

**MEETING SUMMARY**  
**JULY 9, 1999**

**Present:** Sen. Toni Harp (Chair), Sen. Edith Prague (Vice-Chair), James Gaito (DSS), Gary Blau (DCF), Marie Roberto (DPH), Holly Miller Sullivan for Paul DiLeo (DMHAS), Robert Gribbon (Comptroller's Office), David Guttchen (OPM)), Cynthia Matthews (Com. On Aging), Dr. Edward Kamen, Ellen Andrews, Judith Solomon.

**Also Present:** James Linnane and Rose Ciarcia (DSS), Paula Armbruster, Mary Alice Lee, Debra Russo (Qualidigm), representatives from MCO's (Anthem BC, Health Choice, PHS, Kaiser, and CHNCT), and Mariette McCourt (Council staff).

**DSS Report**

**Kaiser Exit**

James Gaito reported that Kaiser Permanente has announced the decision to cease all health care operations in the Northeast Division, which includes New York, Massachusetts, Vermont and CT (Kaiser has commercial and HUSKY A and B lines of business in CT) by the end of the 1999 calendar year. Kaiser is discussing with other insurers the potential to sell aspects of their business. The Permanente Medical groups, incorporated separately from Kaiser, will continue to exist, contracting with other health plans. This will provide an opportunity for both commercial and HUSKY members to remain with their providers. The Department will report on the Kaiser phase out process at the September Council meeting.

**Outstanding Receivable Claims**

Mr. Gaito reported that the Department, MCO's, and Methadone/substance abuse providers have met over the past 18 months to resolve the reported \$2.3 million disputed accounts receivables. As part of the final stage of the process, the Department developed a mediation process for final resolution of the claims. Of the 13 providers initially involved, only one provider group, CT Counseling Centers, responded in the affirmative to the DSS letter to providers regarding participation in the mediation process. Mr. Gaito stated that a number of organizations were satisfied with the resolution process. The Department will continue to work with Community Mental Health providers with the more recent submission of disputed claims, establishing contact points with providers and plans. In both processes, Linda Tatarczuch of the CT Association of Community Providers has facilitated the resolution process. All parties have worked very hard to resolve the initial set of claims from the Methadone providers and it is expected that this cooperative process will continue with this second set of claims.

**Quarterly Utilization Report**

All the Health plans were invited to the table for the discussion of the HUSKY A quarterly data report, based on MCO encounter data submitted to DSS as required by

contract. James Linnane reviewed highlights of the data that had been distributed to the Council (18 pages, which are available in LOB RM 3000), focusing on BH and EPSDT, as changes in the periodicity schedule makes comparisons with other EPSDT time periods difficult. Connecticut has joined with the National Association of State Medicaid Directors, a subsidiary of the American Public Human Services Association, which is working with NCQA in developing comparisons of state Medicaid data. Mr. Linnane presented data comparing CT's data with national data.

#### *Behavioral Health (BH)*

There was a continued decline in utilization of all BH services across all six plans (Kaiser data was incomplete for SA) in the 4<sup>th</sup> quarter of 1998. There is no clear explanation for the gradual decline in BH services since the 1<sup>st</sup> quarter of 1998, according to DSS. Council members raised the following issues regarding:

##### Data collection:

DSS stated that some psychiatric home visits may not be included in the encounter database, as they do not meet HEDIS specifications. HEDIS requires the provider be a MH provider and specifies CPT codes for specific interventions in in-home psychological treatment. At present, some providers in Health Choice (Preferred-One) may not meet the HEDIS criteria. Health Choice stated that in addition, CPT codes change yearly, (January) with new codes added and old ones dropped; provider adjustment to the changes may contribute to services not included in the data report.

While there remains problems in subcontractor data reporting, DSS stated that CT has the best encounter data in the country. The Department is continuing to work on improving data reporting and expects to review psychiatric home visit standards and coding that will capture this service in the encounter data.

Senator Harp stated that changes in one plan's treatment protocols (i.e. home care used by P-1) should not influence the overall data that shows lower utilization this quarter, preceded by a continued decline after the 1<sup>st</sup> quarter (98). These numbers suggest an ongoing problem with Behavioral Health service delivery. Mr. Linnane stated the Department is concerned and is looking at this.

Health plans were asked for their comments about the declining BH rates. Only Preferred One responded, stating that they had implemented a new program for reporting with their subcontractor and will be applying this new program to past data for an improved retrospective assessment of service. The plan also commented on the HEDIS changes that providers may take time implementing, effecting the data reports. In response to a comment that while the program may broaden definitions that change data, this makes it difficult for retrospective comparisons, the Department agreed that it is important to measure change in a consistent manner across quarters, yet allow innovative approaches to BH to be implemented.

