

Medicaid Council Quarterly Report: 1st & 2nd Quarters 2005

Date Accepted: September 9, 2005

*This report of the Medicaid Managed Care Council is submitted to the General Assembly as required under CGS 17b-28. This report is for the time period of **January through June 2005**. The Medicaid Managed Care Council is a collaborative body established by the General Assembly in 1994 to advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program. Specifically, the law charges the Council with "advising the Commissioner of Social Services on the planning and implementation of a system of Medicaid Managed Care and shall monitor such planning and implementation and shall advise ... on matters including, but not limited to, eligibility standards, benefits, access and quality assurance". The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans and state agencies. The Council has several working subcommittees: Consumer Access, Quality Assurance and the Behavioral Health Committee.*

The Medicaid Managed Care Council met monthly during the first half of 2005. Key issues addressed were the ongoing plans for the program's service delivery system, 2005 CGA HUSKY and Medicaid legislation, program administration, quality measures including 2003 CTVoices reports, and HUSKY A/B enrollment patterns. Special reports included the:

- Legislative Program & Review Medicaid eligibility study,
- Office of Health Care Access 2004 household insurance survey,
- Department of Public Health's Medical Home Initiative for Children & Youth with Special Health Care Needs (CYSHCN),
- Council's work group recommendations regarding the connection of the medical home initiative and HUSKY managed care,
- Department of Children and Families Psychotropic Medication Committee's work product, and
- Overview of the CT Covering Kids activities.

Medicaid Recommendations: follow-up on last half 2004 & first half 2005 recommendations

Follow-up on Recommendations last half 2004		
Month of recommendation	Recommendation	2005 Status

July 2004	<ul style="list-style-type: none"> • The MMCC continue to receive program updates and data on the SAGA program. • ACS to provide more detail on “other” reasons for HUSKY member plan changes. 	<ul style="list-style-type: none"> • Received updates through November 2004: will request update last half 2005. • (CA SC) 2005: ACS/DSS doing survey and follow-up of members that change MCOs
October 2004	<ul style="list-style-type: none"> • DSS assess ED/hosp. use by age, gender, “top” diagnoses • DSS outline HEDIS measures, compare to HUSKY data parameters. 	<ul style="list-style-type: none"> • 2005: MCO PIP on ED asthma-related utilization. • 2005: DSS has completed work with MCOs on more uniform reporting
November 2004	<ul style="list-style-type: none"> • MMCC requested PONE provide MMCC with systematic resolution of data problems • DSS requested to take the lead in convening meeting with DPH/MCOs to identify timely birth data match that would meet DSS reporting timeframes. • DSS requested to clearly define MCO case management, # members decline VS # that meet the MCO CM criteria, identify CM performance benchmarks. • Requested BH Oversight Comm. address outstanding BH claims as part of transition, establishing timelines 	<ul style="list-style-type: none"> • PONE reported 12/04: 2005 MMCC will continue to F/U on plan’s utilization performance • DSS/DPH have developed process for 6-month report, more frequent in future. • 2004:DSS met with MCOs regarding CM issues. • 2005: F/U with CM reports. • 2005: The BHP Oversight Council plans to address this as part of transition work with DSS, DCF, MCOs, family rep. and advocates & providers.
December 2004	<ul style="list-style-type: none"> • MMCC encouraged DSS to systematically evaluate the Human Service Infrastructure program. • MMCC requested DSS commit to addressing SBHC uninsured with stakeholders. 	<ul style="list-style-type: none"> • Request F/U status report end of 2005 • 2004:DSS agreed to work with MMCC, others • 2005: 2 meetings, no further action.
Recommendations 1st half 2005		
Month of Recommendation	Recommendation	Status
January & February 2005 June 2005	DSS to provide public input for: <ul style="list-style-type: none"> ▪ HUSKY dollars available after BH dollars deducted. ▪ Waiver development processes ▪ DSS present plans for HUSKY A lock-in to CA SC for input 	<ul style="list-style-type: none"> • Discuss end 2005 • 2005: HUSKY adult premiums concept paper due September • CA SC will F/U with DSS

