

**Medicaid Council Quarterly Report: 1<sup>st</sup> & 2<sup>nd</sup> Quarters 2006**

*Date Accepted: September 2006*

*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 2006**. 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 (HUSKY A) and in 1998, the State Children's Health Insurance Program (SCHIP), which is HUSKY B. The law also charges the Council with monitoring such planning and implementation and advising DSS 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 and Quality Assurance Subcommittee.*

The Medicaid Managed Care Council and Subcommittees met monthly from January through June 2006. A summary of the topics/themes evident during the last six months include:

- Administration of the HUSKY A and B program included DSS/MCO rate adjustment negotiations, the BH financial carve-out negotiations and associated contract amendments, which had not been concluded by the June meeting. Discussions about adequacy of program funding, in the context of the state budget, spending cap and federal funding generally raise the specter of the loss of managed care plan (s). DSS stated their main concern in the negotiations is maintaining continuity of health plan contracts that meet HUSKY enrollee medical needs. Contingency program plans such as recruiting new plans or adding another delivery system model is often mentioned in these annual discussions. Questions about the impact of MCO rate increases on HUSKY provider rates were raised. The Freedom of Information (FOI) ruling on MCO rate disclosure was discussed as part of the rate/contract issues, although DSS sees these as unrelated. As of June 2006 one plan, WellCare/Preferred One, agreed to include provider rate disclosure language in the contract with DSS. The other three plans will challenge this requirement through the State Superior Court on August 1, 2006. The Court will decide, based on the 2001 Public Act, what if any MCO documents are related to governmental function.
- Program policy changes (state and federal) impact on enrollment was explored in view of the declining HUSKY A & B enrollment that began July 2005. Inherent in this are added administrative costs to DSS and MCOs and difficulty for MCOs to project PMPM revenues.
- Discussions about HUSKY quality and access to health care were broadened with special reports from CtVoices, the Office of Health Care Access and the Easy Breathing (asthma) Program. There have been notable improvements in children's preventive care, meeting the federal performance measure of 80% in EPSDT services in HUSKY A and increasing pre and adolescent preventive care rates. Maternal pre-post partum service rates also improved

in the last half 2005.

The 2006 legislative session restored funding for policies that had contributed to enrollment barriers in HUSKY as well as funded the development of an on-line application system, added funding for some Medicaid and Stated Administered General Assistance providers and separately funded children's dental services in the primary care setting. The federal law requiring Medicaid applicants/recipients who declare U.S. citizenship to now provide original documentation of this has the potential to offset any positive changes the State has made in simplifying the HUSKY application process.

### **Council Requests/Recommendations**

<b>Request/Recommendation/ &amp; Council meeting date</b>	<b>Status as of June 2006</b>
<b>Recommend MCO quarterly report authorization denials 1/06</b>	<b>DSS worked with Consumer Access SC to define report parameters; report will be available fall 2006</b>
<b>Improve asthma outcomes: DSS/MCOs collaborate with the Easy Breathing Program -2/06</b>	<b>Pending?</b>
<b>Legislative receipt of 1) HUSKY members/employer -2/06 &amp; 2) rationale for dental expansion for children - 5/06</b>	<b>Legislators received information</b>
<b>Enrollment: 2-5/06</b> <ul style="list-style-type: none"> <li>▪ Quantify # children ineligible for HUSKY A referred to ACS, of these, # enrolled in HUSKY B</li> <li>▪ Provide children's enrollment losses by age</li> <li>▪ Identify insurance status of those lost HUSKY</li> <li>▪ Estimate administrative cost of “churning” enrollment</li> </ul>	<ul style="list-style-type: none"> <li>▪ In progress</li> <li>▪ Future meeting summary</li> <li>▪ DSS/OHCA/UCONN doing a survey of those that lost coverage in past 13 months and those that lost TMA; survey completion by September 2006.</li> <li>▪ Difficult to asses per DSS</li> </ul>
<b>DSS work with OHCA to produce ACSC reports for HUSKY A child/adults, HUSKY B and ABD Medicaid populations 3/06</b>	<b>Pending?</b>
<b>DSS adopt same ED reporting indicators for MCO utilization, Mercer audits. 4/06</b>	<b>Pending</b>
<b>DSS work with MMCC to produce a “HUSKY 101” video program for distribution to community. 2005</b>	<b>June 9, 2006, video taping with Q&amp;A. DSS will insert vignettes for final product.</b>
<b>DSS determine best approach for MCO 6-month MCH reports that are more complete and less administrative burden to providers &amp; MCOs 2005 &amp; 4/06</b>	<b>Being reviewed</b>
<b>SAGA reports: add ED/hospital diagnoses, assess reasons for enrollment increases, consult with DMHAS 4/06</b>	<b>In progress</b>

