

Medicaid Council Draft Quarterly Report: 3rd & 4th Quarter 2004
Date Accepted: 1/21/05

*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 **July through December 2004**. 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, Public Health, Behavioral Health and Quality Assurance.*

During 2004 the key issues included continued implementation of 2003 statutory cost sharing changes affecting Medicaid and HUSKY, followed by implementing 2004 statutory rescissions of the Medicaid cost sharing and program structural changes. The State Administered General Assistance program (SAGA) was fully implemented in 2004. Plans for carving out behavioral and dental services have been reviewed through the year.

In the last half of 2004 the Medicaid Managed Care Council met monthly, with the exception of the month of August, during the last half of 2004. During these meetings there has been ongoing discussion of the proposed HUSKY changes for dental and behavioral health services and the implementation of the reorganization of the State Administered General Assistance program (SAGA). HUSKY program quality and performance assessments were assessed through discussion of the HUSKY MCO data reports. Special reports were presented that impact HUSKY members as well as other CT residents. The Commissioner of DSS presented an overview of the Human Service Infrastructure initiative.

Medicaid Council Recommendations for the 3-4th Quarters 2004

Month Recommendation Made	MMCC Recommendations	Status of Recommendations

<p>July 2004</p>	<ul style="list-style-type: none"> · The MMCC continue to receive program updates and data on the SAGA program. · ACS provide more detail on “other” reasons for HUSKY member plan changes. 	<ul style="list-style-type: none"> · Received updates through November. · Pending
<p>September 2004</p>	<ul style="list-style-type: none"> · DSS, DCF, MCOs encouraged to focus on integrating medical/BH services in carve-out · MMCC approved Obesity Rec. 	<ul style="list-style-type: none"> · Will be part of the BH Oversight Committee & work group issues. · QA SC follow-up
<p>October 2004</p>	<ul style="list-style-type: none"> · DSS requested involvement of DSS Dental Committees in service transition in carve-out. · 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"> · DSS agreed: committees formed in Dec. · DSS noted ED utilization will be part of Mercer’s work. · Information provided in Nov, DSS/MCOs reviewing reporting parameters
<p>November 2004</p>	<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 · Pending · DSS met with MCOs regarding CM issues. · The Committee chairs plan to address this as part of transition work with DSS, DCF, MCOs, family rep. and advocates & providers.

<p>December 2004</p>	<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"> · DSS agreed to work with MMCC, other stakeholders.
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Summary of Meeting Content July-December 2004

HUSKY and Medicaid Programs

HUSKY Waiver Renewal

The Centers for Medicare & Medicaid (CMS) renewed the 1915(b) waiver, under which the Medicaid HUSKY A program operates, for a two year period beginning **July 1, 2004 through June 30, 2006**. The Title XXI (SCHIP) HUSKY B program operates under the State Plan previously approved by CMS.

DSS/MCO contracts

The current contract, set to expire 9/30/04 has been extended through 1/31/05. This contract will probably be extended beyond January 2005 now that the dental carve-out February implementation date has been postponed.

Restructure of Dental and Behavioral Health Services

Dental Carve-out

In July 2004 the Department of Social Services (DSS) announced the Agency had offered the opportunity for two of the three bidders for the dental Administrative Service Organization (ASO) to negotiate contracts with the Department. United Health Care -DBP, the dental subcontractor for Anthem Blue Care Family Plan and Doral Dental, the Health Net dental subcontractor, are negotiating a contract for a statewide, non-risk dental ASO, which will serve HUSKY A and B members (Medicaid fee-for-service clients may be included in the future). Initially the DSS had planned to contract with one ASO, however two ASOs were chosen to ensure client choice, DSS leverage for contract compliance and relieve the agency from sole dependence on one ASO entity. The DSS will amend their contract with the State enrollment broker, ACS, as HUSKY members will choose a dental ASO through this entity.

The dental carve-out was to begin February 1, 2005; however in December 2004 the Department announced the implementation date has been postponed. Public comments to the notice of the dental restructuring published in the CT Law Journal at the end of October included concerns about dental fees and client access to services. These issues, part of the ongoing litigation, have budgetary implications that need to be addressed during the biennial budget session beginning January 5, 2005.

Behavioral Health Carve-out

The proposed restructured Behavioral Health program will include HUSKY A children and adults, HUSKY B and Department of Children & Families voluntary services populations. In 2004 the Legislature did not approve the three agency BH Partnership that also included Medicaid fee-for-service adults in the DMHAS program. Subsequently the DSS and DCF released a new RFP for the BH ASO in September and bidder proposals were submitted at the end of October 2004. As of December 31, 2004 the successful bidder had not been announced.