January 2005	DSS review & consider rate variance among dental providers, impact on dental access now that there is no dental carve-out.	• Continue discussion last half 2005
January 2005 April 2005	DSS: • Develop more uniform data system with retrospective & current provider level data for QA, policy • Develop QA outcomes, less reliance on process measure	• DSS will report on data warehouse plans Sept or Oct. 2005 • Refer to QA SC, recommendations to DSS
March 2005	DSS develop mechanism to F/U families already enrolled in HUSKY A, who apply for B	(CA SC): DSS is working with ACS on this and have asked MCOs to contact these members.
April 2005 May 2005	• MMCC medical home work group recommendations to DSS. • DSS/DPH collaborate on pilot to assess cost efficiency & QA for child/family with special needs.	• F/U with DSS, led to May recommendations DPH/DSS developing tool for Mercer to apply to HUSKY A to assess CSHCN complexity.
May 2005	DCF & DSS work with BHP OC & MCOs on DCF psychotropic drug product	Referred to newly formed BHP Oversight Council.
April 2005	Suggest OHCA continue to collaborate with Office of Comptroller on HC purchasing initiatives.	MMCC will request updated insurance survey OHCA Fall 2005
May 2005	Requested RWJ Covering Kids identify most efficient/effective outreach initiative	To request follow up

Summary of Key Council Issues: January – June 2005

Changes in HUSKY program service delivery system

- In January 2005 DSS stated the agency would not implement the *dental service carve-out*. Applying a weighted average rate methodology in the carve-out would result in lower fees for some dental providers that receive reimbursement above the average rates. Dental services will remain within the managed care system. Two MCOs have risk-based dental vendor contracts: Anthem/DBP and Preferred One/BeneCare. CHNCT/BeneCare and Health Net/Doral have an ASO type contract with their dental subcontractors.
 - The DSS Dental Advisory Committee continues to meet, focusing on reductions of barriers to provider participation such as consistent prior authorization policies, developing a standard dental claim form with EDS and a uniform provider credentialing form.

➤ Throughout the first half of 2005 there was regular discussion in the Council on the proposed ***behavioral health service carve-out*** and oversight issues of the BH Oversight Committee of the Medicaid Managed Care Council. The legislative committees of cognizance approved the BH waiver amendment, with strong recommendations for ongoing oversight of the program May 24, 2005. Action by the CT General Assembly in June 2005 resulted in legislation (PA05-280) that creates and funds the Behavioral Health Partnership, which involves a ‘carve-out’ of BH services for HUSKY A adults and children, HUSKY B and some DCF voluntary service populations. The anticipated implementation date is January 1, 2006. Creation of a BHP Oversight Council was included in the legislation. The Administrative Service Organization, ValueOptions, will be negotiating a contract that includes recommendations from the BH OC and work groups with DSS/DCF during the summer of 2005.

2005 HUSKY and Medicaid Legislation

At the June 2005 meeting DSS reviewed the legislative changes in HUSKY A/B and Medicaid changes:

Policy Change	Description of Change	Probable Implementation dates (from July 2005 meeting)
Increase HUSKY A adult/caregiver income eligibility level to 150% FPL	Parent/caregivers of HUSKY A children income eligibility level is increased from 100%FPL to 150%, allowing the state to insure more families.	July 1, 2005
Reduction of transitional medical assistance (TMA)	TMA enrollment reduced from 24 months to 12 months, impacting clients as of <u>June 30, 2006</u> .	TBA. Requires State Medicaid plan amendment and CMS approval.
Elimination of self-declaration of income in HUSKY application.	In 2001, applicants could state their income on the application without verification (i.e. pay stubs). DSS matched this with Labor data and F/U with clients if discrepancies. Self-employed clients had to submit accompanying income verification. As of <u>July 18, 2005</u> all applicants must submit income verification along with their applications.	July 18, 2005
Re-implementing children’s presumptive eligibility (PE).	Qualified entities apply HUSKY A PE to children seeking medical services, with coverage for 30 days. Completed full application has to be submitted at the PE time for HUSKY eligibility determination.	October 2005
Expedited Eligibility for pregnant women	Provision for 1) emergency eligibility determination in 24 hours; 2) within 5 days for other pregnant women.	September 2005