### **Program Administration**

DSS/MCO Contracts (1-6/06 meetings)

- ✓ DSS/MCO negotiations for the **'carve-out' of behavioral health dollars** from the MCO monthly capitation rate had not been completed at the time of the June 2006 council meeting. DSS will reconcile the rate adjustment back to January 1, 2006, the start of the new Behavioral Health Partnership program. Contract amendments related to the MCO coordination of care with the BHP program are associated with the carve-out negotiations.
- ✓ These BH negotiations are the precursor to the MCO negotiations for SFY 07 rate adjustments, which had not been completed for the June 2006 Council meeting. In January DSS outlined key contract change areas under consideration that included:
  - Capitated MCO dollar investment in health plan marketing.
  - Specialty provider panels and service access with development of a process for MCO periodic validation of specialty network panels to DSS. Validation may be based on a calendar reporting period or triggered by access complaints.
  - Negotiation of the 'across-the-board' MCO rate adjustments for SFY 07 had not been concluded as of the June 9<sup>th</sup> Council meeting. The SFY07 budget included a 2% MCO rate increase. Discussion points related to the rate adjustments at the June 9, 2006 Council meeting included:
    - Last June the MCOs agreed to across the board rate increases with the proviso that if a MCO found the rate adjustment unacceptable the plan would give DSS six months notice (January 2007) of the intent to no longer participate in the HUSKY program.
    - Sen. Looney had proposed that MCO rate increases be withheld until the MCOs disclose provider rates per the FOI, which was not agreed to by DSS and the Office of Policy & Management. DSS asserted that the MCO rate adjustment negotiations are unrelated to the FOI issues.
    - In response to questions to DSS about contingency plans if one or more MCO chooses not to participate in HUSKY as of January 2007, the department stated there is a RFP for new plans and the agency has, in the past, looked at the Primary Care Case Management (PCCM) model.

Risk Adjustment & Medicaid Rate Setting (3/06 meeting)

Mercer, the state actuary for Medicaid, provided an overview of the risk adjustment methodology applied to the SFY06 rates. According to Steve Schramm (Mercer), the process of determining risk adjusted rates involves predicting health care expenses based on previous diagnoses and distribution of MCO capitation payments based on the health risk of members enrolled in each plan. This process leads to rate *allocation* not rate setting. Risk adjustment requires data validation, measurement of MCO efficiency relative to the illness burden of enrolled members and establishment of MCO risk scores. Mr. Schramm stated that SFY06 MCO rate issues were data quality, risk volatility, MCO trends versus overall trends and program financials. Negotiation issues for all MCOs were quality of care, member satisfaction, network size and financials/rates. Below is the summary of plan risk scores applied in the DSS/MCO negotiations:

MCO	Risk Score	SFY 06 Rate Increase	Est. Member Months	Annual \$ Increase
Anthem	1.015	5.50%	1,522,956	\$15.9M

CHNCT	1.036	3.00%	669,852	\$3.8M
HealthNet	0.987	4.70%	1,055,472	\$9.2M
WellCare/Preferred One	0.919	1.85%	401,388	\$1.4M
Wt Average Total	1.000	4.41%	3, 649,668	\$30.4M

