

Connecticut Appropriations Committee RBA Template

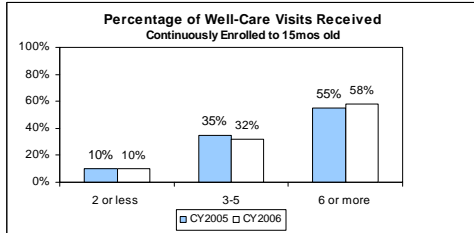
Part II, Program/Agency/System Accountability Summary

Program/Agency/System: HUSKY A and HUSKY B CT Department of Social Services .

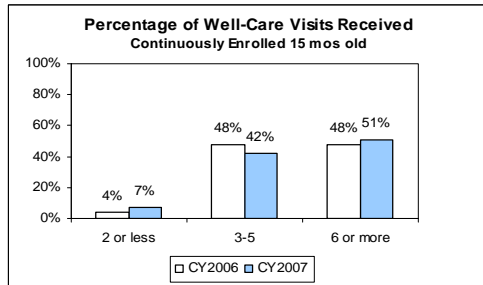
Quality of Life Result: All Connecticut children are healthy and ready for school success at age 5.

Program/Agency/System Purpose: To provide access to medically necessary and medically appropriate health care to uninsured children and low-income pregnant women and families.

Performance Measure 1: Well-care visits received for those 15 months old (HUSKY A)



HUSKY B

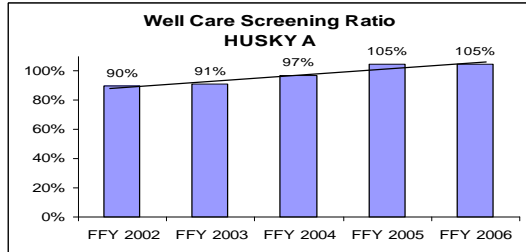


Story Behind Measure 1

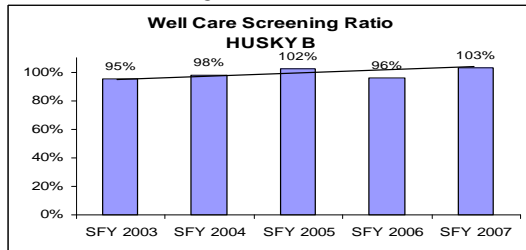
These charts show the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled with the MCO, and received the noted number of well care visits during their 15 months of enrollment. This is a small number of children due to the requirements as defined above but even so shows that there is room for improvement in this area.

Performance Measure 2

Well-Care Screening Ratio (HUSKY A) for children under 6



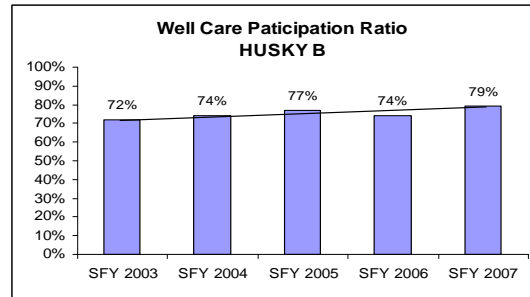
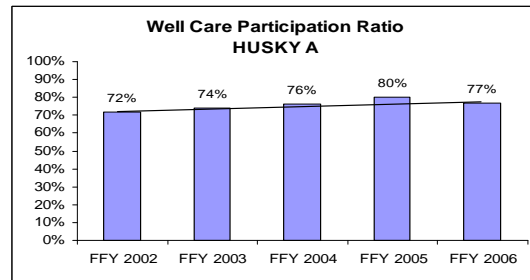
Well-Care Screening Ratio (HUSKY B) for children under 6



Story Behind Measure 2

The screening ratio represents the percentage of check-ups received compared to how many should have been received. For example, infants receive several visits during the first year of life, however children between 2 and 5 would be expected to receive just one annual checkup per year. The age is determined at the end of the period of time, which is why the percentage here can be over 100% (younger children are expected to have more screens but could be counted in a category which expects less screens). National specifications are used to calculate the screening ratio, therefore this data could be compared with other State's Medicaid and SCHIP program data.

Performance Measure 3



Story Behind Measure 2

The participation ratio represents the percentage of children receiving at least one well child visit during the year, regardless of the number of visits that are recommended for the child's age in that year. Improvement has been realized over time due to concerted effort by HUSKY MCOs to educate parents about the periodicity schedule (AAP recommended schedule for check-ups) and postcard reminders to parents of when children are due for their regular check-ups. Follow-up "overdue" reminders are also sent if claims data don't show a billing for the check-up. A limitation of the screening measure is that it does not consider whether the well-child visits were received timely according to the AAP guidelines. Federal

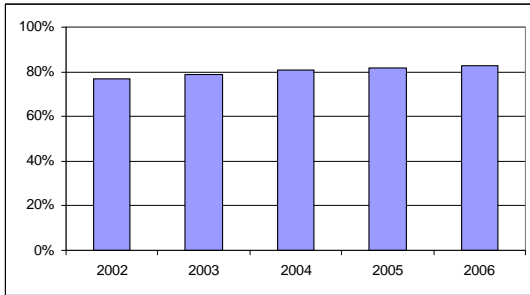
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specifications are used to calculate the participation data represented here, therefore this data could be compared with other State's Medicaid and SCHIP program data.

