with no risk adjustment for DCF children.

County adjustments remain, rather than a statewide rate.

Birth and Maternity payment will remain in the capitated rates, rather than adopt the kick payments.

There will be no risk adjustment for general cases over $100,000.
Cost-based reimbursement to FQHC, previously paid to plans that then paid the clinics, will now be paid directly to the clinics and will not be in the rate structure.
$1.6 million will be added back for post-Riverview enrollment as these children will no longer be disenrolled from managed care during hospitalization.
There will be risk sharing between plans and the State for 'Appendix K' children. In place of Appendix K, risk sharing will be based on hospital days:
0-15days: State share is 0%, MCO share is 100%
16-45 days: State share is 75%, MCO is 25%
46-60 days: State share is 90%, MCO is 10%
Over 60 days, State share is 100%, MCO is 0%
All rate cells for all plans were increased by 2.78%. Since some plans had bid below 90% in the October 1997 contract extensions (Blue Care, CHN, Kaiser and Preferred One), the effective rate cells for August 1, 1998 will range from 90.90% to 92.5%, with all plans receiving the 2.78% increase.
Incentive payments based on specified quality standards will be awarded in August 1999, for plan performance during this contract period. Approximately 1% of program expenditures ($4 million) has been added to the program and will be set aside for these incentives.

Council members raised the following issues in the discussion that followed this presentation:

The county adjustment had previously been viewed as an unfair way to assign resources. Indeed the legislature had previously increased money for one county that had lower rates based on the county adjustment. It was unclear why this adjustment was kept. Mr. Ryan stated that there were winners and losers in the adoption of a statewide adjustment and all plans agreed to keep the county adjustment. Dr. Helen Smits (HRI) stated that HRI was agreeable to replace the county adjustment if there were risk adjustments for fertility rates and DCF children as HRI has high fertility rates and a relatively high DCF child ratio.

Concern was expressed that the cost negotiations were not based on competitive bidding, that quality issues should drive this process rather than who (plans) sustains monetary gains or loses and that the target of the negotiation process appeared to be the health plans rather the children served by the program. Mr. Ryan responded that loss of a plan(s) with substantial numbers of covered lives and provider networks would weaken the program through a reduced capacity for services. Mr. Ryan suggested that the number of plans in the program might be a proxy for access. Eva Bunnell stated that the Department has shown a commitment to quality care by inviting plans and advocates to develop quality incentives within the program.

Sen. Harp asked if there is anything planned above the rates and risk adjustments that will ensure coordinated quality care for DCF children. Mr. Parrella stated that DCF has provided a list of issues to be included in the contracts that will improve care. While the risk adjustment created a better opportunity to accommodate DCF children issues within the contracts, DSS now has every intention to incorporate the DCF list into the contracts. Sen. Harp questioned how DCF and DSS will coordinated efforts and who will be responsible for the development of a level of care not now present, that meets less acute, chronic needs outside the psychiatric inpatient services. Mr. Ryan stated that Commissioners Ragaglia and Thomas will be meeting in late July with OPM to address these issues, recognizing that the crucial component is solving the post hospital care availability. Although payment is available to plans, providers and institutions through the risk sharing process between the State and health plans, Mr. Ryan agreed that we can not forget that

children may be in inappropriate settings, based on their level of care needs.

Rep. Nardello requested clarification that incentives are not in lieu of sanctions in areas of unmet performance goals. DSS stated the incentives are an addition, not a replacement for performance standards sanctions.

The concern was again raised by Rep. Nardello that practitioners receive accurate and timely information about patients' continuous eligibility and plan lock-in status through the automated eligibility system (AES). Mr. Parrella stated that the lock-in period will not start until later in the year, perhaps by Fall; continuous eligibility for children <19 years has been started in July with the start of the Husky B program. In the Fall both could be added although the logistics of adding this lengthy message into the system is problematic. DSS agreed with the concept and Rep. Nardello made a strong recommendation that the Department include both in the AES.

Jeffery Walter observed that the issues of program capacity and plan numbers would probably again be raised at the next contract period, and asked if the Department is analyzing the future impact of plan dropout. Mr. Parrella stated that managed care might experience resistance in cost containment beyond reduction of inpatient stays and inappropriate ED use. Other areas of cost savings may be resistant to further savings. While there is a case mix and volume necessary for absorption of administrative costs and plan survival, it is not clear the number of plans needed for program capacity. It is individual plan capacity rather than the number of participating plans that determine program capacity. Mr. Ryan stated that five of the six Medicaid plans have significant membership numbers. The loss of one of these would have significant impact on the system, hence the State's efforts in this contract period was to keep all the plans in the program.