The Council Chair and some members expressed concern about the lack of clarity of the Agency's rate adjustment process. The process has the potential to create disincentives for implementing better management of chronic illness and profit-based positive health outcomes. Multiple variables were not quantified in the presentation. Questions about efficiencies within managed care in managing illness and the relation to establishing rates remained unanswered given that:

- The Office of Health Care Access (OHCA) report on Ambulatory Care Sensitive Conditions (ACSC) shows rising overall Medicaid costs for certain avoidable hospitalizations and in particular Medicaid conditions that may apply to the HUSKY populations, such as pediatric asthma, low birth weights and adult asthma.
- HUSKY utilization reports that are descriptive in nature of screens/services, rather than quantitative data on intervention/outcomes. The department's agreed-upon collaboration with OHCA on ACSC may yield quantifiable data for HUSKY and fee-for-service (FFS), (*as would MCO reports on disease management and case management programs*) that would better inform the Council about profitability, efficiency and improved health quality factors in the delivery health services in the public program and associated rate adjustments.

#### Carve-out of Behavioral Health Services in HUSKY A & B (1/06 meeting)

Public Act 05-280 authorized the separation of behavioral services for HUSKY A children/adults and HUSKY B children from the existing HUSKY managed care program and established a Behavioral Health Partnership (BHP) Oversight Council. The provision of behavioral health services, now the Behavioral Health Partnership (BHP) program, is the direct responsibility of the departments of Social Services and Children & Families. The agencies selected an administrative service organization (ASO), ValueOptions. Providers will contract with DSS and claims other than for DCF services will be paid by the DSS contractor EDS. The managed care organizations retain responsibility for pharmacy, transportation, emergency visits and coordinated case management with CTBHP ValueOptions. The health plans are responsible for resolving claims incurred under the managed care program.

#### **Program Policy**

#### Children's Presumptive Eligibility & Pregnant Women's Expedited Eligibility (4/06 meeting)

Children's Presumptive Eligibility (PE) and pregnant women's Expedited Eligibility (EE) were implemented November 30, 2005. Updated reports were provided during the 1<sup>st</sup> half of 2006:

- ✓ **Children's PE:** about 56 PE assistance units (about 140 children) are granted per week. There are 3 Regional Processing Units (RPUs) and over 100 qualified entities throughout the state that may grant PE. The child's medical care is covered under Medicaid Fee-for-service while the completed HUSKY application is processed at one of the RPUs and eligibility is determined. The number of PEs granted weekly seems low

given the ongoing monthly loss of children in HUSKY A & B.

- ✓ **Pregnant Women's EE: as of April 2006**, of the 2,245 EE's granted:
  - **66%** of the overall percentage of new applications granted was **within one-five days**. Since Dec. 2005 there has been an increase in one-day determinations.
  - **10%** of the total applications (2,245) were granted **after 5 days**. Since Dec.–Jan. there has been a slight increase in this category.

Transitional Medical Assistance (TMA) Duration Changed (2/06 meeting)

PA05-280 reduced the length of time individuals with earned income can remain covered by Medicaid from 24 months to 12 months. Approximately 8,600 families (about 15,000 adults/children) would lose TMA coverage **June 30, 2006**. In anticipation of the 'drop-off' of HUSKY enrollment, DSS provided each managed care organization with information on their members that would lose TMA coverage June 30<sup>th</sup>, 2006. The MCOs attempted to contact members to encourage them to reapply for HUSKY. Two plans reported they were able to contact 25-30% of these members by phone. Community organizations were alerted to the pending loss of coverage if the person didn't reapply for HUSKY. The policy impact will be seen in the July enrollment numbers.

