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September 15, 2014

Richard R. McGreal
Associate Regional Administrator
HHS/CMS Division of Medicaid & State Operations
JFK Federal Building, Room 2324
Boston, MA 02203

Dear Mr. McGreal:

In our recent conference call on September 5, 2014, CMS stated that the plain language of the ACA necessitates use of the date of service methodology. We have taken another look at the Act and do not agree with this assertion. Nevertheless, during the call CMS requested information regarding the difficulties the State would face by temporarily changing our claiming convention to reflect a date of service methodology. In response, we are providing extensive detail below on why this requirement would uniquely disfavor Connecticut.

CMS has taken the position that only newly eligible claims with dates of service after January 1, 2014 are eligible for enhanced match. For most early adopter states, this position does not have a significant adverse impact given their service delivery methodology. Under the managed care arrangements in these states, capitation payments are by their nature prospective, eliminating or significantly reducing the impact of a date of service interpretation. Connecticut, with an innovative managed fee-for-service arrangement, pays for services in a retrospective manner after service delivery. Therefore, the CMS date of service interpretation significantly impacts Connecticut and its means of making payments in a managed fee-for-service system.

As you know, Connecticut's managed fee-for-service (FFS) approach sets us apart from the methods of payment utilized by other states (primarily managed care). Connecticut's conversion to the managed FFS system has allowed the state to achieve excellent results in both quality of care and management of costs:

- Increased the number of primary care providers enrolled in Medicaid by 14.6% and increased the number of specialists enrolled in Medicaid by 11.4%
- Increased the number of participating dentists in Connecticut's Dental Health Partnership to over 1,900, a 12.7% increase over the previous year
- Overall hospital admissions per 1,000 member months decreased by 6.0%
- Utilization per 1,000 for emergent medical visits decreased by 0.6%
- Utilization per 1,000 for non-emergent medical visits decreased by 14.0%
- Overall readmission rate within 30 days decreased by 2.9%

- Increased well-child visits in the first 15 months of life (6 or more visits) by nearly 11% and the well-child visits in the third, fourth, fifth and sixth year of life by over 5%
- Increased access to primary care practitioners for children age 12-24 months by 8%
- Increased immunization rate for adolescents (Tdap/Td total) by nearly 6%
- Increased lead screening in children by nearly 6%
- Increased breast cancer screening by 4%
- Increased the number and percent of children age 3 to 19 who received preventive care to 69% (HUSKY A) and 73% (HUSKY B).

This has been accomplished with a per member per month (PMPM) cost that has remained remarkably steady since the program's January 2013 implementation. In contrast, PMPM increases of 5% or higher were not uncommon during our managed care experience. This program structure also enables the Department to have direct and robust access to service data, helping guide program administration and improvement. This data transparency was virtually non-existent under our managed care system, and has facilitated the Department's ability to move forward with our programmatic and payment reform agenda in ways that simply would not have been possible under managed care.

Connecticut Medicaid is uniquely situated in its data analytic strength. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data.

The structure of each of the ASO contracts also supports the Department's desired results. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures. ASO arrangements have substantially improved beneficiary outcomes and experience through centralization and streamlining of the means of receiving support. ASO arrangements have also improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and 'clean claims' are paid completely and promptly through a single fiscal intermediary – Hewlett Packard Enterprises (HP). This promotes participation and retention of providers, as well as enabling monitoring of the adequacy of the networks needed to support a growing population of beneficiaries.

It is with this experience in mind that we ask that Connecticut not be unduly penalized for the progressive choices and demonstrated results it has achieved with regard to our Medicaid services. The date of service determination for the enhanced FMAP inadvertently hurts a system that we believe could serve as a model for other states in terms of program effectiveness, transparency and cost efficiency.

As with all Medicaid claims processing systems, Connecticut's MMIS is an intricate and complex claims processing engine that links both eligibility and claims payment processes to meet the long-standing federal requirements related to accurate reporting of expenditures by date of payment. Retroactive eligibility determinations and retroactive rate/claims adjustments are transacted within the system and affect the proper reporting of expenses by funding group (and subsequently link to appropriate FMAP reporting levels). To disaggregate one portion of the report to try to develop a subset report by date of service would disrupt the entire pattern of expenditure reporting that the system is constructed upon. Altering our MMIS federal reporting system to meet the new requirement, would result in significant unbudgeted costs, and would require resources to be diverted from other critical needs. In addition, our MMIS is approaching the end of its life cycle. The State would prefer to avoid making a significant investment in system processing and reporting changes unless they are absolutely necessary, as it would be difficult to realize both the State's and federal government's return on investment as we are working toward replacing the system entirely in a few years.

Other significant considerations include the following:

- Our current MMIS change agenda is extremely challenging. In addition to a multitude of small and medium-sized projects, we have the following large-scale projects in process or on the near-term horizon:
    - Large-scale interface and processing changes to support operation of the emerging integrated eligibility system
    - Hospital Payment Modernization
    - ICD-10 code set implementation
    - ACA Section 1104 Operating Rules changes
    - Medicare/Medicaid Dual Eligibles demonstration
    - Interfacing with the developing Health Information Exchange Infrastructure (e.g., HIE Provider Directory)
    - Processing to support State Innovation Model (if test grant awarded)
    - Stage 3 Meaningful use (changes to EHR Incentive Program attestation system)
- Adding another system re-design for federal reporting changes would be impossible to accomplish in a timely manner given the many high priority items that are already in process. Further, the effort to design, develop, and test new reports and related changes to MMIS processing based upon DOS would be both costly and time consuming and would likely require an APD to receive appropriate federal share for the necessary work.

- If one portion of the report is adjusted and based on date of service, without consideration of retroactive adjustments and the interrelationship of the various elements that comprise the claim reports, the report will no longer reconcile to actual expenses in the ledger. We believe this may represent an audit concern for our internal processes, but also for reviews completed by our Office of the State Auditors and HHS Office of the Inspector General auditors.

- Our MMIS reports used for federal reporting for over 20 years have been designed (and approved by CMS) to be based on date of payment or processing of claims, consistent with all known federal guidelines.

- Claims are adjusted often for various reasons. Adjustments for some of the claims, but not all of them, would need to claim as prior period adjustments. This would require a complete redesign of our MMIS reports and rerunning of the last 8 quarters of reports each quarter to capture claim adjustments in the correct prior quarter to obtain the correct federal share on the adjustment amount. This would be very complex as the FMAP reductions are phased in annually beginning in calendar year 2016.

- FMAP for both the ARRA periods (with changing FMAP rates) and for the BIP enhanced reimbursement (both effective at the start of a quarter) were all implemented in a much more practical manner based upon date of claims processing instead of date of service. This is also true for the temporary ACA physician fee increase and the federal 100% reimbursement for that change during the January 1, 2013 to December 31, 2014 period.

- All federal references we have reviewed relative to the application of FMAP percentages refer to "expenditures" of funds and do not make any distinction as to dates of services. There has been clear direction to states to base their reporting on date of payment. Our current CMS 64 reports and associated processes are based upon a date of payment construct.

- Newly eligible FMAP rates will be reduced over time. When the rates are reduced, we will need separate reports to track the claims by date of service in order to continue to request FMAP at the correct FMAP for the date of service after the higher FMAP period ends.

- Connecticut received clear direction that the date of payment would be the criteria for enhanced reimbursement for the enhanced FMAP in earlier CMS all states SOTA call.

Thank you for your consideration of the impact of these issues on our State. We look forward to working with you as expeditiously as possible to resolve this issue.

Sincerely,

Roderick L. Bremby
Commissioner

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