The Medicaid Council's Behavioral Health Subcommittee was reconfigured to serve as an interim oversight committee for the BH carve-out and the ongoing implementation of the DCF KidCare program. A core membership committee, based on representation outlined in 2004 proposed legislation was developed, is chaired by Sen. Chris Murphy and Jeffrey Walter. The BH Oversight Committee met for the first time in November 2004. The Committee will review and make recommendations to the legislative Committees of Cognizance on the rate methodology as well as address clinical management, BH/medical service integration and transitional issues.

State Administered General Assistance Program (SAGA)

This State-funded program has undergone major changes since 1998, including change from municipal to state administration, SFY02 elimination of non-emergency transportation services (dialysis, chemo and radiation therapy exceptions), SFY03 elimination of optional Medicaid services, SFY04 co pays added, SFY 05 co pays removed and SFY04-05 restructuring of the service delivery system. For SFY05 (July 1, 2004-June 30, 2005) SAGA funding by medical service type is:

- Hospital - \$47million plus ancillary adjustment, 12 months
- Ancillary services - \$7.6M
- Primary/specialty care - \$16.5M
- Pharmacy - \$33.9M

The stated purpose of the SAGA restructuring was to contain health care costs within the appropriated funding through effective management of services, including coordination of health services.

- On August 1, 2004 Community Health Care of CT (CHNCT) contracted with DSS as a non-risk ASO, responsible for managing non-inpatient primary and specialty medical services, pharmacy services, developing and maintaining a provider network and claims processing for non-inpatient services.
- Hospital inpatient and outpatient services, with the exception of hospital primary care and OB/GYN clinic services and associated ancillary services (CHNCT responsibility) will be paid by DSS under the capped appropriation.
- Mental health services will continue to be managed by the Department of Mental Health and Addiction Services (DMHAS) but the psychotropic medications remain in the DSS SAGA budget. Clients seeking BH services are instructed to call 211, the CT Infoline for provider contact. There is no BH SAGA client service contact within DMHAS or their two ASOs.
- SAGA provider policy and reimbursement changes can be found on the DSS website: www.ctmedicalprogram.com, policy transmittal 2004-21 & -16.
 - o Hospital SAGA payments have been reduced to approximately 64% of the previous reimbursements. The shortfalls may be accounted for through the Disproportionate Share Hospital (DSH) pool, although they will have to be claimed separately as the State cannot claim twice to CMS for the same service
 - o Services delivered in the Federally Qualified Health Clinics will not have the "wrap-around" reimbursement associated with federal programs. SAGA is not a federally funded program rather a state funded program.
- SAGA clients were assigned a primary care provider (PCP) effective 8/1/04 and as of

10/1/04 clients will remain with their chosen or assigned PCP. Requests for out-of-network (OON) and non-PCP authorized services will require prior authorization after 9/30/04. Decisions for OON will be made on a case-by-case basis based on established criteria

- The SAGA provider network has expanded under CHNCT to 570 PCPs (70 PCPs credentialing in process), including all 12 FQHCs, 1598 specialists (236 provider credentialing in process), representing a 121% and 422% increase respectively since 8/1/04. .

- SAGA transportation is for emergency services only; non-emergency (NEMT) transportation is limited to clients undergoing dialysis, chemotherapy and oncology treatment.

The Medicaid Council will continue to request periodic updates on the status of the SAGA program.

MCO Revenue and Expense Report Calendar Year (CY) 03

	Anthem 02	Anthem03	CHNC T 02	CHNC T 03	HN02	HN03	PONE 02	PONE 03	Mean02	Mean03
Revenue	252,477,000	273,270,273	\$100,832,084	\$115,755,706	\$204,851,951	\$218,338,116	\$37,254,274	\$39,198,519	595,415,309	647,012,614
Expenses	251,094,000	279,290,661	98,589,517	113,736,912	198,435,166	217,946,426	36,162,807	37,347,154	584,281,490	648,124,602
Net Income	\$899,000	(\$3,620,798)	\$2,242,567	\$2,018,794	\$4,023,324	\$252,815,3	\$1,035,266	\$37,347,154	11,133,819	(157,024)
Med Loss	91%	93.9 %	87%	87%	90%	91.3%	83%	79.9 %	89%	91%
Admin. Loss	9%	8.2 %	11%	11%	7%	8.5%	14%	15.2%	9%	9.2%
Margin	0%	(1.3%)	2%	1.7%	2%	0.1%	3%	2.1%	2%	0.0%
PMPM Margin	-	(\$2.29)	-	\$3.39	-	\$0.20	-	\$4.20	\$3.21	(0.04)

The report shows variations on per member per month (PMPM) administrative and medical expenses among the MCOs.