Impact of Policy Changes on HUSKY Enrollment (2/06 meeting)

The department was asked to provide a summary of the impact of policy changes on HUSKY enrollment over the past several years in order to evaluate future policy and budget provisions. Kevin Loveland (DSS) provided information on significant HUSKY policy changes and corresponding enrollment changes. The impact on enrollment was notable in:

Time Period	Policy	Enrollment Impact	Comments
April 2003	<ul style="list-style-type: none"> <li>▪ Elimination of Continuous (CE) &amp; Presumptive (PE) Eligibility</li> <li>▪ Reduction parent/caregiver income level to 100% FPL</li> </ul>	<ul style="list-style-type: none"> <li>▪ Loss of 11,615 enrollees from May-June 2003.</li> <li>▪ Over next 2 yrs. monthly increase in enrollment to highest # of 312,208 in 6-05</li> </ul>	In 2003 court ordered continuation of parents in HUSKY to 150%.
July 2005	<ul style="list-style-type: none"> <li>▪ TMA period reduced to 12 months (impact in 6-06)</li> <li>▪ Increase parent &amp; caregiver income level to 150% FPL</li> </ul>	June – July 2005 loss of 9,781 enrollees	A brief period of state-funded adult HUSKY A coverage followed by legislation to raise FPL eligibility. Clients received several notices about their status during that time.

July 2005	<ul style="list-style-type: none"> <li>▪ Elimination of self-declaration of income</li> </ul>	<ul style="list-style-type: none"> <li>▪ Losses offset by &gt; adults to 150% FPL.</li> <li>▪ Over the Enrollment remained under 302,000</li> <li>▪ &lt;19 yrs reduced by 7572 (A &amp;B)</li> <li>▪ Adults &gt; 2509</li> <li>▪ 2-3 times # of pending &amp; discontinuances due to incomplete documentation</li> </ul>	Reasons for increasing # loss of children unclear: the income documentation thought to impact completeness of applications.
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In February meeting Sen. Harp identified three key policy issues that needed to be addressed within the 2006 session appropriations process:

- Put the client eligibility end date on the AVES system for providers and inform MCOs.
- Develop a flexible on-line application system that interfaces with the eligibility management system.
- Reinstate self declaration of income with monitoring indicators in HUSKY A & B.

**The budget for SFY 07 (see summary below) included \$2 million dollars to reinstate self declaration of income effective July 2006 and \$850,000 for development of an on-line application system.**

HUSKY Enrollment (1-6/06 meetings)

From August 2005 – June 2006 children's enrollment (HUSKY A & B) **decreased by 7572 enrollees with a HUSKY A reduction of 6422**. Adult HUSKY enrollment decreased by 294 in June 2006, but had increased by 2509 since August 2005.

The reasons for declining children's enrollment remain unclear, although documentation of income is thought to contribute to this decline. Sen. Harp stated it is important to know the reasons for these enrollment losses as additional losses are expected in July related to TMA coverage ending. The department plans to identify “what happens” to those who lose TMA after July and a sample of HUSKY A children prior to July 2006 would be included in the UCONN study. The department was asked to:

- Identify enrollment losses by age group.
- Provide the Council with information on the percentage of children ineligible for HUSKY A that were eligible for HUSKY B and of these children the number enrolled in B.
- Estimate the administrative costs associated with HUSKY members losing and then regaining enrollment.
- Consider implementing automatic transfer of ineligible A children to the enrollment broker for HUSKY B eligibility determination (policy & budgetary issue).

Medicaid Budget SFY07 (May 2006 meeting)

DSS provided the Council with the budget highlights for HUSKY & Medicaid that included reversal of the elimination of HUSKY self declaration of income, \$850,000 for on-line applications, expansion of the Medicaid Council oversight for SAGA managed care, an unfunded HUSKY A medical home pilot, retain federal “medical necessity” definition, increases in hospital rates for outpatient clinic/tests, ED with a managed care pass through (\$7M), \$11M for crisis hospital relief, \$4M added to CCMC state grant, \$2M stability planning fund, \$5.1M

Other policy issues:

- ✓ DSS stated that the **Family Planning Waiver (2005 legislation)** has been drafted, cost effectiveness has been determined and the waiver is now under agency review; it has not yet been submitted to CMS for approval.
- ✓ **Uninsured pregnant women** ineligible for Medicaid often have unaffordable pregnancy-related services in addition to prenatal care. Labor and delivery services alone can be covered for some under the Medicaid emergency medical assistance program but not prenatal care. The appropriations budget had included \$1 million dollars for this population but it was not part of the final state budget.

