

**MEETING SUMMARY**  
**JANUARY 22, 1999**

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, Dr. Kamen, Dr. Wilfred Reguero, Robert Gribbons (Comptroller Office), Lisa Sementilli-Dann, Marilyn Cormack, Judith Solomon, Eva Bunnell, Ellen Andrews, Marie Roberto (DPH), Dr. Leonard Banco, Gary Blau, Dorian Long (DCF), Janice Perkins (MD), Laraine Milazzo, Arthur Evans (DMHAS), David Parrella, James Gaito (DSS), Jeffery Walter, Cynthia Matthews. Also present: James Linnane, Rose Ciarcia (DSS), Dr. Tom Van Hoof, Judith Barre (Qualidigm), Paula Armbruster, Mariette McCourt (Council staff).

**DSS Report**

Contract Status

The Department of Social Services expects the start date of the new contract to be February 1, 1999. All plans are on a one-month extension, until the end of January 1999. In view of the concerns raised in the Department's decision not to renew a Medicaid Managed Care contract, the Department believes that the new contract provisions will provide more effective monitoring and regulation of the behavior of health plans in the HUSKY program.

Transition Plans

David Parrella stated that in the first week of January the Department notified HealthRight (HRI) that DSS intended to allow the HRI contract for HUSKY A and B to expire at the end of January 1999. This decision was based on:

A pattern of program compliance issues with HRI.

The results of the investigation of the Attorneys General Office (AG) of ongoing issues, with the most acute involving the delivery or lack of delivery of behavioral health services to HRI enrollees.

The results of an onsite visit performed by Mercer of the two of the unlicensed health plans, CHNCT and HRI. The results confirmed problems involving organizational structure and compliance issues that had been of concern to DSS.

The Department has notified, by mail, all HRI clients and health providers of this decision not to renew the HRI contract. The Department presented HRI and their legal counsel with the terms of a transition agreement that will allow for the orderly movement of 34,000 members to the remaining HUSKY plans. Given past experiences with the Oxford transition, DSS recognized the time and effort that is required for a smooth transition of a large number of enrollees. The Department outlined the following processes included in the agreement:

HRI will continue to give services through the end of April 1999 and be responsible for outstanding contractual obligations and claims 90 days beyond April 30, 1999.

Financial withholds and other measures have been included in the transition agreement to ensure HRI compliance with the agreed-upon process.

Birch and Davis, a management company that has performed monitoring services in other states,

is currently the monitoring entity on site at HRI. The monitoring functions include decision making regarding medical necessity authorization of physical and behavior health services and oversight of administrative functions such as claims processing and payment. Birch and Davis will assume the level of review that was previously done by the Medical Director.

Pro Behavioral Health became the behavioral health carve-in for HRI January 1, 1999. Pro BH will continue to work with DSS and HRI during the transition phase, ensuring continuity of behavioral health services.

The Department and the remaining plans have reached some agreement for the transitional process as it effects these plans' function in continuing care in a manner that will not have an adverse effect on enrollees. The Department has been working closely with the other plans regarding authorization and care, reinforcing the continuity of care policy previously established by DSS to ensure no interruption of care plans as members move to other plans. Mr. Parrella stated that all the remaining managed care plans have been cooperative in beginning the transition phase.

The first population to be moved from HRI to other plans was approximately 1300 DCF children Commissioner Ragaglia and then-Commissioner Thomas determined that, given the seriousness of the behavioral health service problems, transition of these child would begin prior to the end of January. A written notice to foster parents was sent by DCF on December 30, 1998 indicating the DCF decision to change health plans based on the "desire to enroll our children in more appropriate plans". The decisions regarding the transition process were based on an agreement between the two departments.

Mr. Parrella stated that the transition is a serious challenge to the HUSKY program. The Department is saddened that this decision had to be made given the three-year relationship established with HRI and the plan's providers. Faced, however, with the clear issues identified within the program oversight and those of the AG office investigation, DSS felt that it was not in the best interests of the clients or the Department to continue this business relationship. Mr. Parrella declined to elaborate further on the HRI issues at this time. Since the case has not been filed in court, neither DSS nor the AG office can speak further about the specifics of the case. As the case proceeds, probably throughout the summer, DSS will report on the process to the Council.