- Administrative expenses reflect plan membership volume, which may explain PONE having the highest administrative expenses (15.2%).
- The medical loss ratio, which reflects medial expenditures, generally should be over 85%. Each of the MCOs, with the exception of PONE, was greater than 85%. PONE noted that lack of tertiary contracts in the first half of 2003 influenced their member case mix.
- Anthem BCFP reported a net income loss of \$3.6 million, which the plan attributed to paying higher hospital reimbursement in order to maintain the network. The health plan stated that their medical expenditure trends would exceed the 2% rate increase in SFY05.
- CHNCT stated that their increased medical costs are related to an increase in enrollment of pregnant women in CY03.

The two largest MCOs, Anthem and Health Net, showed either a loss (Anthem -1.3%), or small profit (HN 0.1%) while the other two MCOs profit margins were greater (CHNCT 1.7% & PONE 2.1%). Similarly the PMPM margins showed the same pattern with Anthem showing a loss while PONE, the smallest MCO had the highest the PMPM margin of \$4.20.

Total dental and behavioral health expenditures were notable, given that future service carve-outs will require adjustments of the MCO PMPM capitation rates minus these services. The MCOs and the DSS will negotiate these adjustments as part of the new contract.

Total Dental and Behavioral Health Expenditures 2002-03

	2002	2003	Percent Change
Member months	3,441,027	3,575,789	3.9%
Net BH Expenditures	\$49,463,122	\$57,726,691	16.7%
\$ Per member per month (PMPM)	\$14.37	\$16.14	12.3%
BH Reinsurance \$	\$23,107,956 (<i>47% of all BH Expenditures</i>)	\$27,837,092 (<i>48% of all BH expenditures</i>)	20.3%
Dental Expenditures	\$26,282,728	\$28,057,622	6.8%
\$ PMPM	\$7.64	\$7.85	2.7%

HUSKY Quality Measurement (October & November)

Review of maternal health, preventive care and Emergency Dept (ED) visits elicited discussion

and recommendations for problem resolution:

ü **Maternal health:** the problem of missing data was quite apparent, making it difficult to accurately quantify women's access to prenatal care, percentage of women that receive 80% of PNC visits and postpartum visits. The health plans spend considerable administrative resources in obtaining service information (some of which may be difficult to sort out with global MCH rates) and practitioners time is also taken in providing data that is in the Department of Public health vital statistics birth data. While DSS and DPH have a Memorandum of Understanding to match vital statistics birth data with Medicaid enrollment data, the match is done yearly. This does not meet the reporting requirements of DSS. The Council requested DPH and DSS consider the possibility of matching data more frequently, reducing the redundancy or data gathering. Both agencies agreed to meet with the MCOs to assess the feasibility of this.

ü **Emergency visits** have steadily increased since the 1Q02, approaching the FFS rate. The Quality Assurance Subcommittee had relayed Sen. Harp's request that ED visits be assessed by age (in an attempt to look at HUSKY adult trends), gender and "top" diagnostic reasons.

· The DSS stated that Mercer, the DSS Quality Review contractor, would report to DSS on the above measures as well as on diabetes and asthma diagnoses associated with ED visits. The MCOs will focus on asthma, and follow up outpatient care, identifying action steps to decrease ED asthma related use.

· Sen. Harp outlined two areas of concern: 1) there is no break down of emergent, urgent and non-urgent visits and 2) the policy issue of hospitals expanding urgent care centers, which may emphasize this service availability at the expense of more continuity of care through the PCP system.

ü **Preventive care services:** positive aspect is that 45-50% of both females and males aged 13-17 years continuously enrolled in HUSKY received preventive care visits. The troubling aspect is the low percentage of women receiving breast (30% in a year) and cervical cancer screens (40% in one year).

· All DSS reporting parameters do not conform to HEDIS measures, which prevent comparisons to national performance benchmarks. For example the preventive cancer screens are reported annually by the MCOs, while national measure assess mammograms over 2 years and cervical screens over 3 years. Some of the HEDIS measures do not conform to federal reporting requirements, Hedis measures do not include reports such as ED use and HEDIS reports are generally based on a continuously enrolled population. The latter is of concern as HUSKY members can change MCOs monthly; this could discount 30% of Medicaid member's utilization. The DSS and the health plans will be meeting to review HEDIS measures that could be adapted to the HUSKY reporting parameters.