Federal Deficit Reduction Act (DRA) Proof of Citizenship/Identity (April- June Council meetings)

Kevin Loveland (DSS) provided the Council with information about the DRA 2006 requirement that states verify the citizenship and identity of any Medicaid applicant/recipient that declares U.S. citizenship. The law, **effective July 1, 2006**, applies at the time of a person's Medicaid application and at the time of a recipient's next annual redetermination. Initial CMS guidance sent to states **June 9<sup>th</sup>** established a complicated hierarchical approach that states must follow for citizenship/identity verification.

- NEW Medicaid applicants otherwise eligible for Medicaid cannot be enrolled in Medicaid until citizenship/identity is verified, primarily with original documents.
- Medicaid recipients can remain enrolled as long as they make a good faith effort to comply with the federal law.

*(Subsequent to the June 9<sup>th</sup> guidance, CMS released interim regulations in July that exempted 'dual eligibles' and most SSI clients and allowed states more flexibility in vital statistic data matches.)*

The Department of Social Services has worked diligently to prepare for the implementation of the law by July 1, 2006 and disseminated information to the community and Medicaid clients in order to minimize any potential negative impact on applicant/recipient health coverage and state financial risk in loss of federal dollars. Council members expressed concerns about the impact of this federal law on CT and U.S. citizens' access to Medicaid health coverage in letter to the Governor and the Congressional delegation.

**Program Quality Assessment**

HUSKY A Utilization Reports (April & June meetings)

- ✓ Hilary Silver (DSS) assumed the leadership in organizing a representative work group that made major revisions to state (voluntary) EPSDT forms that now have a more comprehensive list of age-appropriate anticipatory guidance items as recommended by the Quality Subcommittee and the Council.
- ✓ **Maternal health care:** though the number of pregnant women enrolled in a health plan during the first trimester dropped by 10%, women's participation in 80% of prenatal services increased several points to 78% and timely postpartum visits increased during the 1<sup>st</sup> half of 2005 to 70% from 55% for the same period in 2004.
- ✓ **Emergency room** utilization has continued to increase during 2004 – 2005. Emergency room utilization reporting parameters differ in the DSS Mercer audit and these reports. For 2003-2004 Mercer reported a decrease in ED usage from 600/1000 members to 420/1000 members, while the utilization reports show an increase from 58/1000

member months (MM) from 4/04-9/04 to 62/1000 MM 4/05-9/05. DSS was asked to determine a common reporting format so that comparisons across plans and similar time periods can be compared.

- ✓ **EPSDT:** Steady improvement in children & youth preventive care with the State reaching federal performance targets:
  - Screening ratios remain over 80% in the second half of 2005, probably reflecting school physicals.
  - Participation ratio for children < one year of age, 3-5 and 6-9 years is **above 80%** (federal guideline expectation).
  - Screening and participation ratios for 10-14 and 15-18 year old members has increased (10-14 rate is over 70% and 15-18 rate is just about 60%) from previous rates in the 40-50% range. Each health plan had developed a quality improvement program targeting increasing adolescent preventive care.
- ✓ **Dental services** for members ages 3-20 remains very low and unchanged: less than one-third received any dental care during the 6 month reporting periods and less than one quarter receive preventive care except for Health Net that provided preventive care to 28% of members in the 6 month period. There has been no resolution of the 2000 dental law suit to date. **The SFY07 budget provides \$2.9M for Medicaid dental well-baby/sealants program.**