Council members supported the Department in taking these difficult but necessary steps to ensure the continuation of the quality of the Medicaid managed care program. Council discussion is summarized as follows:

Complete data reporting and timely claims payment by HRI are of concern, based in part upon the experience with the Oxford termination in which data reporting stopped at the end of the plan's contract period. Absence of this data impacts on the HCFA 416 reports of the overall HUSKY program. Mr. Parrella stated that the transition agreement includes measures to ensure HRI compliance with outstanding obligations. The reality, however, is that it will be difficult getting data from a non-existent agency in May 1999. Timely payments are of serious concern to the Department and DSS will do everything that can be done to ensure that there is no interruption in the processing and payment of claims.

The letter from DCF (12/30/98) regarding the need for foster parents to change health plans appeared to indicate there was no choice in plan selection. The Department stated that Benova did receive calls, although the volume was low and most children were assigned plans by the 15th of January (see Benova report below).

DSS was asked if there will be an effort, after the case is settled, to begin looking at other

HUSKY contractors to ensure that problems are not occurring in other areas. Mr. Parrella responded that the genesis of the investigation process stemmed from a global concern about the delivery of categories of services. Complaints against a variety of plans were investigated and it was determined, in the opinion of the AG office, that there existed a unique situation involving HRI. The Department stated that DSS would continue to look at other entities.

Senator Harp observed that quarterly data and other reports did not reveal the HRI problem to be as serious as the AG discovered, to the Oversight Council. The Senator asked DSS to respond, considering what questions the Council could have asked that could have alerted the Council to the serious service problems and the missing communication links between agencies, especially the Children's Health Council, that would have identified patterns that would have identified problems.

The Department stated it had been aware of the HRI problems, as was the AG office, for over a year, but DSS was constrained because of the investigation. There are reports that DSS can share with the Council, such as quarterly utilization reports, but that behind such reports there has to be validity and sincerity on the part of the plan of what is reported in the monitoring process.

Aggregate reporting of data gives little depth to the issues. This data can reveal how much service occurred or what someone wants you to think has happened but these reports, in themselves don't reveal the quality of service. The Department has learned that there is no substitute for hands-on chart review in addition to data collection. The Department continues to believe that managed care in the HUSY program is a good idea; however it has to be accompanied by effective oversight. While the Department did the best it could with given resources, DSS takes the responsibility for not implementing adequate oversight in certain areas. Mr. Parrella stated that the most useful monitoring over the past three years was the site visits by Qualidigm, in which operational measures were assessed and plans provided correction processes to address deficiencies, followed by deficiency correction audits.

Judith Solomon (CHC) stated that monitoring utilization data identifies outlier problems.

Anecdotal reports such as calls to the CHIL allow trend identification that have been brought to the attention of DSS. Senator Harp suggested that this also should be regularly shared with the Council. Ms. Solomon observed that it is everyone's responsibility to use the grievance process. The grievance data suggests there is a low use of this process compared to the number of anecdotal reports that identify service problems. Ms. Solomon noted that the new contract intermediate sanctions will allow earlier problem identification and a response by the State payer before the issue becomes so severe as to require termination.

A major problem that the HRI issues revealed was the inadequacy of the current contract to ensure parent plan oversight and DSS monitoring of the subcontractor performance. While all plans use at least one subcontractor for various services (all but Kaiser use a behavioral health subcontractor) HRI had the greatest overall reliance on subcontractors, perhaps too much so for the client's safety. The new contract has attempted to correct this, with sanctions tied to subcontractor performance and parent plan responsibility for performance standards.

In response to Rep. Nardello's observation that the State generally fails to provide adequate resources to agencies for systems monitoring, Mr. Parrella stated that the issue may not be more resources, rather the kind of resources needed for adequate monitoring. The evolution of managed care within DSS highlights the lack of appropriate resources available to the Department as the system changed from FFS to managed care. In 1994, the DSS staff knew little about managed care, yet developed this system within 1 and one-half years with the addition of only two to three more full time staff. Mr. Parrella stated that James Gaito, Rose Ciarcia and

James Linnane adapted to the managed care process and he is proud of their work. Now, as the program has evolved into one of the largest fully capitated Medicaid managed care systems in the Northeast, decisions have to be made about ensuring the quality of the program. The Department has to consider whether to bring in staff with actuarial, insurance and managed care contracting backgrounds. Obstacles to accomplishing this are agency budget constraints and government job specifications that do not specify the skill sets needed to meet the challenges of the changing health care system. Mr. Parrella will be discussing the overall management of the Medicaid managed care system as well as oversight of behavioral health services with the new Commissioner of DSS when he/she is appointed.

Marie Roberto (DPH) stated she appreciated DSS honesty in discussing issues involved with program development and oversight. Agencies face constraints in developing new programs, providing technical assistance as well as oversight that includes surveillance, monitoring and regulation within that same agency.