Re-implementation of HUSKY B (children) monthly premiums	Band 1 (185-235% FPL) new- \$30/child/M to \$50/family max/M. Band 2 (235-300%FPL) incr. to \$50/child/M to \$75/family max/M	October 1, 2005
HUSKY A adult premiums/outpatient (OP) co-pays	HUSKY A adults with incomes >100%FPL, \$25/adult/M premium & \$1.00/OP visit co-pays	Requires waiver form CMS. DSS will complete a concept paper on this in September. Expect implementation late Spring/summer 2006
HUSKY A health plan lock-in	Enrollee has a 90-day free-look period with chosen HUSKY A MCO. They can remain or change MCO during that time and then remain in their chosen plan for the remainder of the 12 M (plan change with ‘good reason’ allowed)	TBD as additional support needed form DSS systems.
SAGA Pilot	2-year pilot for 100 individuals ages 19-20, with chronic medical and BH conditions, live with family & are uninsured.	DSS will begin with identifying youth aging out of HUSKYA that meet guidelines, consider young adults referrals from advocates, etc.
Family Planning (FP) Waiver	Provide FP services to uninsured women up to 185% FPL.	TBD
Katie Beckett Waiver Expansion	Expand slots from 125 to 200. Model waiver based on child’s income eligibility, not family income.	Could start in Fall 2005, later if CMS requires waiver amendment.
Behavioral Health Partnership (DSS & DCF)	BH service carve-out for HUSKY A adult/child, HUSKY B & some DCF voluntary services, other DCF children.	January 1, 2006
Medicare Part D: Medicare Modernization Act (MMA)	Affects Medicaid dual eligibles, ConnPace, as well as other Medicare eligibles. No plans for State wrap around drug coverage or State payment Medicaid co-pays.	Federal government implementation date January 1, 2006. More information: www.medicareadvocacy.org

HUSKY Program Administration

- ✓ DSS/MCO contract has been extended through Dec. 31, 2005.
- ✓ SFY 2005, MCOs had a 4 % rate increase (commercial insurers were charging employers 12% rate increases). SFY 2 % rate increase was budgeted.
 - DSS will be using Mercer’s MCO financial review in negotiating individual MCO rate adjustments retroactive to April 2005.
 - Individual plans will negotiate rates with DSS on the deduction of BH carve-out dollars prior to Jan 2006.

- ✓ As part of the discussion of the proposed premium assistance plan (not included in the budget) DSS discussed Medicaid third party liability (TPL) that now exists in Medicaid. Approximately 26% of HUSKY A eligibles have access to employer sponsored insurance and Medicaid is the payer of last resort. DSS suggested creating a policy steering committee of consumers, advocates, business, health practitioners and MCOs to provide a forum for a broader discussion of health coverage.
- ✓ By October 1, 2005, DSS will add new coverage groups for Department of Children & Families (DCF) HUSKY children, which should capture all DCF children in HUSKY A.
- ✓ At the request of the MMCC, DSS and DPH have finalized memorandum of understanding (MOUs) for more frequent data matches between DPH and Medicaid for lead data and HUSKY births. Provision of more timely data to MCOs will allow the health plans to:
 - Track children's lead screens, remind providers of patients that have not been screened, and identify children with elevated blood lead levels.
 - Have 6-month birth data for reports required by DSS, reducing both MCO and practitioner administrative costs of redundant data collection.
- ✓ MCO network capacity, based on fee-for-service ratios, was presented in January 2005. The *percentage* of member enrollment to provider capacity (in the MCO provider network) measures the adequacy of the MCO provider network in each of the 8 counties. When a health plan's enrollment in a county exceeds 90% capacity, DSS sends a warning letter to the plan. If enrollment remains over 90% capacity the health plan's enrollment is 'frozen' until the plan either has a reduction in member enrollment or increases their provider network to lower the percent capacity below 90%. Key observations from the report:
 - Anthem is at or over 90% in 2 counties, Hartford and Tolland. Hartford capacity is related primarily to dental capacity. There are fewer dentists in Tolland and of those, few participate in Medicaid.
 - Health Net has exceeded the 90% in Fairfield county, with dental capacity the main problem area.