Mercer (HUSKY External Quality Review contractor) MCO Audit 2005 (April 2006 meeting)

This report, the second year of a three-year reporting cycle, evaluates processes and outcomes within the HUSKY managed care organizations. This second year review focus included:

- Timely access to services, network adequacy and coordination of EPSDT. Several of the plans need to improve processes to monitor timeliness of care. Council noted that the network indicators reflect the MCO planning and documentation of provider network, not the *adequacy of networks*.
- Performance Improvement projects (PIPs): Health Net did not have outcomes of their PIPs ready for the audit. The three plans achieved goals for the majority of their projects.
  - CHNCT continues to struggle with increasing NICU admissions and length of stays, but did show a 4% decrease in low birth weight deliveries. Adolescent well care increased by 4%.
  - WellCare/Preferred One had a 9.5% decrease in asthma-related ED use and 3% increase in prenatal care access. Adolescent access to preventive care increased 10.4%. Anthem had a 4% increase in member breast screening rates and adolescent access to preventive care.
- 6 Performance measures showed plan performance variability:
  - NICU admits/100 births decreased slightly in 2004 to slightly over 10%.
  - ED use by asthmatics was highest (13%) for CHNCT.
  - Inpatient readmission rates were highest (1.2%) for CHNCT while WellCare showed a decrease.
  - About one-third of women ages 41- 69 had breast cancer screens; less than one-quarter of WellCare members had screens.
  - About 14% of members diagnosed with diabetes had diabetic retinal exam. This is an area Mercer identified for improvement by the 4 MCOs
- Compliance with selected HUSKY B contract amendments was present in the 3

participating HUSKY A/B plans

- Mercer has received the MCO corrective action plans for non-compliance areas in the EQR audit. The third year cycle will begin with a desk review in June 2006.

*HUSKY A Children's Services 2004 Annual Reports: CTVoices, Mary Alice Lee (reports can be found in their entirety at [www.ctkidslink.org](http://www.ctkidslink.org))*

Report data is based on continuously enrolled HUSKY A members under age 21. There was minimal change in the reporting parameters since 2002 with exception of hospitalizations.

- ✓ **Asthma** prevalence and related health care (January 2006 meeting): Asthma prevalence remains at 9.4%, with highest rates in children ages 1-5, members that live in Bridgeport (11%) and Hartford (10%) and Hispanic children. Asthma health care indicators:
  - Asthma-related ED visits remain at the same level since 2002 (25%) and hospitalizations at 4%, unchanged from 2002.
  - Less than half the children (43%) with asthma-related hospitalization were seen in primary care for follow up within 2 weeks of discharge (Anthem had the highest rate of 52% and Preferred One the lowest at 33%).
  - Less than 20% of children with an asthma-related ED visit had a follow-up primary care visit within two weeks of the ED visit.

**Follow-up: Easy Breathing Program: Dr. Michelle Cloutier, CCMC** (Feb. 2006 meeting)

In response to the 3-4 years unchanging asthma data in HUSKY A, Sen. Harp requested a presentation from Dr. Michelle Cloutier, Director of the **Easy Breathing Program at CCMC**. This is a community-based asthma disease management program that includes over 300 primary care pediatrician in 113 private practices and 14 urban clinics in 39 cities and towns in Connecticut. Using Medicaid claims data for Hartford's children and claims data from a private managed care organization (ConnectiCare) for children in private practices, Easy Breathing process/outcomes measures over 3 years include:

- 93% of the children with asthma have a written asthma treatment plan used by parents, schools, etc, compared to 5-10% prior to the program.
- Provider adherence to the NAEPP guidelines for anti-inflammatory therapy increased from 38% to 96%.
- Asthmatic children in the program had a 35% decrease in hospitalization rates, 27% decrease in ED visits and 19% decrease in outpatient visit compared to pre-program data.
- Administrative cost of implementing Easy Breathing program in Hartford is \$34/child/year with a calculated savings of \$355/asthmatic child/year (excluding pharmacy costs).