Judith Solomon stated that rates and access is based on a FFS model that is built on assumptions of low utilization, particularly in Dental and EPSDT services. In addition there is no risk adjustment for children with special health care needs and Ms Solomon wondered if there would be a point at which data other than FFS will be used in rate setting. Mr. Parrella replied that the 1915b waiver is predicated on FFS as mandated by federal law, yet may be inappropriate for mature Medicaid programs (IE Wisconsin is 16 years away from FSS yet continues to trend from FFS data). Mr. Ryan observed that the State attempted to move away from FFS benchmarks in the Husky B program and will assess this process and outcome over time. In the interest of creating a competitive process that involves good quality and rates, the State is looking to bundle purchasing in Medicaid and other programs such as the state employee health plans. This is a future plan that will require the cooperation of multiple state agencies.

Sen. Harp thanked Mr. Ryan and Mr.Parrella for the discussion and hoped that although the cost contact process is finalized, the State will continue to look at principles we were not able to adjust to this contract and find a way in the future to develop a more rational system.

Sen. Harp thanked DSS for their continued receptivity to the Council's concerns and ideas and their efforts to upgrade the program in the new contracts, with the addition of new resources to reward outstanding performance. Sen. Harp thanked all the DSS staff for continuing to work with the Council on these often difficult issues to create a program for which we can all be proud.

Follow-up on June council items

Following the June meeting the Council sent a letter to Commissioner Thomas regarding the concerns raised at that meeting. David Parrella reported on the Department's response to the Council requests:

The Department of Insurance requires an independent audit of HMOs entire book of business. The Council had requested a separate audit for the Medicaid book of business. Mr. Parrella

stated that such an audit would be performed on an annual basis.

The inclusion of the lock-in status in the automated eligibility system and the coordination of care for DCF children were discussed earlier in the meeting.

The Council's role in the contract process had been raised at the June meeting. Judith Solomon, Council representative in the contract process, has begun attending meetings with the DSS internal team that composes the new contract language. Mr. Parrella stated that the Department's goal is to have one generic contract, although the additional financial reporting requirements for non-licensed HMOs may remain in the new contract. Once the generic contract is finalized, plans will review it with their legal staff. Any substantive changes will need to be accepted by all plans to maintain a uniform contract for the six plans. Changes will be communicated to Judith Solomon who will keep the Council informed of the process. Sen. Harp thanked the Department for responding to the Council's concerns. While the Council would like a more active role in providing input to the contract process, Sen. Harp appreciates the Department's willingness to accommodate the Council's request.

The Department will provide an analysis of the diagnoses and services associated with the Medicaid highest care costs as requested by Marie Roberto, at the September meeting.

Report on the outstanding receivable resolution

James Gaito reported on the June 24 meeting with provider representatives, DSS and plans. There has been a significant decrease in the unpaid reimbursements, thus a DSS audit is unnecessary. The Department will arbitrate the remaining disputed claims, completing the process by summer's end. Mr. Gaito thanked all participants for their diligence in working to resolve the problem.

CPRO Report: Second Deficiency Audit

Judith Bell described the second deficiency audit performed to review health plan deficiency corrections cited in the 1997 contract compliance audit, mandated by HCFA. Plan-specific data was collected to determine the status of deficiency correction prior to health plan recontracting July 1, 1998. Over six days, all plans were reviewed for uncorrected or partially corrected deficiencies that remained at the close of the business day April 3, 1998. Six of the seven plans were audited (MD and PHS as separate plans); Preferred One had no remaining deficiencies, despite the absorption of two plans into their plan. The following data was reported:

A total of 23 deficiencies across the six plans remained at the time of the audit, with 14 of the 23 involving access availability and member services.

Only CHN-CT and PHS had corrected 100% of their deficiencies by April 3; Blue Care corrected 80%, HRI 67%, MD 40% and Kaiser 14%.

The audit revealed that the six plans are ready for recontracting as they had corrected the majority of their deficiencies as well as the most serious ones. Ms. Bell stated that DSS plan liaisons were exceptionally diligent in follow-up with each plan. The new contracts will stipulate that the remaining deficiencies are to be corrected and DSS will continue to work with the plans. The deficiencies will be corrected. A 1999 operations audit will be performed with a higher scoring standard in place and plans will have to achieve a higher level of compliance to complete the audit without deficiencies. Sen. Harp thanked CPRO for this important work that ensures the quality of the Medicaid program.

Benova Update

Lynn LaPenta, operations Manager at Benova presented a Husky update that will be followed by a month end report to DSS and the Council. The following information about enrollments was

presented:

A total of 1,1014 applications have been received by Benova ; 425 of the 916 prescreening application mailed were returned.

194 cases have been approved for Husky B, with 60% in the 'no premium' band, 30% in band 2 ($30/child/month, maximum of $50/family/month) and 10 % in band 3 (full premium payment).

517 applications are pending (incomplete forms), 272 have been referred to DSS for Husky A eligibility determination.

As of July 1, 86 enrollments have been completed for B, with 62% (53) enrolled in Blue Care.

The call center has experienced a 30% increase in call volume during May and June, with the calls evenly split between Husky A and B information requests.

Outreach activities have been increased with 119 statewide Benova presentations, some of which were at new sites (IE malls, career centers, and thrift shops). Benova hours have been extended to weekday evening hours and Saturday hours.

