



**Department of Social Services Programs and Services
Related to Adolescent Health**

**Presentation to the Legislative Program Review and
Investigations Committee**

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Health Care

The Connecticut Department of Social Services (DSS) is the state's federally designated agency for the administration of the Medicaid Program and the Children's Health Insurance Program (CHIP) under Titles XIX and XXI, respectively, of the Social Security Act. For Medicaid, Connecticut receives 50% federal financial participation (for every dollar spent by the state, the federal government matches that dollar); for CHIP, the federal government pays 65% of the cost of the program. DSS is also the home of numerous other health programs, most notably the Charter Oak Program, the state funded health coverage for uninsured adults not otherwise eligible for other government funded coverage, and most recently the state's Pre-existing Condition Insurance Program (PCIP). Overall, more than one of every six residents, one of every five children, and one of every three pregnancies in Connecticut, is covered by a health care plan from DSS.

Across the nation, Medicaid is the "safety net" health program and is usually the largest line-item cost in state's budgets. Most Medicaid recipients are children; most Medicaid resources are devoted to the care of adults. For every dollar spent caring for a child, nine dollars is spent for each adult, often in long term care facilities or for chronic disease care. Medicaid is also the safety net for the commercial insurance industry. For most of us, commercial insurance covers most but not all of our health care expenses. For those children and adults with severe chronic illnesses, multiple diseases or devastating injuries, the most but not all that commercial insurance covers leaves individuals and families with massive unaffordable health care expenses. These excess expenses eventually lead them to Medicaid.

DSS Models of Health Delivery

DSS administers its various health programs using three models. Medicaid services provided to the Aged, Blind and Disabled (ABD) coverage group, otherwise known as traditional Medicaid, as well as the recently created Medicaid Low Income Adult coverage group (MLIA, formerly the State Administered General Assistance Program) are administered directly by the department and claims are paid on a fee for service basis. Both programs are therefore commonly referred to as Medicaid “fee for service.” Presently, there are approximately 105,000 people enrolled in the ABD group including 75,000 who are dually eligible for Medicare and Medicaid (“dual eligibles”), and almost 70,000 enrolled in MLIA.

The second way the department administers its health programs are through capitated managed care arrangements. The state began to enroll its family coverage group (children, eligible adults caring for these children, and pregnant women) beginning in 1995. In 1998, after enactment of the federal State Children’s Health Insurance Program legislation, Connecticut created the Healthcare for Uninsured Kids and Youth (HUSKY) Program. HUSKY A is the family Medicaid coverage group for families <185% of the federal poverty level (FPL) and 250%FPL for pregnant women; HUSKY B, the Children’s Health Insurance Program (CHIP) provides health services to children of families with higher incomes (above 185% of FPL) and is funded by a federal block grant. Unlike HUSKY A, HUSKY B resembles a commercial insurance plan; families have cost sharing requirements, such as co-payments and premiums. The third program administered under managed care arrangements is the Charter Oak Program. Started in 2008, Charter Oak provides coverage to uninsured adults who are not otherwise eligible for federally supported health coverage. Charter Oak is structured even more like a commercial product, with premiums, deductibles and other cost sharing arrangements. Currently, HUSKY A and B and Charter Oak are managed by three managed care organizations (MCOs): Aetna Better Health, AmeriChoice by United HealthCare, and Community Health Network of Connecticut.

Lastly, the department has two specialty carve-outs; the Behavioral Health Partnership and the Dental Health Partnership. These specialty services are administered using a blend of the two models above. The programs are administered by outside organizations under contract with the department (behavioral health by Value Options and dental services by Benecare, respectively), however providers’ claims are paid by the department largely on a fee for service basis.

It should be noted that the medical service delivery models will all change dramatically on January 1, 2012 when DSS will end all capitated managed care arrangements and transition all 600,000 of its health care recipients into a medical Administrative Services Organization (ASO) model of care, much like the current specialty carve outs. The ASO will be responsible for member and provider services,

utilization review, quality improvement, and intensive care management for all recipients of the department's health services, with the exception of most waiver services; the department will retain responsibility for client enrolment, provider credentialing and enrollment, and claims payment. The Behavioral and Dental Health Partnerships will remain in their current management arrangements.