Dr. Cloutier attributed the success of the program to practitioner involvement throughout the process of program development, implementation and evaluation. A respected community practitioner was identified to help coordinate the community aspect of the program with their colleagues. More than 50% of pediatricians and family practice physicians are in the program. Considering the positive health outcomes and financial efficiency of this program, Sen. Harp requested DSS take the lead in developing a collaborative process with the MCOs and the Easy Breathing Program and provide the Council with a progress report on the collaboration.

- ✓ **HUSKY A children's 2004 Emergency Department** (ED) use, not associated with a

hospital admissions, and **hospital utilization** for 170,937 continuously enrolled children under age 21 years:

- 33% of HUSKY A children had **ED visits** in CY 2004 with 1.9 average number of visits/child, unchanged from 2002, 2003. Children *without* a recorded well visit actually had a lower ED visit rate of 29% compared to 34% with a well visit.
- Leading **ED diagnoses** remain injuries (28% of ED visits) and respiratory (17%), similar to the 3 previous years.
- 2.9% of children were **hospitalized, down from 4%** in 2002-2003 and the average number of hospitalizations/child **decreased from 2.4 in 2003 to 1.3 in 2004.**
- Leading hospitalization diagnoses, excluding behavioral health, continue to be respiratory (at 23% compared to 10-12% in previous years) and pregnancy/child birth (21%).

Injuries continue to be the leading cause of children's ED visits; while work with CCMC Injury prevention program may promote some reduction in injury-related ED admissions, the cause of injuries are not known as the E-code (reason) is not in the HUSKY encounter data for non-hospitalized ED injury visits. Office of Health Care Access will provide the Council with information from the hospital CHIME database to identify ED/hospital injury reasons.

#### **Other Special Reports**

Office of Health Care Access (reports can be found at [www.ct.gov.ohca](http://www.ct.gov.ohca) )

- ✓ **Working HUSKY Families:** A phone survey funded by remaining dollars in the HRSA State Planning grant of 1,004 HUSKY families and 402 employers whose employees use HUSKY was completed in October 2005. The survey, preformed by the University of Connecticut's Center for Survey Research and Analysis showed that:
  - 90% of the working head-of-household HUSKY family respondents were women, 71% were not married and 53% were non-Hispanic white, 47% minority.
  - 1 in 5 working HUSKY parents does not have health insurance coverage. ( **HUSKY A parent income eligibility is 150% FPL; children is 185% FPL.** While 64% of their employers offer coverage, only 30% of HUSKY parents are enrolled in employer sponsored insurance (ESI) compared to 79% of all working adults. Thirty-four percent (34%) of the survey respondents explained they did not participate in ESI because they couldn't afford it (18%) or were currently ineligible for ESI (16%). Forty-one percent (41%) of the surveyed HUSKY parents are enrolled in HUSKY.
  - Type of work (i.e. retail/service, work status (full/part time) and income level influence access to ESI. Among HUSKY families 80% of those with income between 185-300% FPL have access to ESI compared to 52% of those with incomes under 100% FPL.
  - Employer purchased insurance benefits: of the 402 employer respondents, over 75% of HUSKY employers offer some type of health coverage and 67% offer family cover. Of those that do not offer ESI, over half attributed this to insurance cost. Lower insurance premiums would motivate 52% of these employers to offer employee benefits.