Performance Measure 4

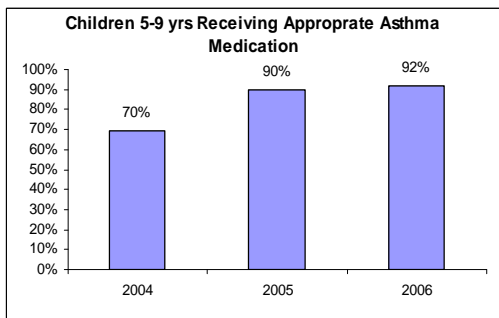
Immunization Rate (HUSKY A and B)



Story Behind Measure 4

The above chart depicts the percentage of children who were determined to be fully immunized by age 2. The overall rate for HUSKY A and B is 83% which is the same as the statewide rate for all CT 2 year olds. Connecticut has a good immunization rate due to efforts by the Connecticut Immunization Registry System (CIRTS) to outreach to providers and families as well as HUSKY MCO postcard reminder mailings to families when children are due for their immunizations.

Performance Measure 5

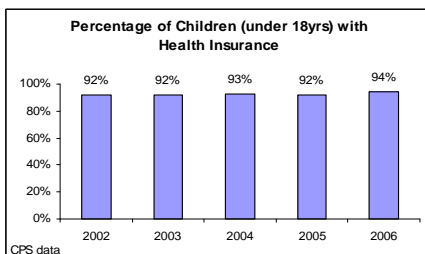


Story Behind Measure 5

The increase from 2004 to 2005 in asthma appropriate medication is partially due to a change in the HEDIS definitions on which these rates are based and partially due to focused efforts by the HUSKY MCOs.

Performance Measure 6

Percent of Children, under 18yrs old, who have insurance (including HUSKY A, HUSKY B, or private insurance)



Story Behind Measure 6

The percentage of children in CT who are under the age of 18 and have insurance (private or public) is represented above. These figures are taken from the U.S. Census Bureau's Current Population Survey (CPS).

Turning the Curves: What do you propose to do over the next two years and why?

1. Disease Management Program (diabetes, cardiac conditions; childhood obesity, asthma) to improve health status of individuals via management of their chronic conditions.
2. Medical home pilot - to pilot effectiveness of the medical home model at selected pediatric primary care sites in the delivery of care coordination and case management in addition to the traditional preventative, primary and referral services and the impact on patient quality of care.
3. Pay for Performance program – direct provider incentives initially targeting pediatric providers to meet established performance targets related to comprehensiveness of well-child visits, e.g. certain % of children in the provider's practice receiving check-ups, immunizations, etc.
4. Increase the number of children receiving developmental screens, using a validated tool, at the 9mo., 18 mo., and 24/30mo. visits. This was a recent recommendation by the AAP in order to increase the early identification of developmental delays and thus address those issues earlier through, for example, referrals to other programs such as Birth to Three or by providing services such as speech or physical therapy at an earlier age.

*Indicates, low-cost, no-cost action steps, including reallocation of existing resources.

Key Budget Information	
Total Current Program Year Funding	
Funding as Percent of All Funding for Population Result	
Program Funding As Percent of Total Agency Budget	
Funding Distribution	
Total Federal Funds	
Total State Funds	
Capital Projects Subtotal	
Other Funding	
Percent of Total Current Funding Contracted to Third Parties	

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Program/Agency/System:

Program/Agency/System Purpose
Contribution to Population Result
Key Budget Information (<i>Dollars reported in millions</i>)
Total Current Program Year Budget
Funding as Percent of All Funding for Quality of Life Result
Program Funding as Percent of Total Agency Budget
Budget Distribution:
Federal
State
General Fund
Capital Project Funds
Other State Funding
Other Funds (Not Federal or State)
Percent of Total Current Funding Spent on Direct Service
Percent of Total Current Funding Contracted to Third parties

Basic Program Facts: The Department’s Medicaid and State Children’s Health Insurance Program (SCHIP) funded managed care program is called HUSKY (Healthcare for Uninsured Kids and Youth). HUSKY A is a Medicaid program for children and families whose household incomes are at or below 185% of the federal poverty level (FPL) and pregnant women with household incomes at or below 250% FPL. HUSKY B is the SCHIP program for children whose household incomes are above 185% FPL.