Covered Services

According to federal guidelines, Medicaid recipients are entitled to a broad array of preventive, acute, and chronic care services on both an inpatient and outpatient basis. States may choose to cover care from an additional list of optional services and still receive federal match. Such optional services include dental care, medications and hospice services. States also have wide latitude to set financial eligibility limits for Medicaid and CHIP services within federal guidelines.

Connecticut Medicaid provides a broad array of services to recipients from birth, through the life span, to elders dually eligible for Medicare and Medicaid. This array of covered services is far more complete than any commercial plan and more complete than most state's programs. HUSKY B (CHIP) and Charter Oak provide a less complete but still very comprehensive service package.

In addition, DSS enrolls an extensive list of provider types and specialties, including physicians and nurse practitioners; inpatient and outpatient acute care, chronic disease, rehabilitation and mental health hospitals; community health centers; community, school-based, and rehabilitation clinics; ambulatory surgery centers; and long term care, residential and partial day treatment facilities. Each provider and facility type is paid by the department and by the MCOs using a variety of payment methodologies, including fee for individual services (physicians), revenue center codes (hospital outpatient departments), various cost-based methodologies (hospitals, community health centers), and capitated arrangements (MCOs, some vendor types).

In addition to the required and optional services for adults under Medicaid, each infant, child and adolescent on Medicaid is required to undergo Early Periodic Screening, Diagnosis and Treatment (EPSDT) according to the schedule of preventive services in the Bright Futures Guidelines from the American Academy of Pediatrics. These include comprehensive health and developmental/behavioral history (including assessment of both physical and mental health development and assessment of nutritional status); appropriate immunizations; dental, vision and hearing screenings. Medically necessary health needs identified within EPSDT are covered benefits under Medicaid regardless of whether the service is otherwise a covered benefit.

How DSS Measures Health Care Access and Quality Performance

As a condition of receiving federal funds for Medicaid and more recently CHIP, states must report to the Centers for Medicare and Medicaid Services (CMS) on utilization of EPSDT-related services for infants, children and adolescents. In addition, CMS requires managed care Medicaid and CHIP programs to conduct independent external reviews of each MCO, each to include performance improvement project (PIP) measures to ensure continuous quality improvement. PIPs are an essential component of the review process, they're used to identify, assess and monitor improvement in processes or outcomes within a particular care focus. Lastly, Connecticut now requires its MCOs to report an extensive list of Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS was developed by the National Committee on Quality Assurance (NCQA) as a means of evaluation and comparing the performance of commercial MCOs nationally, and more recently has been used to compare Medicaid managed care programs across the country. Several states, soon to include Connecticut, also use HEDIS to measure their non-MCO Medicaid services. Connecticut's Medicaid MCOs reported HEDIS measures for the first time this year.

How and How Well Do We Provide Care to Adolescents?

Children and adolescents 10 – 19 years of age make up 21% of the department's recipient population. The monthly capitation expenditures for this group were \$18.9 million (\$17.7 million and \$1.2 million for HUSKY A and B, respectively) in April, 2011. In our PowerPoint presentation corresponding to this narrative, we have provided several charts showing diagnosis categories of services and associated costs.

Recent Connecticut EPSDT and preliminary 2010 HEDIS data on adolescent health measures are also included in the PowerPoint. Interpretation of the data must be with a clear understanding of both the limitations of the reporting measures and adolescents' patterns of health care utilization.

For the most part, adolescents consider themselves to be a healthy group whose health will remain excellent despite their excess rates of unintentional and intentional injuries, pregnancy related complications, sexually transmitted and other illnesses. Teens consequently seek healthcare services accordingly and use healthcare services sporadically, most often for care of acute illnesses rather than for primary or preventive care; frequently in non-traditional health care settings such as school-based health centers and neighborhood clinics. Whereas infants and children receive most of their preventive care in one place (their primary care provider) and at one time (their annual check up), teens receive preventive care (if they receive it at all) at different times and in different settings. An adolescent may get their hearing and vision screens at a school mass screening, a complete examination at a sports physical conducted in a school gymnasium, and a hemoglobin or other laboratory tests at an illness visit in an urgent care center or emergency department.