DSS stated that there are no similar capacity calculations for other specialty services; however the DSS will be assessing specialty access more closely in the future and developing contract standards

Assessment of Program Quality

HUSKY A Data Reports

February, May & June 2005 Council meetings (approximate % determined from DSS bar graph reports):

	1 st Half 04	2nd Half 04	CMS 416 FFY 03/04
EPSDT Screens Ratio	75%	84%	73%/76%
EPSDT Participation Ratio	64%	72%	53%/60%

Dental –Preventive (ages 3-20)	25%	25%	NA
Dental-Any Service (ages 3-20)	34%	32%	42%/43%
MCH-1 st Trimester enrollment	58%	60%	
80% PNC visits	81%	80%	
Timely Post Partum visits	55%	NA	

March & May 2005 Data reports:

	4 Q/03 – 1 Q/04	2Q – 3Q 04	Comparison 02-03
Discharges/1000 MM	8.5	8.3	Lower (range 9.5-10.3)
ALOS	3.4	3.3	Higher (range 3.1-3.3)
	10/03-9/04	4/04-9/04	
ED visits/1000MM	60	58	(FFS '94) 72
% Members with any BH Services*	8.8%	9.8%	Range of 7 – 8%

*91% were ambulatory mental health services, 5% inpatient MH

87% were ambulatory substance abuse treatment, 7% inpatient treatment

The Council commended DSS and the health plans in reaching over an 80% screen ratio for preventive EPSDT screens; however dental access remains inadequate. The Court has not ruled on the dental access lawsuit. At this time DSS has no new long-term strategies to improve overall dental access. DSS is working with MCO on strategy development and with the Community Health Centers that can contract with private dental practices to see patients in the practice offices. The Centers will provide administrative support for appointments and billing. This initiative may demonstrate increased access to dental services over time.

CTVoices: HUSKY A Children's Service Reports: 2003

Some funding was reinstated for regular reporting of continuously enrolled (represents about 65% of children enrolled in HUSKY) children's service patterns. Highlights of the reports (full reports can be obtained at www.ctkidslink.org):

	FFY 2001	FFY 2002	CY 2003
Any Ambulatory Care	82.4%	85%	85%
% of well care visits	48%	53%	51%
% with ED care only	5%	4%	4%
No Ambulatory Care	17.6%	15%	15%
Asthma			
Prevalence	9.4%	8.1%	9.1%
Average # office visits		4.1 asthma-related visits	4.2 asthma related visits
ED for asthma	28%	26%	24%
Hospitalized for asthma	5%	4%	4.3%
ED & Hospitalizations			
@ Least one ED visit		33% of children	33% (38% for plan changers)
% Hospitalized		4% (average 2 hosp. per child)	4% (average 2.4 Hosp. per child)

Key observations:

- 10% of children had no record of any care in 2003: teens/pre-teens, AA children and Preferred One enrollees were more likely to not have received ambulatory services in 2003.
- Less than 20% of children had a follow-up office visit within 2-4 weeks of an asthma-related ED visit and less than 50% were seen for follow-up within 2-4 weeks of hospitalization for asthma in 2003. In Quality Assurance SC, practitioners noted *they usually do not know of ED visits unless the patient contacts the office*, therefore offices cannot schedule a follow-up visit for all patients.
- Top diagnoses for ED use continue to be injuries (26%), respiratory (21%), nervous system (12%).
- Top diagnoses for hospitalization remains mental disorders (56%) and respiratory (10%).

Youth ages 6-14 account for 78% of the MH admissions, followed by 15-20 year olds (50% of MH admissions). These are the age groups that are least likely to have used preventive well visits. It was puzzling that the MH average length of stay was 7.1 days, in light of the burgeoning HUSKY psychiatric inpatient reinsurance expenditures.