When asked about the linkage of other agencies and the communication processes, Mr. Parrella stated that the Department of Insurance (DOI) was asked to take a role in licensing health plans in the Medicaid program. Since Medicaid is not a risk program, rather an entitlement program, the DOI did not consider Medicaid regulatory functions under its purview. One would question if this is the best way to regulate Medicaid managed care in the future. Mr. Parrella reminded the Council that in waiver hearings three and one-half years ago there was a consensus that unlicensed plans such as Federally Qualified Health Clinics (FQHC) should be permitted to participate in managed care. The Department is not advocating excluding licensed health plans; still the issue remains as to where the regulatory authority or partnership should be focused. Mr. Parrella stated that the Mercer audit of both HRI and CHNCT revealed a favorable report of CHNCT in the fiscal solvency and operational and structure assessment.

Rep. Nardello stated there has been communication that suggests there is cost shifting from the Medicaid managed care program to agencies that deal with mental health. Rep. Nardello asked the Department if we could agree this issue would be looked at in the future. Mr. Parrella stated that cost shifting is tightly tied to the HRI case and he could not elaborate about this issue at this time.

Senator Harp stated that we know that various departments are serving the same or similar populations; how do we know who is paying for what and how is this communicated among departments? A question unrelated to HRI, rather to HUSKY A and B enrollment, has been raised in the legislative Public Health Committee that illustrates these concerns. Is there a disincentive for hospitals to enroll patients who present to the ED in the HUSKY programs because the hospital needs a critical mass for uncompensated care monies that allow the institution to meet its budget? Is the hospitalization and care rates set so low that it is not in the interest of the hospital to encourage enrollment because of the adverse effect on the DISH payments? Senator Harp observed that the State no longer regulates rates in order to encourage business and the benefits of competition; yet we may in fact be creating cost shifting back to the state/federal government. The Senator asked the Department to think about this as a general policy issue, and at a future Council meeting, define how DSS protects itself from this and if there are mechanisms in place to identify cost shifting when it occurs.

Mr. Parrella observed that uncompensated care distribution is a complicated process; however there are federal guidelines that govern this. Medicare shortfalls (the difference between allocated uncompensated care costs and hospital charges for the care) cannot be included in the Disproportionate Share Payments (DISH) payments. Medicaid shortfalls can be included in the

DISH payments. Hence the distribution of DISH monies is higher in inner city hospitals that care for larger numbers of Medicaid and uninsured, lower income patients. Rural/suburban hospitals have larger Medicare populations rather than Medicaid, and thus receive less DISH monies. How this effects HUSKY A and B enrollments is unclear. Health regulation is a factor in Connecticut. The State still has a Certificate of Need for hospitals and we have no for-profit hospitals as other states. The licensing bylaws mandate hospitals to give care regardless of ability to pay. This is an important safety net. States that have for-profit hospitals find that these hospitals close their ED and patients have to travel distances to a not-for-profit hospital in order to receive care. Senator Harp stated it is important to consider the potential for enrollment disincentives as the State attempts to expand insurance to the uninsured. This is especially relevant to urban hospitals in which many uninsured access care through the ED.

Senator Harp closed the discussion with the observation that the Council and the Department are partners in the Medicaid program. The Council has been clear in its position that it is important for the program to work both for the people it serves and those who work in the program. The change from FFS to a fully capitated system involves a cultural change that requires support which the General Assembly did not always provide. The Council can often express the needs of the Department that DSS cannot express. That is the Council's use to the Department and when it cannot do that perhaps it should cease to exist. As an oversight Council, there is a sense of failure about the HRI issues, in that we didn't prod the Department enough, didn't demand enough from the Governor and OPM level to give the Department the tools needed nor scrutinized at a deeper level what happens in the program. Senator Harp expressed confidence that as we move forward together we will be committed to do this. The Senator stated she is proud of the work DSS has done; aspects of the HUSKY program are considered the best in the country.

The Senator challenged the Council to consider the kinds of recommendations to DSS and the level of information that is needed for Council oversight. Dr. Kamen stated that a systems approach that includes scrutiny of the organization leadership, community commitment, performance processes and outcomes is needed to verify the level of excellence we are striving for.

### **Plan Capacity**

During the negotiation process the Department was concerned about the impact of the potential loss of plans on program capacity. This discussion is a general description of the use of a statistical model to monitor plan capacity as well as capacity projections of the re-allocation of HRI membership among the remaining plans. Data sources for the determination of plan capacity are MCO membership provided by Benova and EDS data of provider networks. Fee For Service (FFS) 1994 data is analyzed to determine ratios of client to providers by broad specialty. The following ratios have been established, based on 1994 FFS data:

Adult primary care: one adult PCP/387 members.