EPSDT screens are defined as a complete assessment at one visit; however, because teens often receive their assessments at multiple times and places, adolescent EPSDT rates are annually low. The HUSKY MCOs annually work diligently to develop interventions to improve outreach to this age group and promote wellness. Outreach calls and mailings are sent to remind youth and their caregivers of due and over-due well-visit schedules, encourage the use of school-based health clinics for routine wellness care, particularly through voucher or gift card incentive programming. MCOs also work directly with providers supplying them with profile reports detailing utilization metrics and reminding them of their role in preventive health care for this group. Notably, of all of the department's interventions to improve teen's use of preventive services, HUSKY Primary Care, the Primary Care Case Management (PCCM) pilot program is the only one to demonstrate any success.

In conclusion, because of the many different ways the department pays for care, mostly through capitation and revenue center codes, we do not have data on specific procedures and visits that would make it easier to quantify where and how often adolescents receive care and what care they are receiving. However, with the measures we do have, EPSDT and HEDIS, we can say that Connecticut does quite well in providing care to adolescents in comparison to other states' Medicaid programs.

Nutrition Assistance

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, helps low-income individuals and families afford the cost of food at grocery stores and farmers' markets. The rules for getting SNAP benefits in Connecticut require that a person must be a resident of Connecticut whose income and assets are within set limits. Benefits are provided by Electronic Benefit Transfer (EBT) card – a plastic swipe card that looks and is used like a credit or debit card, and accepted at most grocery stores. SNAP helps families to meet one of the most basic health needs – access to food.

In addition, SNAP includes a nutrition education component. The department receives approximately \$3,000,000 from the USDA Food & Nutrition Service to provide nutrition education. The department contracts with the Dept of Public Health, the Hispanic Health Council, the University of Connecticut Health Center, and the University of Connecticut to deliver quality nutrition education to Connecticut residents who are under the SNAP income limit of 185% of the federal poverty level. These contractors provide an array of activities aimed at educating families and individuals from pregnant women to seniors on the basics of good nutrition and eating habits. Activities take place across the state and venues include

pre-schools, grades k-8, high schools, community health centers, farmers markets, health fairs, and senior centers.

SNAP has seen a surge in enrollment over the past few years, due in large part to changes in eligibility rules and the poor economy. Specifically, in 2009 the department eliminated the asset limit for most households, raised the income limit to 185% of the federal poverty level and allowed most households to get the maximum utility allowance (an income deduction) which increased the number of households eligible and the amount of benefits they were eligible to receive.

In May 2009, approximately 240,500 Connecticut residents were receiving SNAP benefits, and of those, 34,544 were adolescents ages 10-19. Currently, in May 2011, there are approximately 358,000 SNAP beneficiaries; of those 57,358 are adolescents ages 10-19. This means that in two years the program has seen an increase of almost 23,000 adolescents.

Summer Electronic Benefits Transfer for Children (SEBTC)

This year Connecticut received a federal grant from the United States Department of Agriculture (USDA) to increase access to food for children in Eastern Connecticut during the summer. The program, called Summer Meals on the Move, will provide benefits to 2500 children who were eligible to receive free meals from the Child Nutrition Programs during the school year. Of the 2,500 children selected for the Summer EBT program, 762 are middle school or high school children. Summer Meals on the Move benefits are issued via EBT cards and are worth \$60 for each eligible child for each summer month. Food can be purchased at any store that accepts SNAP EBT cards.

DSS, the State Department of Education (SDE) and End Hunger CT! (EHC!) developed an outreach letter and application form for the program. The letters and forms were distributed to each of the 23 School Food Authorities (SFAs) in the demonstration area. The demonstration area consists of the following 23 towns: Ashford, Bozrah, Brooklyn, Canterbury, Chaplin, Columbia, Coventry, Franklin, Griswold, Hampton, Killingly, Lebanon, Lisbon, Mansfield, Norwich, Plainfield, Putnam, Scotland, Sprague, Stafford, Thompson, Willington, and Windham. The SFAs in turn mailed the letters to every family in the demonstration area who had children eligible to receive free meals during the school year through the SDE-administered Child Nutrition Programs. Children were randomly selected after choosing to enter the lottery by filling out a form and returning it to SDE

The program recognizes that during the summer months, children who would have been receiving at least one meal a day at school will not be receiving that meal, which may be the only meal the child receives on any given day. Existing "summer food" programs administered through SDE do currently provide meals and fun physical activities at specified locations during the summer months. However, participation is

historically very low. In an effort to increase participation, the USDA is testing new ways to provide benefits, including the EBT model being tested here in Connecticut.