##### BH service delivery/plan practices:

DSS was asked if the penetration rates are at all correlated with overall denial rates for service and has DSS asked the BH subcontractors to address BH rates with the Department, linking providers and enrollees or changes in subcontractor carve-ins. The Department stated that there is a constant dialogue on a case-by-case basis between DSS and the plans; however it is hard to correlate claims (or denials of service) with the data reports.

Oversight of plans' accountability for implementation of new services: the Department was asked if plans are free to change the way in which service is delivered. Mr. Linnane stated these

are treatment –based clinical decisions that the MCO makes when requiring authorization. Senator Harp stated that while she recognizes the importance of innovative treatments certain activities such as psychiatric home care need a strong definition of the service and the need for such service. Mr. Linnane agreed that this is important and DSS and the MCO’s will be developing a definition of home care and provider credentials as well as defining the CPT codes to be used.

In response to a question about the impact on HUSKY of mental health parity included in the Managed Care bill passed in the 1999 legislative session, Mr. Linnane stated that parity has always been in HUSKY A, in that there are no limits on BH care.

EPSDT/Healthtrack

There is a decline in EPSDT participation this quarter 1998 (4<sup>th</sup>) as compared to the last quarter influenced by the implementation of the new periodicity table and the unusually high rates in the 3<sup>rd</sup> quarter, related to school physicals. Participation and screening rates are twice as high in the two youngest groups (0-2) as compared to the two oldest groups (15-20), a pattern seen across all plans.

The primary increase in the periodicity table screens is for the older groups, doubling the number of screens for the 15-18 year olds. The number of required screens remains unchanged for those 5 years and younger, yet the participation ratio for the 1-5 aged group is lower in this quarter (59.9%, the average for the two age groups) compared with the 4<sup>th</sup> quarter 97 (69%). This age group showed a marked increase in screens in the 3<sup>rd</sup> quarter (85%), despite their noninvolvement in school at that age.

The following table summarizes data presented by DSS:

Median EPSDT Screens	1998	1997	1996
% total age 3-6	64.4%	61.1%	58.9%
% total age 12-20	36.5%	32.5%	22.2%
Overall screens 98(4)	58% (4 <sup>th</sup> quarter)		

Marie Roberto stated that one would expect the 0-5 aged group to have a higher rate because of health care contact for immunizations, yet this group’s rate remains well below the targeted 80% participation rates. This suggests that improving well child care (WCC) is a multi-faceted problem involving client and provider based issues and/or reimbursement issues. Judith Solomon stated that while EPSDT services are based on the American Academy Pediatrics (AAP) standards, the locus of control for WCC shifts from the consumer (in the commercial market) to the state in federal programs. The state, through managed care, delegates the responsibility to the MCO’s who partners with the providers in ensuring that WCC is received. The member’s role is not clearly defined. Several suggestion were offered to improve WCC in the HUSKY program:

Emphasize the MCO/provider/member partnership for WCC through developing creative incentives that would capture the attention of the providers and members regarding the importance of WCC and other preventive care.

Have all MCO's identify the level of practitioner providing the WCC services, those responsible for sending in claims and provide practitioner groups with data on WCC performance. Both Marie Roberto and Dr. Kamen suggested that health professionals do not want to be outliers and that progress in other clinical areas (i.e. cardiovascular disease) suggests that improvement in the quality of care is driven by data and professionalism. Recognition of performance variability creates the incentive to shift practice patterns.

While pediatric providers (PCP) are aware of the WCC guidelines, they must take the responsibility for emphasizing the importance of WCC visits and set up the preventive visit with the family. The member, in turn, needs to be incentivized to keep the appointment, gradually learning to shift health care utilization from sick care, often crisis driven, to preventive care. The Council has the responsibility to ensure that the partnership for responsibility for WCC among the State, MCO's, providers and members is facilitated and preventive care does occur.

### Comparison of Medicaid plans 1997/HUSKY A MCO's 1998

Mr. Linnane presented information, summarized on the next page, comparing national NCQA HEDIS measures of 111 Medicaid Plans with HUSKY A data:

HEDIS Measures	Nat'l Medicaid Plans 97	HUSKY A Plans 98
%WCC, aged 3-6 years	60	<b>64</b>
% Post-partum visits	44	<b>64</b>
% Cervical CA Screen	64	<b>43</b>
ER visits/1000MM	38	<b>39</b>
Inpatient Discharges/1000MM	12	<b>10</b>
Inpatient Aver. LOS	3.0	<b>3.5</b>

Connecticut **exceeds** the national rates in well child visits (EPSDT) and post-partum visits; while CT has a slightly longer average LOS, the fewer hospitalizations probably equalize these last two measures. The most significant gap in these reports is in cervical cancer screens, with CT reporting only a 42% rate (98). Unfortunately this has been a consistent pattern, with low rates of 36.4% (96) and 46% (97). Mr. Linnane stated that the positive overall CT HEDIS measurements represent a great deal of work by all involved. The Department recognizes the need to improve participation rates in preventive care and requests input and suggestions from the Council. Sen. Prague recommended that the health plans evaluate their preventive care performance rates

and develop an action plan to improve member/provider participation, reporting this plan to DSS and the Council, where a dialogue that includes suggestions for improvement strategies could occur.