✓ ***Preventable Hospitalizations - Ambulatory Care Sensitive Conditions- 2000-2004***

Michael Sabados, Ph.D, Assoc. Research Analyst, OHCA reviewed the agency's report on CT's prevalence of preventable hospitalizations, which is based on 16 *Ambulatory Care Sensitive Conditions* (ACSC) clinically validated by AHRQ. The indicators can provide an assessment of statewide and community-based quality of the health care system outside the hospital setting. Highlights of the report relevant to Medicaid:

- CT has lower ACSC rates, with the exception of low birth weight hospitalizations compared to U.S. rates.
- From 2000 – 2004 hospitalizations for ACSC increased by 7% while expenditures increased by 46%.
- Public payers are responsible for nearly 75% of ACSC charges. Medicaid had the highest expenditure increase (60%) over four years.
- ACSC hospitalized patients “cycle” through the health care system more than non-ACSC patients (2/3 had previous hospitalizations, 80% were admitted from the ED, 25% were transferred to another facility and 20% had home care services post-discharge).
- 60% of ACSC patients are elderly, but younger minorities are over-represented in ACSC admissions for: asthma & diabetes-related hospitalizations, which are more prevalent in African Americans, asthma and low birth weights are more prevalent in Hispanic ACSC patients.

This report provides important comparative information about preventable ACSC hospitalizations and patient demographics, diagnoses, payer source and expenditures that can frame future discussions about HUSKY health care utilization. Sen. Harp requested DSS consider working with OHCA to produce a similar ACSC report for HUSKY A children/adults and HUSKY B children as well as the Medicaid aged, blind, disabled clients. DSS will review with OHCA the Medicaid data warehouse data for compatibility with the study data elements.

**State Administered General Assistance Program** (*April 2006 meeting*)

DSS was asked to report on SAGA enrollment, revenues by service provider and service utilization patterns pre-and post program budgetary caps in SFY04. CHNCT assumed responsibility for SAGA non-hospital ambulatory services, pharmacy use, service access & network development, member outreach and care management while DSS retained financial responsibility for hospital inpatient, ED and clinic services. Report highlights:

- Since July 1, 2003 **SAGA enrollment** has increased by 15% (5,347 enrollees), despite overall improvement in the State economy. DSS will assess reasons for enrollment increases in order to better predict future trends and report back to the Council. Sen. Harp suggested DSS consult with DMHAS as the rate of mental health service utilization is higher in this population compared to other Medicaid populations.
- **Service use and service revenues** changed between SFY 03/04 and SFY 04/05. The decrease in community primary care and hospital clinic services was anticipated with the implementation of a managed care model under which primary care would be mainly delivered in federally qualified health centers (FQHCs). DSS agreed to include primary diagnoses for hospital/ED use in future reports.
- **ED use** increase (14%) may reflect capacity problems in areas that do not have FQHCs, although the SAGA population is concentrated primarily in 5 of the largest CT cities with FQHCs. CHNCT will be updating SAGA geo-access analysis and assess distribution of

the enrollees across FQHCs and individual clinic capacity.

- CHNCT is unable to provide **comprehensive care management** to SAGA clients because CHNCT does not have integrated data for hospital and ambulatory services. DSS will be providing CHNCT with SAGA client hospital data, that if received in a timely manner, will allow CHNCT to provide comprehensive client care management.

***PA06-188 Sec. 46 expands the Medicaid Managed Care Council scope of oversight to include recommendations for the managed care portion of SAGA medical assistance.***

### **Subcommittee Activities**

- Quality Assurance Subcommittee, chaired by Paula Armbruster, organized a women's health forum in February 2006 focusing on the rationale and importance of 1) oral health as part of prenatal care and during the early years of the child's life and 2) screening for depression during pregnancy and postpartum as the mother's mental health impacts the child's development and later development of mental health problems. The Subcommittee also is working the MCOs on ED utilization patterns/interventions and pediatric obesity.

- Consumer Access Subcommittee, chaired by Christine Bianchi, developed recommendations approved by the Council for regular MCO reports on prior authorization denials, disseminated information about upcoming policy changes (TMA duration reduction and federal citizenship law) to community, following up on the HUSKY address change plan and on-line applications.

At Sen. Harp's request DSS worked with the Council to create a "HUSKY 101" tape for consumers, explaining the HUSKY programs, how to enroll, how to choose a plan, and how to receive health care services. DSS will insert brief vignettes illustrating these topics into the tape and get these out to community groups and local cable stations.