DSS/MCO Performance Improvement Projects (PIP) for 2005

- ✓ Appropriate asthma medication use for members ages 5-54 with persistent asthma.
- ✓ Asthma-related Emergency Room use, with each MCO developing a strategy to decrease the number of ED visits by members who have received prior asthma-related ambulatory services.
- ✓ Increase adolescent well visits utilization. There is **no provision** in the PIPs for MCOs' assessment of the comprehensiveness of the care received in these visits, as recommended by the Council.

Mercer (Medicaid Quality Review Subcontractor) Quality Audit

The HUSKY A & B audit results were presented in February with follow up information that had been requested by the Council in April 2005. The 2004 audit results will:

- Establish the current status of MCO compliance to BBA,
- Service as a baseline for future reviews,
- Establish a starting point for MCO Action (correction) Plans for areas of partial or non-compliance and
- Provide baseline for Performance Improvement Projects (PIP)

Several key areas that require corrective action by the MCOs included:

- Two criteria were partially or not met by all MCOs that included MCO shared assessment results with other MCOs and Program Improvement Programs.
- Two MCOs partially or did not meet 3 criteria that related to consistent use of criteria in making authorization decisions, dissemination of practice guidelines to providers & members, mechanisms to assess quality & appropriateness of care for special needs members (*this seemed to be the lowest performing area across all MCOs but Anthem*).
- The Performance Improvement Project (PIP) review results, with 2004 as the baseline year, revealed the expected need for improvement and clarification of PIP design.

The Council recommended:

- Future audits more clearly define differences among MCOs and comparisons with national benchmarks. Mercer stated that the 2004 audit creates a baseline for more detailed subsequent reports.
- There is more focus on process measures than actual outcome measures. While CMS and NCQA accept process measure, Mercer noted that outcomes measurement should be encouraged. The Performance Projects (PIP) will provide assessment of interventions.

HUSKY A & B Enrollment

	Jan 05	June 05	Change	Jan 04	June 04	Change

All HUSKY A	307,048	312,208	5160 (1.7%)	299,056	303,404	4348 (1.4%)
< 19 years	215,647	219,224	3577 (1.6%)	209,705	212,509	2804 (1.3%)
Adults	91,401	92,984	1583 (1.7%)	89,351	90,895	1544 (1.6%)
HUSKY B	15,423	15,696	273 (1.7%)	14,640	14,571	(69) (0.5%)
HUSKY A/ B	322,471	327,904	5433(1.7%)	313,696	317,575	4279 (1.3%)

- Over the past six months in 2005, overall enrollment has increased by 1.7% compared to a 1.4% increase during the same months in 2004. On average overall HUSKY A enrollment increased by 860 members/month during the six month period. Comparing Jan 2005 to Jan 2004 enrollment, Jan 2005 enrollment was 7992 (2.8%) more than Jan. 2004, averaging an increase of 666 enrollees over 12 months.
- Children's enrollment accounts for 69% of the increases seen in six months.

While HUSKY A enrollment continues to grow, recent census data reveals that, of the 71,000 uninsured children in CT, approximately 40,000 could potentially be eligible for HUSKY A. About 20% of current HUSKY A enrollees are using cash assistance. Insuring families (parents and children) increases children's enrollment by 16% (CT Covering Kids). The characteristics of the uninsured children, in that what percentage are ineligible because of legal immigrant status, is unknown. School Based Health Centers reported a growing number of uninsured children in their centers in 2005; however the reasons for this remain unclear. The SBHC, DPH and DSS began to address the uninsured issue in SBHC but to date have not pursued this discussion. Rep. McCluskey suggested that a task force focused on immigration issues might be helpful in getting answers to the uninsured questions.

Special Reports

Legislative Program Review & Investigations Committee

The committee authorized a study of the Medicaid eligibility determination process and the impact of state employee layoffs, early retirements and agency restructuring on the administration of the eligibility determination for the program. The study request was prompted by concerns that processing the applications was taking too long and that delays might affect client access to Medicaid programs. The study can be viewed on the committee's web site at: www.cga.ct.gov/pri.