There are no co-payment or premium requirements for HUSKY A families. HUSKY B has nominal co-payments for some services and premiums depending on family income. Eligible children in families with incomes between 185% - 235% FPL pay no premiums, those with incomes between 235% to 300% FPL pay a monthly premium of \$30.00 for one child or \$50.00 for two or more children and families with incomes exceeding 300% FPL pay the full group rate premium negotiated by the state.

HUSKY A benefits and services are the same as those covered in the Medicaid fee-for-services(FFS) program. The HUSKY B benefit package is modeled after the Connecticut state employee benefit plan. Children who are enrolled in HUSKY B and who have intensive physical health needs may qualify for wrap-around services under the HUSKY Plus program.

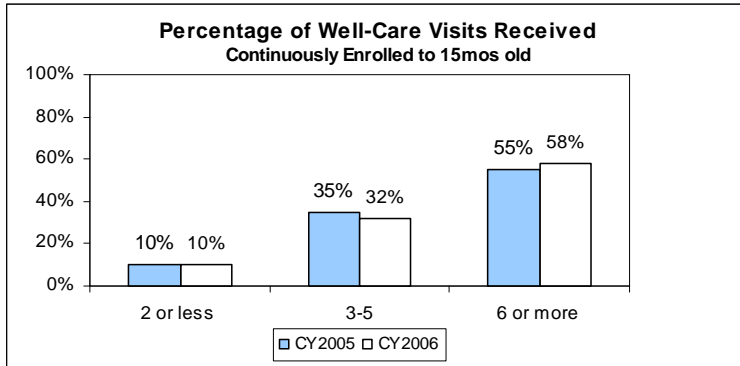
Medical and Dental care are provided through contracts with four managed care organizations (MCOs) with responsibility for arrangement and payment of services. Behavioral health services are managed through an administrative services arrangement with a behavioral management company with the Department retaining responsibility for provider reimbursements.

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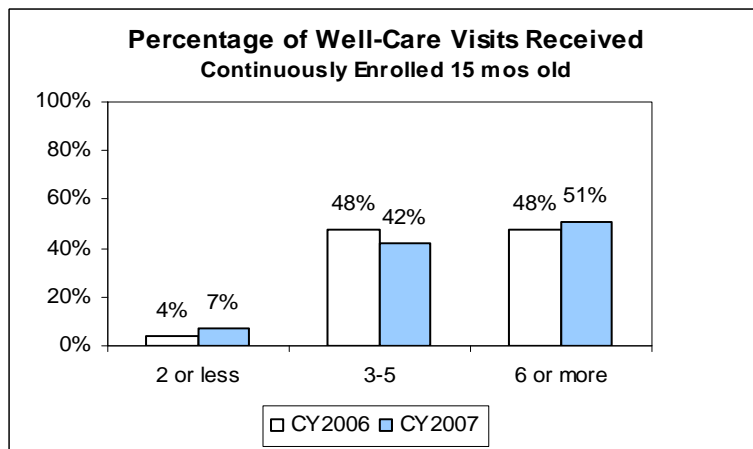
Performance Measures and Story Behind the Baselines

Performance Measure 1

Well-care visits received for those 15 months old (HUSKY A)



HUSKY B



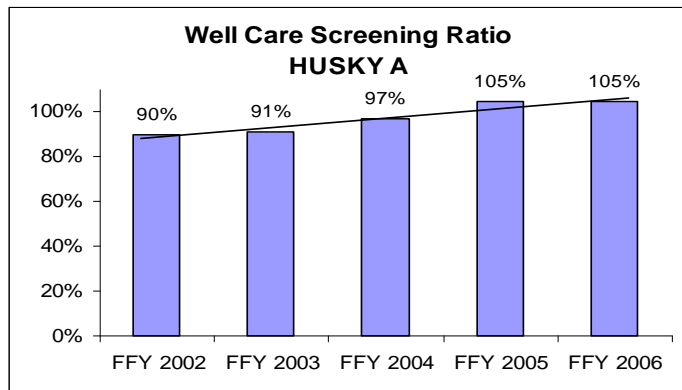
Story Behind Measure 1

These charts show the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled with the MCO, and received the noted number of well care visits during their 15 months of enrollment. This is a small number of children due to the requirements as defined above but even so shows that there is room for improvement in this area.

