

MEETING SUMMARY
SEPTEMBER 11, 1998

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella, James Gaito (DSS), Paul DiLeo (DMHAS), Steve Netkin (OPM), Dr. Edward Kamen, Dr. Helen Smits, Ellen Andrews, Judith Solomon, Dr. Wilfred Reguero, Lisa Sementilli-Dann, Eva Bunnell, Marie Roberto (DPH), Jeffery Walters, Dorian Long for Gary Blau, Loraine Milazzo.

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

DSS Report

MCO Contract Process

David Parrella reported that the consolidated draft for the Managed Care Organizations (MCO) contract would be completed by the end of today, Friday, September 11. Judith Solomon, Council representative was involved throughout the development of the draft contract. The Department's administration and the Attorneys General Office will next review the draft contract, which includes issues raised by the Council, before it is released to the MCOs for consideration. The timetable for the completion of the contract process is dependent in part on the level of review by DSS and the Attorneys General office. Mr. Parrella stated he anticipates that contract negotiations would be completed in October. A contract extension may be necessary as the Department and MCOs move through the negotiation process.

Appendix K

The Appendix K contract negotiations represented long standing issues among DCF, MCOs and institutions relative to how the system deals with the child who is admitted or remains hospitalized beyond medical necessity because of unavailable step-down placement. The goals of this contract were to safeguard the child and family within this system of care as well as resolve some of the financial concerns of the plans and institutions. The Appendix K Amendment removes the child from the center of an adversarial relationship created by financial issues; admission denials based on medical/social necessity will now be addressed through the reinsurance process. The child receives behavioral health care and a safe placement while the institutions and the MCOs are relieved of financial burdens associated with social necessity admissions and/or prolonged hospitalizations. Since the risk adjustment for DCF children was not included in the final cost agreement, this Amendment addresses the specialized inpatient and outpatient needs of this vulnerable population, based on DCF recommendations.

The Appendix K amendment has two reinsurance levels:

Administratively necessary days: on a limited basis (once per child per calendar year), a health

plan may authorize admission for 24 hours observation, paid by the plan at an acute care rate, during which the child's needs can be more fully assessed prior to the 15 day MCO payment obligation. If the plan determines that the admission is not based on medical necessity but there is no immediate placement for the child, the remainder of the inpatient stay will be reimbursed 100% on day 2 by the Department. The plan will pay the institution a negotiated rate and bill DSS for the cost of care. DCF will then reimburse DSS for the rates paid to the plans by DSS. Medically necessary days: the cost for inpatient care, deemed medically necessary by the plan and provided at either an acute or sub-acute level, that extends beyond 15 days will be shared between the plan and the State. Court ordered admissions would be considered medically necessary provided there is consultation with the plan prior to the court order regarding the appropriate level and setting for care.

The Department will review each case retrospectively for MCO costs relative to the level of care and reinsurance level. The payment system, now centralized within the managed care system regardless of MCO risk, creates a claims database that quantifies the volume, level of care and cost of services to this population. This database can be used in the review of and improvement in the present system of care, an effort that DSS, DCF and OPM had committed to at the July Council meeting.

The Appendix K amendment will be implemented in stages that include the following MCO responsibilities:

September 1, 1998

Administrative and medical necessity reinsurance as defined by the contract.

Foster parent training for special equipment or medications.

Designated MCO liaison staff will regularly collaborate with providers and DCF to identify, address and resolve health care delivery issues.

The health plan panel shall include mental health providers qualified to assess and treat sexual abuse and juvenile sexual offenders. DCF will assist in the identification of such providers.

Placement medications will be provided by the plan in addition to standard prescription coverage.

MCO will provide a Notice of Action, delivered to an identified DCF staff, when a service is to be reduced, denied or terminated. DCF will distribute this to appropriate personnel.

October 1, 1998

Discharge planning and reinsurance provisions will apply to all state-operated facilities effective October 1, 1998.

The plan will reimburse the state facility at the rate calculated by the Office of the Comptroller.

January 1, 1999

The health plan will pay for the multidisciplinary comprehensive examination within 30 days of out-of-home care placement. These exams are separate from routine well-child visits.

The Appendix K amendment, developed with institutions' input, has been signed by the health plans (**see Appendix K amendment text at the end of the summary**).