A thorough review of programmatic aspects of Medicaid, including federal and state laws, regulations and Medicaid eligibility requirements as well as standard of promptness was undertaken. The study recommendations (total 31) that specifically impact HUSKY include:

- The HUSKY Enrollment broker (ACS) should submit address changes electronically to a central location within DSS and a technician would routinely update the changes into the eligibility management system. *At this time, through work with the Consumer Access subcommittee of the MMCC, CHNCT is piloting an address project with DSS and results will be reviewed in September.*
- Restore 14 positions of the ERIP losses at the regional level. *Restoration of positions was included in the biennial budget.*

- Implement “expedited eligibility determination for pregnant women instead of ‘ presumptive eligibility’ in statute. *DSS is working on this and will review the process at the MMCC in September.*
- Restore presumptive eligibility (PE) for children in HUSKY A. *This was in the budget.*
- DSS should develop a proposal for a new contract for the enrollment broker and single point of entry system.
- DSS should begin planning and developing an online HUSKY application system in 2005-2006.

The Council and Subcommittees will continue to work with DSS and follow-up on the status of the recommendations that were in 2005 legislation.

Children with Special Needs Medical Home Collaborative Update (May 2005)

At the request of the Council, Martha Okafor, Maternal & Child Health Director, DPH, provided the federal context for medical homes (MH) and the Title V Regional MH Support Centers (RMHSC) and the current status of these two inter-related programs as part of the system of care for children with special health care needs (CSHCN). (For more information: www.state.ct.us/dph).

- There will be 5 Title V RMHSC that will begin providing care coordination, family support services, respite care, extended services coverage and medical home capacity building after July 2005.
- The practice site MH for CSHCN is the basic component of the framework for the community-based system of care. The CT MH Training Academy was established in March 2005. Practitioner training will be sustained through web casts, practice trainings and audio/CDs. There are 8 MH practice sites participating in the MH collaboratives.

The definition of CSHCN is broad. National data shows that of the 120,000 children identified as CSHCN, 17.5% have a high severity of need index. An analysis of 10 states shows that about 1 % of CSHCN with a high severity index are in Medicaid. Sen. Harp requested DSS and DPH work together to develop a pilot that can be assessed for cost efficiency and improved quality of care for the child/family. The agencies agreed to this. The first step the agencies have undertaken is identifying the number of children in Medicaid by severity.

Medicaid Council: CSHCN Work Report/Recommendations (April 2005)

(See report on Council website: www.cga.ct.gov/ph/medicaid open April 05 meeting summary under MMC “minutes”)

Rep. Mary Eberle chaired the work group and outlined the task of the work group and recommendations. The Council Chair asked the work group to clarify the definition of the targeted population, differentiate MCO case management and physician directed care coordination, identify financial reimbursement for MH practitioners that perform documented care coordination and consider funding alternatives for a specific project for managing care for medically complex children and their families. The recommendations included:

- Develop a standard definition of Children with Special Health Care Needs, to be used by all MCOs. The Work Group recommends using the Title V eligibility definition.
- Screen all children, with special attention to children on SSI or under state care, for eligibility as CSHCN, as part of EPSDT.
- Reimburse primary care physicians for care coordination services performed for identified CSHCN.

- Develop uniform standards for MCO case management eligibility, covered CSHCN care coordination services, and PCP care coordination billing and reimbursement procedures for all MCOs.
- Consider using Program Improvement Plan funds, or other grant funding, to train pediatric primary care practices in the Medical Home model of care coordination
- Evaluate current DPH Medical Home pilots for costs/benefits of providing Medical Home care coordination services to Husky children.

Based on the recommendations, Sen. Harp presented her request to the agencies (see above) to develop a pilot based on the recommendations.