· Preventive care for children and youth may be under-represented by the data, in part related to billing issues. School Based Health Centers identified reimbursement issues including non-PCP status, which prevents EPSDT reimbursement in some cases and an inadequate billing system. In December the SBHC representative outlined the billing challenges further as well as the growing number of uninsured in the SBHC population (increase from 27% in 00-01 to 30% in 03-04). Rep. Nardello requested DSS work with her and SBHCs to identify and address the uninsured problems.

The Medicaid Council requested 1) the four MCOs respond to variations in their performances (both under-performance & above-average performances) in the data reports and 2)

FirstChoiceCT/Preferred One (PONE) outline the systematic resolution of past data problems.

MCOs response to performance variations:

§ **Adult preventive care:** PONE rechecked their mammography data and found a reporting error, however their annual screening rate remains lower than the other 3 MCOs. All 4 plans noted the differences in HUSKY/HEDIS reporting parameters; however each plan has identified action plans for enhanced member outreach for preventive cancer screens.

- **Maternal child health:**

- **Anthem** noted there is overall missing data and postpartum (PP) services delivered outside the 21-56 day reporting time frame (taking these visits into account would adjust the PP visit rate to 86%).
- **Health Net** exceeded the average MCH utilization rates; the MCO stated it diligently collects birth data from practitioners, thus having less missing data. The Health plan will implement a new prenatal care program with aggressive outreach to members and providers in January 2005.
- **CHNCT** has had consistently higher than the average member participation in MCH services. The plan attributes this to their Outreach staff success in contacting and following up with members.

• **Inpatient Stays:** CHNCT report showed the highest days per 1000MM inpatient stays. While CHNCT's internal data review showed 38.2 days rather than 53 days/1000MM, CHNCT noted their inpatient days variance was in part attributed to 10-12% of all newborns are 'preemies' requiring Neonatal Intensive Care extended stays. Action plan: The plan will continue to internally monitor report discrepancies and sick newborn rates, hiring a perinatologist consultant to work with the MCO in 2005 regarding high premature birth rates.

• **Emergency Room (ED) visits:** Both CHNCT and PONE had higher ED utilization rates compared to the other two MCOs.

CHNCT stated that:

- o Overall ED and urgent care use is rising. More facilities and satellite ED/urgent care centers are billing ED codes and these entities are aggressively advertising the availability of these ED services.

- o The use of EDs for non-emergent care has increased, related to the proximity of urban EDs to the member population, frequent PCP changes and increasing fragmentation of care between the PCP and specialty services.

Action plan: CHNCT will continue to report those members with frequent ED use to their PCP, and contact the member post ED visit to assess assistance need for PCP contact. CHNCT plans to implement a new pilot that offers incentives to an identified health center to increase staffing and off-hours services.

PONE reported that it has an exclusive contract with one facility that has extensive urgent care services and 30% of all ED services in December 2003 were provide by this facility. The high Dec03 ED rate was attributed to the 2003 severe flu season. There was no specific action plan outlined; however the PONE Medical Director's expertise is in ED services and will be addressing this issue.

• **Behavioral Health Services:** PONE recalculated their BH utilizations rates, found a BH subcontractor reporting error and reported that the previously reported 4% BH service rate is

actually 9%.

PONE response to persistent data problems:

The Council Chair had expressed concern that PONE continues to report data for some services that are significantly lower than the average HUSKY MCO rates, which are recalculated at higher rates and expected the MCO to provide a data reporting correction action plan to the Council. David Smith (COO) reviewed the data issue noting that over the past several years the inability of PONE to consistently provide accurate and timely data reporting often resulted in the plan “recasting” their reports, which raised questions about the plan’s performance credibility. The MCO’s *action plan* for improving data integrity includes corporate audits for technical & clinical peer review groups, creation of a Regulatory Reporting committee with corporate oversight of all data reporting and reconciliation of all data reporting prior to data submission to Mercer and DSS.