Outlier Costs in the Medicaid Managed Care Program

James Gaito provided 1995 claims data greater than \$150,000 per case, as requested by DPH. The total cost of \$4,462,828, incurred by 21 recipients (.01% of the Medicaid population), represented mainly Medicaid fee-for-service (FFS) as the managed care program began late in 1995. The distribution of claims by diagnosis is:

neonatal 21%,

mental health 16%

digestive disorders 14%

Marie Roberto (DPH) asked if greater specificity of data will be available through managed care to help understand the allocation of resources among such small numbers, given the skewed allocation, especially in the neonatal area. Mr. Linnane (DSS) stated that providers rarely submit more than one ICD-9 diagnosis for claims data, although scrutiny of individual claims data would provide more discrete information about the diagnoses and costs. Dr. Smits (HRI) stated that while most hospital discharges do carry more than one diagnosis, this is less apt to be true for younger age groups. While she would like more information from the HRI database, the data specifics have already been established and it would be costly to request different reporting at this point. Other data resources, such as the CT Hospital Association, could provide more detailed information about specific diagnoses and level of service.

Husky Enrollment

Senator Harp stated for the record that based on the Husky statute, the Medicaid Managed Care Council has oversight responsibility for the coordination of coverage for the Husky program. This oversight was reinforced with the addition of DCF and OPM representation on the Council. The Council will, within the parameters of its statutory responsibility, request information about both the Husky A and B program.

The Department was asked about the current enrollment numbers; however Council staff did not request the Department provide this information, prior to the meeting. The Department indicated a willingness to supply the Council with this information at the next meeting; however Sheila Bell (Benova), present at this meeting, was able to provide the most recent enrollment numbers:

Husky B – 1556 applications have been approved and 1193 children have been enrolled.

Husky A – 3106 calls have been referred to DSS for eligibility processing.

Rep. Nardello asked about the status of the planned outreach endeavor to the schools, observing that many schools have information about children's enrollment status. Sheila Bell stated that state pharmaceutical companies have cooperated in the outreach by supplying over-the-counter pharmaceuticals (IE Calamine lotion) that will be included in the Husky information package distributed in the schools. Rep. Nardello encouraged the use of school enrollment information to target those children not yet enrolled. For example, 70% of the Hartford school children are already enrolled; hence efforts should target the 30% unenrolled children and families. Ms. Bell reported that the Outreach initiative RFP responses are now being reviewed by the evaluation team. The outreach contracts are expected to be completed by the end of September. **The Council requested the Department to present enrollment data and a report on the outreach efforts at the next meeting.**

MCO Quarterly Utilization Data

Senator Harp had requested MCOs attend the quarterly data presentations in order to facilitate discussion about the results with the Council. Kaiser, CHNCT, Anthem Blue Care, Preferred ONE and HealthRight were available to attend this meeting. In the future, health plans will be informed one month in advance of when the data will be presented.

James Linnane (DSS) prefaced the data review with the observation that data for the first quarter of 1998 is missing from Oxford and Kaiser. This quarter's participation numbers may be lower for some services, because of the missing data rather than a decrease in Medicaid numbers. The Kaiser representative explained that their data difficulties are related to the massive system conversion resulting from the merger of

Kaiser with another New York plan. While the new data system allows review of New York and CT data, the conversion of the old system with the new has led to duplicate reporting and inaccurate provider claims submission. Kaiser anticipates persistent data problems in the second quarter but improved data quality by the third reporting quarter.

Behavioral Health

Utilization of these services is with the same range across plans but lower than the fee-for service (FFS) penetration. There seems to be an improvement in utilization compared to the last quarter, however the combination of mental health and substance abuse in managed care data prevents an exact comparison. Dr. Reguero asked if we have data that can tell us if the managed care program is putting the same resources into managing behavioral health issues as we did under FFS, given that the Council has had previous debate about behavioral health spending. The Department stated that conclusions about comparisons of two very different systems is further muddied by the age of the FFS data (4 years old) and trends and technological changes in treatment. Dr. Reguero responded that there have been few changes in behavioral health technology, rather more prominent changes in the delivery system. Dr Reguero stated that taxpayers should know if federal and state funds are being used appropriately. Sen. Harp observed that since 1996, the data utilization trends suggest there may be less spent for these services and requested that the Department present a cost report of individual plan spending for behavioral health and substance abuse that looks at spending trends over the past two years. **The Department agreed to this, stating that this report would take time to organize and would probably be available by November.**