Children's primary care: one Pediatric PCP/301 members.

Women's providers: one provider/835 members.

Dental providers, including general and pediatric dentists: one dental provider/486 members.

Behavioral health providers, including psychiatrist, psychologists, social workers and nurse practitioners by specialty: one provider/459 members.

The enrollment cap for each county is based on the multiplication of providers by specialty in the county by historic FFS ratio of clients to providers. For example, 2 Dentists times 486 = 972, which is the enrollment cap for dental providers. The enrollment cap for each county is

compared to the membership numbers. If membership is 90% of the cap, the MCO is monitored monthly by DSS. If the membership exceeds the enrollment cap, the MCO is given 30 days notice for corrections that involves documentation that sufficient providers have been added to that plan network. Failure to correct the problem results in an enrollment freeze. At this time, Kaiser enrollment is frozen throughout the State. They have exceeded the enrollment cap in Fairfield county, as they are at 225% of the cap.

In an attempt to answer the question as to whether the four remaining plans that can accept new members have the capacity to absorb HRI members (34,000) certain assumptions are made when calculating a projected analysis of HRI re-allocation. One assumption, based on Benova data, is that enrollees change plans based on where their providers are. Many HRI providers are probably in other plan networks, with the exception of HRI sole unique providers such as the community health clinics that will probably join other plans. The projection suggests that the only county that would be at capacity with the HRI re-allocation is Windham County, which would range from 97 to 100% of the enrollment cap across the four plans. When the CHC's join other plans, this would expand that plan's network and would change the capacity percentages. Council comments addressed two areas of concern:

Can membership lists be sold? DSS emphatically stated no, that confidentiality laws prevent this. Further, plans will be expected to adhere to the revised marketing guidelines in the new contract. Providers may belong to more than one plan, which when numbers are combined exceed the cap. The Department stated that an analysis of PCP capacity is made across plans that takes this into account.

Providers can determine the percentage of Medicaid clients they want to include in their practice; thus the provider's internal Medicaid capacity would reflect a different capacity level from that of the PCP/membership ratio. Janice Perkins (MD) stated that plans monitor which providers are not taking new members. In addition, DSS does collect access information that includes appointment wait time, availability of PCP to the Medicaid client.

These issues are not unique to Medicaid managed care or FFS; commercial health plans experience full provider panels also. The Council will request capacity updates from the Department as the transition process continues.

### **Quarterly Utilization Data**

Utilization reports look at services on a population basis and allow identification of trends in utilization.

Success story is the HealthTrack data, which has shown a gradual improvement over FFS. New contracts include incentives to encourage improved participation. Health plans worked with Chris Edelwich (DSS) to develop a uniform face sheet that includes all components of the screens. This tool will allow providers to track EPSDT services for each patient. The Department is considering having Qualidigm look at the charts, comparing the information on the face sheet with that of the chart.

Behavioral health data is comparable to FFS penetration rates, yet continues to show fluctuations that confound an assessment of appropriate access.

Emergency Room utilization shows levels well below FFS; health plans will be reporting ED visits by true emergent/non-emergent visits in the future, providing a more realistic comparison.

Prenatal Care percent of visits is average. The percentage of women receiving care in the first trimester is well below the general population; however this number reflects, in part, when the women enters managed care. Over the last four quarters, less than half (43%) of the women receiving prenatal care in the HUSKY program were enrolled in HUSKY during the first

trimester.

Council members were asked to send questions regarding plan performance in the utilization data to the Council staff and these will be forwarded to DSS.

### **Qualidigm EPSDT Data Validation Study**

Dr. Judith Barr presented the EPSDT study that validated the completeness and accuracy of the electronic database for services provided between 7/1/96 through 6/30/97. The initial sample included 909 children, continuously enrolled in the same plan for 11 months who received their 24-month visit within 30 days of the second birthday. Of the 909 cases, only 383 cases were included in the study in part because:

- 44% of the medical records were available

- 23% were unavailable

- 21% of the providers were not found.

The data quality indicators are agreement rate for Medicaid ID number, DOB, gender and health plan. The processes of care indicators included the average number of preventive services performed, including immunizations, average number of EPSDT visits per recipient and number of cases that received a 24-month visit. The results revealed:

- One-third of the Medicaid ID numbers did not match and 21% of the practitioners could not be found; provider identification information was inaccurate in many cases.

- 60% of the sample had an EPSDT visit within 30 days of their second birthday.