HUSKY Enrollment

Overall enrollment in HUSKY A continues to increase, although at a lower rate than in 2002 (see graph below). Legislation passed in 2003 made significant changes in HUSKY A eligibility (see OLR report 2003-R-0846) including:

- PA03-2: reduction of income limits from 150% to 100% for adult/caregiver coverage, elimination of children’s 12-month continuous eligibility and adult 6-month guaranteed eligibility, effective March 31, 2003.
- PA03-3 eliminated presumptive eligibility for HUSKY A children, effective October 2003.
HUSKY A 12 month Enrollment Change Between Jan & Dec 2002-2004

ü Total *HUSKY A* enrollment was 305,689 as of December 1, 2004.

ü *HUSKY B* enrollment is gradually increasing, recording the highest enrollment numbers since 1998 in Dec. 2004 (15,254) and a gain of 634 members from January to December 2004. The DSS returned the Band 1 & 2 co-pay policy back to the pre- February 04 level effective June 1, 2004.

Special Reports to the Medicaid Council

Special reports were presented during the last two quarters that provided an in depth look at HUSKY services in 2003 as well as programs outside of the managed care delivery system that would impact HUSKY members as well as eligible and/or potentially eligible Medicaid clients. *HUSKY A Program Special Reports: CT Voices, Mary Alice Lee(see www.ctkidslink.org for full reports)*

ü *Health & Health Care Disparities Among Newly Enrolled HUSKY A Children:* the CT Health Foundation funded a longitudinal study of families newly enrolled in HUSKY A in 2002-2003.

· Prior to enrollment, 1 in 3 of these children were uninsured, with 50% uninsured for 1 year. Uninsured children were less likely to have a usual source of health care and more likely to have unmet health care needs.

· After 6 months enrollment in HUSKY A, 7% more children had primary care providers, fewer children relied on the ED for care, 11.5% fewer children had unmet health need (with the

exception of dental care, 20% had unmet dental needs).

- At one year enrollment racial/ethnic disparities were reduced.
- Recommendations included efforts needed to target families whose children have not received care within the 1st 6 months of enrollment, all children should initially be screened for recent insurance coverage, usual source of care, access to Primary Care and dental care.
- ü *Dental Utilization CY 2003* describes dental utilization of children ages 3-19 years that were continuously enrolled in HUSKY 11 of 12 months.
- In 2003 there was a 17% increase in enrolled children within the study parameters compared to 2002.
- While more dental services were provided related to the increased numbers of enrollees, utilization of services (i.e. 2 preventive visits/year) remain stagnate: 47% received any dental service, unchanged from 2002, 40% had preventive services (13% had 2 visits/yr) and 21% received dental treatment, unchanged from 2002.
- Children in communities with enhanced dental infrastructure funded by CT Health Foundation received more dental services than those in other communities. Rep. Nardell stated that additional funding might be necessary to assess the impact of preventive dental interventions on required dental treatment.
- ü *Effects of Medicaid Coverage on Prenatal Care (PNC) & Birth Outcomes:* This report findings, based on 2001 birth Registry data, was similar to other studies in that there is lack of evidence of the impact of PNC alone on improving birth outcomes:
 - Of the women that gave birth while enrolled in HUSKY A, 43% were already enrolled prior to pregnancy, while 57% were assumed to be uninsured prior to enrollment. Women already enrolled in HUSKY prior to pregnancy may be at risk for adverse birth outcomes due to factors beyond insurance status (i.e. lower family income if enrolled as a parent of HUSKY child-100%FPL whereas pregnant women up to 185% are eligible for HUSKY based on income and documented pregnancy).
 - Report conclusions included: Women enrolled in HUSKY prior to pregnancy had improved access to early and adequate PNC, (women enrolled in the 1sttrimester have the *least* inadequate PNC) with no improvement of birth outcomes such as preterm birth or low birth weight; women enrolled prior to pregnancy need access to family planning services; early identification and enrollment of women into Medicaid facilitates access to PNC, reinforcing the importance of timely eligibility determination and community-based coordination of early PNC. Council members noted the importance of systematic identification of “high risk” women at the point of enrollment in Medicaid managed care, use of statewide data to identify women with adverse birth outcomes and the mother’s co-morbidities and the State’s consideration of inter-conception coverage beyond the postpartum period to improve the woman’s health status as well as status of the infant.

Early Childhood Partners (ECP) Initiative: Department of Public Health

The ECP is the DPH response to the federal requirement to develop an integrated system to improve the health and school readiness of every child 0-5 years in CT. The first two years of the federal grant is devoted to the development of a strategic plan for a comprehensive early childhood system of care, focusing on a medical home model and health care access, childcare & early education, socio-emotional health, parent education and family support. The ECP core planning committee work is linked with state/local programs as well as the State Prevention Council and local planning activities. A draft plan has been shared with community partners and

a field test of the implementation plan is in process.