EPSDT

This is an area that has significantly improved under managed care. Utilization is well above the FFS rates; however DSS noted that the FFS rates had been dismal. Improvement was attributed to plans' efforts in outreach and work with the Children's Health Council (CHC), using reports to implement more timely well child visits. Utilization may actually be higher, as confusion over use of appropriate encounter codes may alter the rates by approximately 5%. Mr. Linnane reminded the Council that several codes were allowed under managed care, including state-only codes, CPT codes or in-house codes. HCFA, for the first time, is specifying exact codes that are to be used for EPSDT reporting (CPT). If this draft report materializes as federal regulations, then there will be coding uniformity for EPSDT services, which should provide more accurate reporting of well child services.

Other Services

Mr. Linnane stated that if one assumes that the average person in Medicaid has 2 dental visits per year, this would translate to a quarterly rate of 167/1000 member months (MM). Applying this assumption to the managed care dental data for the large population suggests that people are accessing dental care. However it is unclear if the data reflects more frequent use by only part of the population. Questions remain as to the actual general access of these services and the CHC is studying this. Blue Care was questioned about their vision data that was one-half the overall median range. The MCO stated that specialist exams would not be reflected in their vision carve-out data. The MCO has a large provider network and specialty referrals are not required. **Blue Care will research the numbers, to determine the reason for the low utilization numbers and report back to the Council.**

Inpatient Utilization

The FFS experience inpatient data was 11 discharges/1000MM; this was reduced under managed care to 9/1000MM in the first quarter of 1997. Mr. Linnane stated that the first quarter of 1998 revealed a leveling-out phenomenon common throughout managed care, with the number of discharges unchanged. The first year reduction in hospitalizations is perhaps related to the implementation of new ambulatory services, as well as the effect of managed care efforts to prevent costly hospitalizations. Further cost savings may not be possible in the future in this area.

Emergency Department (ED) Utilization

Another costly service is ED use. Under FFS, hospitals reported emergent and non-emergent ED visits. The Department audited these reports and hospitals had to pay back the difference in visits (\$100/emergent visit versus \$23.75/non-emergent visit) to DSS for those visits improperly coded. Under managed care, this coding differentiation is not done, making comparisons of the FFS data difficult. Managed care plans have created tracking mechanisms and follow-up procedures to control ED use and DSS stated that it appears that general ED utilization is less than FFS. The Department may consider more in-depth ED visit reporting by the health plans as recommended by the Quality Assurance subcommittee (see subcommittee reports).

Sen. Harp observed that CHNCT had consistently lower ED visits during the past several quarters; however in this last quarter had doubled their number of visits. The MCO responded that while they cannot explain this aberration from previous quarters performance, the company does monitor after-hours primary care provider (PCP) availability, reviews emergent and non-emergent visits, using outreach to address member inappropriate ED use.

Prenatal

Managed care does not appear to be doing as well as the general population in accessing timely and appropriate prenatal care and in low birth weight (LBW) rates. Issues that impact prenatal care access were identified in the ensuing discussion:

The number of recommended prenatal visits (80%) is dependent upon when, during the pregnancy, the woman enters managed care. Prenatal care rates are better for those women enrolled in the plan in the first trimester. Dr. Smits (HRI) observed that there are a disturbing number of pregnant women enrolling in managed care late in the pregnancy who had previously been in Medicaid FFS. They may have received timely prenatal care in FFS but this would not be captured in the MCO data. Dr. Smits stressed the importance of quickly processing the pregnant woman's enrollment in managed care from FFS in order for the plan to provide care coordination. Judith Solomon stated that many women come into Medicaid because of pregnancy, often through Healthy Start programs, that are eligibility sites. Healthy Start and the MCOs are developing a Memorandum of Understanding (MOU) that should improve care coordination and provide a more timely transition from FFS to Medicaid managed care. Lisa Sementilli-Dann reported that the Women's Health subcommittee recognizes that the contract process and Medicaid program is more focused on children's eligibility, less on Medicaid women's issues. While the Healthy Start MOU is very important, Ms. Dann stated that it represents only one aspect of women's eligibility issues in Medicaid. The subcommittee will be addressing these issues in the October meeting.