Prorated benefits were issued to program participants on June 17, 2011. Full monthly benefits will be issued on July 1 and August 1 and a final prorated benefit will be issued on September 1.

In 2012, demonstrations that successfully deliver benefits will continue and the number of children receiving benefits will double to about 5000 children.

Children's Trust Fund

Nurturing Families Network

The Nurturing Families Network (NFN) is a program of the Children's Trust Fund within DSS. The program receives \$10.3 million in state funding. NFN has three components:

- Intensive home visiting for new parents who are at high risk for child abuse and neglect. The program focuses on nurturing parenting, child development, and maternal and child health and community resources.
- Nurturing parenting groups that assist parents in developing appropriate expectations of their children and enhance their parenting skills.
- Nurturing Connections that brings new parents together with volunteers and others in the community who can help them adjust to the demands of having a baby.

Services are provided at 42 community locations throughout the state. In 2009 NFN served approximately 2,000 families in intensive home visiting and 600 families in Nurturing Parenting groups. The program screened 7,200 families and provided Connections services to 1,700. In 2009, NFN provided comprehensive home visiting services to 540 adolescent mothers.

Healthy Start

Healthy Start is a program of the Children's Trust Fund in collaboration with the Department of Public Health. The program has shown to achieve positive maternal and child health outcomes through HUSKY enrollment and by connecting pregnant women and new mothers to health care and other services. The program receives \$1.4 million in state and \$200,000 in federal funding.

Services are provided in 15 locations across the state. In 2009, approximately 5,000 mothers received Healthy Start services. The program enrolled 592 prenatal and 135 postnatal adolescents in HUSKY. In addition, the program assisted the adolescents with referrals to pre- and post-natal care and other community resources.

Teen Pregnancy Prevention and Family Planning

Teen Pregnancy Prevention

The goal of the Teen Pregnancy Prevention (TPP) program is to reduce teen pregnancies in Connecticut communities with the highest incidence of births to teens. The program provides young people, who are ages 10 to 18 and at risk of becoming teen parents, with a structured, supportive, and safe after-school environment in which they can acquire the knowledge, skills and opportunities to succeed in life and avoid early parenting. Currently, there are thirteen TPP programs. Ten of the programs are currently operating and three are in the start up phase and are expected to be fully up and running in September of this year. These programs are located in communities with the highest rates of teen pregnancy in Connecticut: Bridgeport, East Hartford, Hartford, Killingly, New Britain, New Haven, Meriden, New London, Norwich, Torrington, Waterbury, Willimantic and West Haven.

In an effort to implement the program in a manner that supports these goals, this program employs two teen pregnancy prevention models that have been evaluated and determined to implement effective strategies. These are the Carrera model, a holistic youth development model, and the Teen Outreach Program, a model based on service learning. DSS also supports efforts to keep abreast of best practices, maintain model fidelity and evaluate program effectiveness.

Program at a Glance

Target Population:	Youth Ages 10-18
Number of Programs:	13
Number Served:	540 (150 more with new programs)
State Funding:	1,986,575

Family Planning

The purpose of the Family Planning program is to provide comprehensive reproductive health care services to approximately 15,000 low-income Connecticut residents. Funding comes from the federal government through the annual Social Services Block Grant (SSBG) allocation. DSS contracts with Planned Parenthood of Southern New England (PPSNE), which allocates the block grant funds to 12

community-based sites statewide. PPSNE provides services such as, one-on-one patient education services, reproductive/sexual health problem follow-up, SDT testing and counseling and options counseling for clients who are pregnant, using a sliding fee scale, which is supported by the grant funding. While the Family Planning program focuses primarily on women, it also provides men with sexually transmitted disease testing and treatment as it specifically relates to women's health.

The most important contribution of this program is consistent and affordable access to quality family planning services across the state to a population of women and young women who might not otherwise have access to such care. Because PPSNE has several sites throughout Connecticut, all of which are located on main thoroughfares and in most cases are accessible by public transportation, access to these services is widely available.

Program at a Glance

Target Population:	Low-income Connecticut residents
Number of Programs:	1 Program with 12 Sites
Number Served:	15,802
Funding: Federal	915,059

We thank the Program Review and Investigations Committee members and staff for the opportunity to discuss some of the DSS programs that most closely touch the health care of adolescents in Connecticut. We welcome any questions you have at this time and look forward to our continued work with committee staff as we explore this issue further.