CT Lead Action for Medicaid Primary Prevention (LAMPP) (contact the Project Director at Rkraatz@ccmckids.org for more information)

This innovative early intervention and prevention program targets the reduction of housing lead hazards for Medicaid enrolled children under 6 years old. Funded through the US Department of Housing and Urban development (HUD) the Department of Social Services is the primary sponsor with support from the DPH and the CT Dept. of Economic and Community Development.

- Six target communities, multiple lead coalition members, health care providers, HUSKY families and the two lead centers in Hartford and New Haven are participating.
- Landlords that voluntarily participate contribute \$600 toward the reduction of their units lead hazards and assist in the temporary relocation of families during the work on the units. The LAMPP project provides on average \$6500 per unit.
- Landlords then agree to give rental priority to families with children <6 years, maintain affordable rent levels and maintain the units in accordance with the federal Housing Quality Standards for the next three years.
- Education is provided to families, landlords, and contractors on low cost lead hazard interventions.

The DSS Human Service Infrastructure Initiative

Commissioner Wilson-Coker provided an overview of this initiative at the December Council meeting. State budget issues prompted the need for a more cost efficient and comprehensive human service system that promotes opportunities for CT residents to achieve self-sufficiency.

- The program goals include better use of existing resources, client connection to community resources, coordination of all “helping” services within the human services infrastructure and client preparation to use the DSS services more efficiently at the regional office level.
- The Initiative foundational partners are the DSS, the 211 Infoline, and the CT Community Action Network (CAAs) that are federally designated Antipoverty Agencies.
- The basis of the initiative is multi-agency coordination that breaks down the silos between programs and among agencies. A “one-stop” assessment at CAA sites supports the holistic evaluation of individual/family service needs. Assessments range from a universal intake to client triage, full assessment for case management of clients with multiple needs and pre-application assistance for DSS programs, including Medicaid and HUSKY.
- The Initiative evaluation initially includes tracking clients along the self-sufficiency continuum, identifying resource use and client status change, unmet needs through Infoline and client focus groups. Eventually evaluations will identify the cost value of services used, assessing the cost benefit of coordinated assessment and service provision for clients/families with multiple needs.

The Council commended the Commissioner for her leadership in developing the Human Service Infrastructure initiative and strongly supported program evaluation that identifies trends in service utilization. While initial service costs may increase, there may be measurable long-term benefits of family stability, shorter length of program involvement and a reduction of re-entry into the system.

Council Subcommittee Reports

Ø Behavioral Health Oversight Committee: Chairs- Sen. Chris Murphy and Jeffrey Walters.

The BH Subcommittee was reconfigured to include a core membership group based on a 2004 legislative proposal. The Committee will have oversight of the proposed BH service restructuring and the ongoing implementation of KidCare. Specifically the Committee will review and make recommendations about the clinical management process through the ASO and the two partnership agencies DSS & DCF, the proposed rate methodology, managed care transitional issues, care coordination with the MCOs and the ASO and integration of medical and BH care. The committee met in November and will continue to meet monthly.

Ø Consumer Access Subcommittee: Chairs -Irene Liu & Christine Bianchi

The subcommittee has worked with DSS, MCOs and representative participants on the potential CT on-line application process, facilitating HUSKY address changes in the DSS system and clarification of special transportation authorization in HUSKY A. The Subcommittee will form an ad hoc work group to review and make recommendations to DSS of MCO major marketing initiatives.

Ø Quality Assurance Subcommittee: Chair Paula Armbruster

The subcommittee, through Pediatrician's input, provided recommendations to the Council on childhood obesity, the prevalence of which has been steadily growing over the last decade. The recommendations focus both on the HUSKY program and the overall state approach to obesity surveillance and application of best practices toward clinical assessment and intervention through a central Steering Committee. Specifically in HUSKY, it was recommended that the DSS have the HUSKY MCOs work with their network pediatric providers & PCPs to ensure documentation of the member's BMI, collaborate with the CT Academy of Pediatrics and others in health practitioner education on appropriate reimbursable clinical screens for co-morbidities associated with obesity and develop a program improvement pilot that evaluates clinical assessment of children and adults that are overweight. An informational tool was developed that outlined each MCO's coverage of obesity-related services.

The Subcommittee has also participated in the DSS/MCO/provider work group on revising the state EPSDT forms and anticipatory guidance items.