The HRI prenatal data is incorrect, according to DR. Smits. There was a data glitch that resulted in HRI's "percentage of deliveries with no prenatal care while in the plan" (23.1%) being

significantly higher than other plans. **The MCO will correct this and provide the Council with the corrected data at the October meeting.**

Pregnant women with a substance abuse (SA) diagnosis are less apt to access prenatal care, according to Dr. Smits. While the plans present reported linkage of SA services with prenatal care, Jeffery Walter observed that SA treatment utilization is consistently low in the managed care program, perhaps because over 70% of participants are children. In view of some of the outlier cases presented earlier, Mr. Walter wondered if early access to treatment would have prevented problems for the mother and child. Mr. Walter suggested collecting and reporting SA utilization data that reflects this group's access to treatment. Eva Bunnell suggested that the Council request MCOs to report on their care plan development that addresses case management and linkage of prenatal care and substance abuse. **Sen. Harp asked health plans to prepare an overview of their prenatal and Behavioral health service linkage for the October or November Council meeting.**

Rep. Nardello requested the Department present a report to the Council on the timing and method of implementation of the plan lock-in program change. Plan lock-in seeks to improve continuity of care and reduce provider administration burdens; however Rep. Nardello expressed concern that the proposed implementation may not reduce the latter. The Department will present this information at the October meeting.

Council Vote on SNP Recommendations and Quarterly Report

Safety Net Provider (SNP) Recommendations

The Public Health subcommittee recommendations were reviewed at the last Council meeting. The main recommendation and issues, as outlined by Rep. Nardello were:

- Design of a surveillance system for SNP monitoring.

- Identification and validation of performance indicators by SNP entities.

- Further legislation will be required to pursue the recommendations.

There was no discussion; the recommendations were so moved, seconded and accepted by voice vote with no opposed nor abstentions noted. The subcommittee recommendations will be included in the next council quarterly report and be included in the legislative action items for the next session.

Council Quarterly Report

There was no discussion; acceptance of the report was so moved and accepted by voice vote with no opposed or abstentions noted.

Subcommittee Reports

Women's Health

The subcommittee has developed a mission statement and beginning work plan. Eligibility and lapses in eligibility for women in the Medicaid program have been prominent in the discussions. On October 14, 10:30AM in LOB 1A staff from the DSS eligibility unit will present a forum on eligibility requirements. This will provide the basis for subcommittee recommendations to simplify adult eligibility as well as contribute to the DSS proposed plan regarding insuring uninsured adults of children in the Medicaid program, due to the legislature January 1999.

Quality Assurance

A copy of the subcommittee report on Emergency Department (ED) was given to the Council. ED utilization varied by health plan, with Kaiser and Preferred One having the consistently lowest rates, whereas PHS consistently reported the highest utilization rates. Health plans report various 'best practices' that may account for plan ED use variation. These include:

Expanded clinic hours for improved member access of the PCP system.

24-hour telephone nursing triage with follow-up calls to ensure members received appropriate care.

Plan follow-up with the ED and the member's PCP for ED visits.

Outreach visits for those members that exceeded the plan's threshold number of ED visits.

The subcommittee plans to reconvene the plans to further discuss ED utilization, best practices and potential health plan collaboration in reducing ED use.

Further, the subcommittee recommended that DSS request MCOs report ED utilization by emergent/non-emergent visits. This will provide a better assessment of the impact of managed care on this costly service as well as an indirect assessment of the use of the primary care provider system. Rep. Nardello applauded the report, stating that identifying best practices in a collaborative setting with health plans is an effective approach to ensuring members are provided quality care. Rep. Nardello credited the health plans with implementing excellent strategies to reduce ED use and improve PCP access.

Sen. Harp announced that a Consumer Access subcommittee, Co-chaired by Ellen Andrews, will be added to ensure consumer input into the program. Sen. Harp expressed the hope that DSS will work with this subcommittee. The Council Chair is aware of legal issues around fair hearings and the subcommittee will ensure that no legal boundaries are breached within the work of this group. Ellen Andrews stated she welcomes suggestions and potential participant information as the subcommittee moves forward in the development of broad-based consumer input into the Medicaid managed care program.

The next two meeting of the Medicaid Managed care Council will be:

***Friday October 9 10:00 AM {note time change} LOB RM 1 D**

***Friday November 6, 9:30 AM LOB RM 1D**