Council comments included the following issues:

Rep. Nardello raised questions about the implementation of outreach efforts in schools in September. Mr. Parrella replied that Commissioners Thomas and Sergi have met to coordinate September Husky outreach efforts through the school superintendents. In addition, a RFP was recently released for community outreach by schools, clinics and other community groups with funding totaling $5-600,000. Another RFP targeting a media campaign by professional media agencies will be released later in the summer.

Follow-up of Husky A applicants, once the application leaves Benova, is done by manual access of the EMS system because the Benova and DSS systems are different and presently do not interact. Benova can track Husky B application status as they are processed solely through Benova.

Sen. Harp thanked Benova for the update and stated that the discussion underscores the importance of follow-up of Husky A applications and would hope both DSS and Benova can develop a strategy to do this.

DPH Report on the Safety-Net Provider Survey

Marie Roberto and Judy Sartucci presented the results of the Safety- Net Provider survey completed December 1997. The Public Health subcommittee had requested an inventory of the Safety-Net Provider (SNP) system in Connecticut {copies are available in LOB 3000}. As global changes in the health care delivery system have evolved in Connecticut, including increased penetration of managed care, expanded insurance for the uninsured and decreasing subsidies for disadvantaged communities, the subcommittee began receiving reports of a weakening safety-net system. The Department of Public Health (DPH) surveyed SNP, defined as community health centers (CHC), school-based health centers (SBHC), local health departments, non-profit visiting nurse associations (VNA), family planning clinics and public health dental clinics. The in-house survey included information about:

Personal care services versus population-based services

Data gaps where information is unavailable to the Department

Fiscal constraints and limitations on statutory authority that prevent DPH from monitoring SNP

Considerations for establishing a SNP monitoring process.

Suggestions for further research.

The survey revealed apparent gaps in services (CHC) in the western, northeast and estuary areas of the state. What are not known is the economy and health needs of these areas; there may enough private providers to meet the needs of residents in these sections of the state. Seven well

child clinics in Danbury, Lebanon, Windham and Willimantic have surrendered their licenses and it is important to determine where children are now receiving services in those areas. Local health departments are the only SNP mandated by law to provide population based services but most SNPs provide both personal and population-based services. Funding for SNP services through state, federal and local grants and sliding fee payments are all vulnerable to changes in the economy and health policy.

A global assessment of the SNP system is compromised by data limitations and legal constraints as to the scope of monitoring performed by DPH. The survey report concludes that a monitoring and surveillance system very different from what DPH currently has in place would be needed to assess the impact of health care, economic and policy changes on underserved populations. The Public health subcommittee recommends further research by an outside entity that includes:

- Development of a surveillance system for monitoring the status of SNP.
- Identification and validation of SNP performance indicators that includes timely, uniform, client-specific service delivery data and financial solvency information of providers.
- Assessment of the impact of Medicaid managed care on the stability of these providers.

Key questions need to be answered that include the kind of information needed from SNP, the capability and willingness of SNP to provide information and whether SNP should be mandated to provide data. The Department is currently focusing on VNA well child clinics assessments, negotiating with the Yale School of Nursing to undertake this assessment. In addition DPH is also focusing on CHC grant administration and data collection. Rep. Nardello, chair of the Public Health subcommittee, requested that Council members review the committee recommendations and be prepared to comment at the September meeting.

Subcommittee Reports

QA subcommittee. Paula Armbruster reported that the subcommittee reviewed emergency department utilization in the Medicaid managed care program and have invited health plans to attend the July 16 meeting to discuss their internal QM process. An ad hoc meeting of DSS, QA and Behavioral Health chairs and CPRO looked at concrete outcomes for children with special health needs that, in part address family participation and function, a proxy for the success of the intervention. CPRO presented a report on the Prenatal and Asthma patient focused study. Ms Armbruster had recommended that the Discharge Planning study be presented at a joint Behavioral Health/QA meeting in mid-September.

Mary Alice Lee, co-chair of the QA subcommittee expressed a personal opinion in questioning what the prenatal study will add to the program. Further discussion involved the following issues around CPRO patient focused studies:

- Council involvement in the development CPRO studies.
- Financial constraints for patient-focused studies in that DSS and the vendor identify tasks and costs as part of the contract negotiations. The Department has demonstrated a willingness to fund additional projects as the need has arisen. Recently, the Department agreed to have CPRO work with DSS, advocates and home care providers to assess home care services for children with special health needs.
- Consideration of coordination of project design with existing state data and DPH state health plan.

Council members recognize that CPRO has performed valuable work in the validation of the encounter data, which is crucial to quality oversight and the Operational audits that ensure quality health plan management. Sen. Harp requested that CPRO, DSS, and the QA and Behavioral Health chairs meet to clarify the process of Council input in the patient-focused

projects.

Behavioral health. Eva Bunnell announced that the Administration has made funding available for outside consultation to the subcommittee for the development of behavioral health outcome measures. A subgroup of the committee has been identified to begin work on this in August.

The next meeting of the Council will be Friday September 11, 9:30 AM.