Department of Children & Families: Psychotropic Medication Advisory Committee

Outcome (see guidelines, protocols at www.cga.ct.gov/ph/medicaid , open April 2005 meeting summary under MMC “minutes”)

Dr Patricia Leebens, Director of Psychiatry, DCF, described the purpose and work product of the DCF Psychotropic Medication Advisory Committee (DCF PMAC). Two significant outcomes of the PMAC, that focuses on DCF committed children/youth and children treated in DCF facilities, were:

- Guidelines for the use of MH medications, monitoring protocols, DCF’s personnel medication information and permission process & policies (see above) were developed for the DCF vulnerable population, many of whom often have not had medical evaluations.
- Development of a medication “formulary” that focuses on client safety, rather than pharmacy cost containment. Certain drugs, or drug combinations, require consultation from the DCF Psychiatrist or RN prior to dispensing.

This topic was referred to the BH Oversight Committee (now the BHP Oversight Council) for more discussion and potential applicability to the BHP system. The MCOs noted that this would be beneficial and would provide opportunities for further collaboration on the initiative.

Office of Health Care Access: 2004 Household Insurance Survey (March 2005)

(See report and more information: www.state.ct.us/ohca)

The report, presented by Michael Sabados and MaryBeth Bonadies, described the approximately 10% of CT population that were uninsured at some point during the past year. Among the uninsured, 58% were working adults; 60% of these adults worked for employers who did not offer employer sponsored insurance (ESI). Families with lower income (<185%) were more likely to be uninsured and Hispanics had the highest rate of uninsured (21%). A percentage of the uninsured that required emergency care did not get care (11.3%), 20.6% did not choose to obtain non-emergent care and 18.5% did not fill prescriptions.

Small businesses are the majority of CT employers. A majority (52%) of firms (2-300 employees) offer employee and dependent coverage health benefits, while 9% covered employees only. Half of the uninsured work for small firms (10 or fewer employees) and many of these employers find affordable employee insurance beyond their reach.

The OHCA plans to:

- ✓ Survey working parents of HUSKY children paired with non-HUSKY working adults regarding coverage, willingness to participate in coverage options.
- ✓ Survey top employers of HUSKY parents paired with a sample of employers in similar economic sectors regarding interest in a premium assistance program.

Covering CT Kids & Families (May 2005)

Lisa Sementilli, Project Director for Covering Kids & Families (CCKF), reviewed the strategies developed to achieve the goals of the Robert Wood Johnson grant, which are reduce the number of the uninsured eligible for HUSKY and build outreach (OR) capacity.

- The CCKF identified outreach best practices including one-on-one application assistance, on-site OR at elementary schools and at health provider sites.
- Recommendations from the CCKF experience include support for ongoing coordinated & collaborative initiatives, broader marketing of the HUSKY Infoline to the public, continuing local community face-to-face OR and enhancement of DSS resources (staff & technology).

Council Subcommittee Activities:

➤ Behavioral Health Oversight Committee – Co-Chairs are Sen. Chris Murphy & Jeffrey Walter. Over the past 6 months the Committee and four work groups have met regularly to review DSS/DCF BHP policy and financial proposals, functions of the administrative service organization and policies for coordination of medical and mental health care. The work resulted in specific recommendations from each work to the two agencies. PA 05-280 also reflected ongoing oversight responsibilities of the BHP Oversight Council that had been recommended in the Committee discussions.

➤ Consumer Access Subcommittee – Co-Chairs are Irene Liu & Christine Bianchi. Activities included:

- Working with DSS/CHNCT on address change pilot
- Addressed more specific plan change information: DSS and ACS have developed a survey of clients that change plans.
- Continue to support on-line application process.

➤ Quality Assurance subcommittee – Chair is Paula Armbruster. Activities include:

1. Supporting DPH providing DSS with matched data on lead screens for enrollees in Medicaid HUSKY, which will provide more timely information to the health plans. The data will allow the MCOs to track children who have had age-appropriate lead screens, identify those with elevated lead levels and evidence confirmatory tests and give practitioner's feedback on lead screens.
2. Working with DSS and the MCO's on improving the EPSDT screening forms so that they are more provider-user friendly, provide prompts for age-appropriate anticipatory guidance and promote consistent chart documentation of the comprehensiveness of the service. This effort is an outgrowth of our adolescent health initiative.
3. Continuing efforts to improve adolescent access to health and ensuring that such health care is relevant to them (adolescents).
4. Planning a Women's Health forum for early November 2005.