Senator Harp noted that both Qualidigm and the Children's Health Council will be reporting on HUSKY data. The Senator questioned if both entities will be collecting the same data, are there data differences and how does DSS plan to handle the integration of both entities data? Mr. Linnane stated that the MCO's send encounter data, based on a HEDIS template, directly to both Qualidigm and CHC. The raw data is the same; however the data processing within each entity differs. Qualidigm staff stated that differences in the editing process of the same raw data results in specific differences in the aggregate data reports.

The use of the data varies by the entity in that the CHC focus is driven by their board and Qualidigm by DSS contract. Since the encounter data is claims-based, additional data may be needed to more clearly define an area. For example, low birth weight reports use both claim data and hospital reports.

Mr. Linnane stated there have been unexpected results when comparing the reports on the same data between the MCO's and the CHC. While this may be related to timing of subcontractors' data submission, there are dramatic month-to-month differences in the data, related to subcontractor submissions. Senator Harp requested the Department assess and explain the inconsistencies with data from the 4 MCO's, their four subcontractors and the two entities aggregating the data. Senator Harp stated that the Department's difficulty articulating the reasons for the differences suggests a need to look further at this issue. While the Council does not expect the data from the various sources to be the same, it is crucial to understand the nature of the data anomalies. Further discussion will take place when the next quarterly data is reported, in October. Senator Harp thanked the Department for their diligent work in tracking quality performance in the HUSKY program, recognizing that it is a difficult process and that the resolution of problems is the responsibility of all parties involved.

#### **Quality Measurement for HUSKY A and B**

Mr. Linnane reported that the HUSKY B quality measurement was included in the Qualidigm contract. While there are no federal requirements for CHIPS encounter data, the HUSKY B plans will submit aggregate reports on specified indicators. Qualidigm, DSS and the MCP's have reviewed the 55 HEDIS items and HUSKY A specifications to format the HUSKY B reporting. The group decided to use the HUSKY A reports in many cases and have added some indicators that are beyond the HEDIS measures. Since the HUSKY B enrollment numbers are relatively small, the Managed Care Plans (MCP) will report data as a group; individual plan reports will be given as the program numbers increase. The MCP's will report the first 6- month data at the end of the summer, containing data submitted from 7/1/98 through 12/31/98. Mr. Linnane highlighted some of the indicators that will be reported on (**see attached format of reporting requirements and dates, provided by DSS**):

The client satisfaction survey (CAPS) report, using the same survey tool and same NCQA-approved vendors, will be a combined report on the HUSKY A and B programs.

The audited financial reports will be a combination of HUSKY A and B plans.

Wellchild care will use the familiar HCFA 416 format for HUSKY A and B.

Follow-up chemical dependency treatment, not a HEDIS measure, will be used as will children's antidepressant medication use. Since the HEDIS specifications for this measure target adult use

of the drugs, the Department will develop a measure specific to children's use of antidepressant medications in the HUSKY B program.

The HUSKY B plans will send information regarding member demographics, disenrollment and provider panels to Benova who will aggregate this data for reporting.

### **Final Unified Grievance/fair hearing (G/FH) Process**

Rose Ciarcia reported on the finalized unified process and notice of action (NOA) requirements that have been developed by DSS. The unified process, which includes new forms, became effective July 1, 1999 with training provided to both DSS and MCO staff.

The process has three components: the NOA, the grievance/fair hearing forms and the consumer pamphlet, developed by DSS and CHC for member information.

Ms. Ciarcia outlined two components of the G/FH process:

Advanced notification to the client: Termination, reduction or suspension of existing services require 10 days advanced notice with mandated continuation of services if the G/FH request is received by DSS within 10 calendar days of the date the NOA is mailed by the MCO. Services can be discontinued if the G/FH request is not made within 10 days.

Notice at the date of action: Denial of services, reduction, suspension or termination of services prescribed by a treating physician require a notice no later than the date of the action. If a member is admitted to an institution he/she may be ineligible for the prescribed services.

Once the G/FH is received by DSS (all grievances are now sent to DSS):

The request is faxed to the MCO the same day it is received by the HUSKY A unit and the MCO schedules a grievance review.

Administrative hearings (DSS) schedules a fair hearing date at DSS and the MCO is notified of the date.

If the MCO does make a grievance decision 10 days prior to the scheduled hearing, the MCO will draft a summary.