- 94% of the children had at least one preventive service

- Preventive services: only **60%** had a history, **47%** a physical exam, **68%**

- developmental/behavioral assessment and **43%** a blood lead level documented on the chart. The rates for Tuberculosis test (**22%**), vision (**22%**), hearing screen (**21%**), dental fluoride assessment (**10%**) were among the least performed services.

### **Qualidigm Study Observations:**

- Medicaid Id was not on the chart in one-third of the audited charts. This may reflect the different system used by plans, in that a plan ID is used, and converted to the Medicaid ID number by the plan when the encounter data is reported to DSS.

- Charts may not have been available (23%) because care is delivered in a multi-site clinic; the chart follows the patient and may not be at the central site at the time of the audit. Qualidigm did notify the clinic of the planned audit ahead of time and requested chart availability.

- Children with a 24-month EPSDT visit had a greater likelihood of being up-to-date on immunization than those who did not have this visit. The overall 80% rate may not reflect true immunization rates as these services may be provided outside the managed care system for some children.

- Low percentages of preventive services may reflect documentation problem.

Council concerns related to the study are as follows:

- Non-uniformity of definitions: EPSDT codes relate to a comprehensive visit, whereas the study reviewed any visit (could have been a sick child visit) at the 24-month time period.. Comparing the EPSDT code to the chart documentation would have fulfilled the initial stated intent of the study that was to assess the comprehensiveness of the visit, identify those elements of a comprehensive visit that were most often missed.

- The Department's purpose of the study was to match the encounter data with the medical record as part of the broader Data Validation study. DSS wanted to look at EPSDT services, but Mr. Linnane stated he had not known the details of the study. Qualidigm stated repeatedly that the three studies almost always involved database problems and the Department was kept informed

on a weekly, sometimes daily basis.

Sen. Harp stated there has been a consistent pattern, in which the initial intent of the project changes at mid-point and the final product is other than what was expected. A communication process had been in place that would have allowed information to be given to the QA subcommittee and the Council when changes in a project were necessitated by unforeseen factors. That communication process was not used. The Council will submit recommendations to the Department, who is ultimately responsible for project outcomes, that will rectify this problem.

Database problems have been addressed through the diligent work of Qualidigm, plans, Medstat and DSS and the expectation is that as the Department goes forward with future projects, data from July 1998 on will be of better quality.

The percentage of missing records is of serious concern and needs to be addressed. DSS has included two provisions in the new contract that address this:

Plans must have a centralized record of services

Plans will submit a specified number of charts per claim type per year to Qualidigm for review.

In addition DSS has taken corrective action with the plan (not publicly unidentified) that had a 5% chart availability in the EPSDT study.

### **Benova Report**

Data presented from 6/1/98 through 1/19/99:

Total HUSKY B enrollments: 2692

Total HUSKY B approvals: 2928

Applications referred to DSS for HUSKY A review: 7,111. *Council requested that future reports include the known disposition of these referrals.*

Total HUSKY A enrollment: 226474.

Break down of HUSKY B enrollments:

**By Plan:** (MD does not participate in HUSKY B)

**ABC HRI CHNCT Pref-1 Kaiser**

1596 485 177 357 77

### **Age Group:**

**<1 YR 1-5 6-10 11-15 16-18**

90 745 814 754 289

### **Income Premium Band:**

**Band 1 Band 2 Band 3**

1751 851 90

HRI enrollments: As of 1/199: 34,194 members. As of 1/20/99: 31321 members.

Of the 1280 DCF children in HRI that need to change plans, 1080 have been moved. *Benova will provide the percentages of the children assigned a plan versus choice at the February meeting.*

Dr. Roberto raised the question, based on the Benova data of the 'plan change' reason related to pharmacy access, if this represented enrollees changing plans because they could not get prescriptions. Rose Ciarcia commented that DSS did instruct pharmacies to access the AES system, using that information as the final word in eligibility/plan status in filing prescriptions for Medicaid clients. While this information may be different from what the client is reporting,

this system would verify the enrollee's status. The Department hopes that the institution of plan lock-in will encourage enrollees to resolve problems at the plan level rather use plan changes as a resolution strategy.

**The next Council meeting will be Friday February 19, 9:30 AM in LOB RM 1D.**

The Agenda will include:

DSS report on:

Plan transition process

Contract implementation

21 month Exit interview and Safety Net numbers, the Employment Success Program and continuity of Medicaid coverage.

Legislative report summary: Uninsured adults plan.

Outstanding claims resolution.

DPH VNA well child clinic survey

Benova report

Opportunity for Health plan response to the Data Validation/EPSTD study.