If a MCO decision is in the client's favor and issued prior to the hearing date, DSS will notify the client that the hearing is not necessary.

If the MCO decision is not in the client's favor or not made prior to the scheduled hearing date, the fair hearing will proceed.

Senator Harp thanked the Department for providing the information, recognizing the Department's work, as well as the MCO's and CHC, in completing this important process in a timely manner.

### **Network Capacity Update**

Member/provider ratio, based on fee-for service (FFS) 1995 data is tracked by the Department, ensuring that there is the same number of providers per enrollees in HUSKY as in FSS as well as reasonable access to the provider. If >2% of a plan's members are more than 15 miles from the designated PCP (20 miles for dental and behavioral health), a Class A sanction will be applied. If a plan's enrollment percent is 100% or greater, the plan's enrollment is frozen until the plans can demonstrate to DSS that the provider/member capacity is <100%. Mr. Linnane stated that lack of dental providers is the primary limiting factor. The Department has asked Anthem Blue Care and the dental subcontractor DBP to verify that dentists listed in their panel are actually accepting Medicaid patients. The June enrollment caps report indicated that the Kaiser enrollment percent is 198% in Fairfield County, CHNCT is 106% in Middlesex County and 111% in New London County. ABC is 111% in Tolland County. Enrollment is frozen for these plans in these counties. The overall enrollment percent is highest in New

Haven (60.3%), and Windham (62.5%) counties, with Fairfield, Hartford, and New London counties ranging from 55.9 to 56.6%. Kaiser members, centered in Fairfield, Hartford and to a lesser amount in Tolland counties, will need to be reassigned by October 31, 1999 when Kaiser exits the HUSKY A and B program (see attached DSS memo).

### **Community-Based Outreach Contracts**

All contracts have been distributed to the organizations for their signature. To date, most have been signed and the outreach efforts have been operational. In some cases, the organizations had begun their work earlier under a letter of intent.

### **DCF: Multidisciplinary Examinations (MDE)**

Gary Blau, Bureau Chief, Bureau of Quality Management at the Department of Children and Families (DCF) presented an overview of the multidisciplinary examinations included in the DCF Juan F. Consent Decree. The language states that "all children, within one month of placement in out-of-home care and regularly thereafter receive a comprehensive multidisciplinary examination from community based assessment team. The purposes of the examination are to provide an evaluation and report assessing the child's functional, health, developmental, education and mental health status, identify children who require further specialized diagnostic or therapeutic services and monitor the child's progress while in out-of-home placement. The examination shall include examinations of the child's health, growth, development, educational achievement, emotional and social status". Since there is no specific service delivery procedure that constitutes this exam, health providers, in the past, have conceptualized the MDE as an EPSDT procedure that includes a medical, behavioral/developmental and dental component. Based on this, DSS, DCF and the MCO's have developed a reimbursement mechanism for the specific components of the MDE, provided as part of the Medicaid program for a child entering DCF placement for the first time. Each of the MDE components can be billed separately, using the appropriate CPT code. The provider must indicate V62.5 in the diagnosis section of the billing form, identifying the MDE. Children being placed in the DCF 'safe homes', an innovative program that DCF expects will provide a safe setting to allow ample time for a thorough assessment of the child that will facilitate appropriate foster home placement, will receive an MDE. The Department goal is to increase the number of children receiving the exam to comply more fully with the Consent Decree. The Department has created a partnership with providers, MCO's and the safe homes to ensure that children's needs are identified in a timely manner. Two safe homes are currently in operation.

Results of the MDE will be communicated to the child's PCP for follow-up treatment and/or referral as indicated. The MDE procedures will take effect August 1, 1999 and reimbursement will be retroactive to May 1, 1999. Senator Harp thanked Dr. Blau for this report, appreciative of DCF efforts to develop a concise plan to carefully evaluate these 'at-risk' children and monitor their assessment and follow-up care. The Council looks forward to an interim report on the status of the MDE at a future meeting.

### **Quarterly Council Report**

The second quarter report for April through June, 1999 was accepted with the added 'friendly amendment' that recognizes the contribution of the CHC in the improvement of the HCFA 416 EPSDT report; DSS had wished to acknowledge their efforts, omitted in the original presentation.

### **Subcommittee Reports**

Quality Assurance: issues related to case management and DME for asthma and lead prevention and treatment were discussed with the health plans. Those performing research and/or innovative asthma interventions will be presented at the July meeting. There was subcommittee consensus to develop a future asthma workshop and consider indicators for lead outcomes management.

The other chairs will report activities at the September meeting.

**THE MEETING FOR THE NEXT COUNCIL MEETING HAS BEEN CHANGED TO FRIDAY, SEPTEMBER 17, 10 AM IN LOB RM 1D** to accommodate scheduling conflicts within DSS.