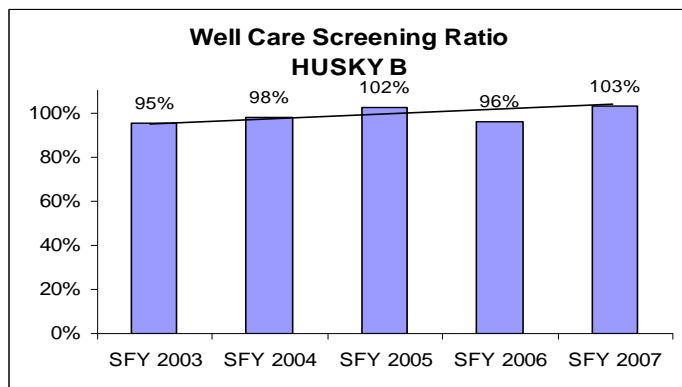
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Performance Measure 2

Well-Care Screening Ratio (HUSKY A) for children under 6



Well-Care Screening Ratio (HUSKY B) for children under 6



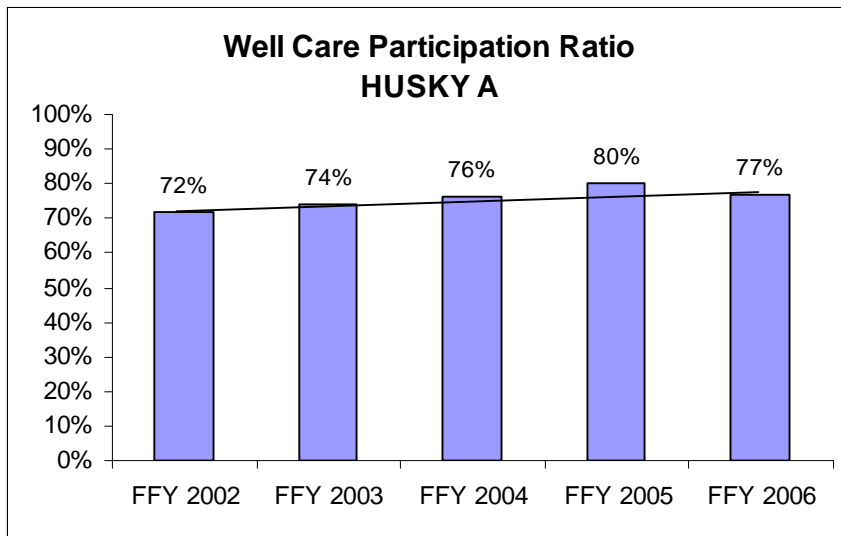
Story Behind Measure 2

The screening ratio represents the percentage of well-child visits (check-ups) received compared to how many should have been received for enrolled children. For example, infants receive several visits during the first year of life, however children between 2 and 5 would be expected to receive just one annual checkup per year. The age is determined at the end of the period of time, which is why the percentage here can be over 100% (younger children are expected to have more screens but could be counted in a category which expects less screens). Improvement has been realized over time due to concerted effort by HUSKY MCOs to educate parents about the periodicity schedule (AAP recommended schedule for check-ups) and postcard reminders to parents of when children are due for their regular check-ups. Follow-up “overdue” reminders are also sent if claims data doesn’t show a billing for the check-up. A limitation of this measure is that it does not consider whether the well-child visits were received timely according to the AAP guidelines, however since Federal specifications are used this data is useful for comparison purposes with other State’s Medicaid and SCHIP programs.

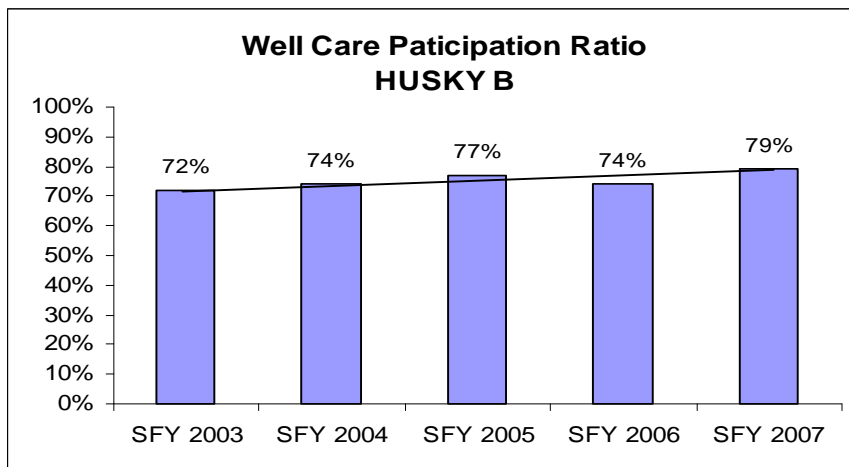
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Performance Measure 3

Well-Care Participation Ratio (HUSKY A) for children under 6



Well-Care Participation Ratio (HUSKY B) for children under 6



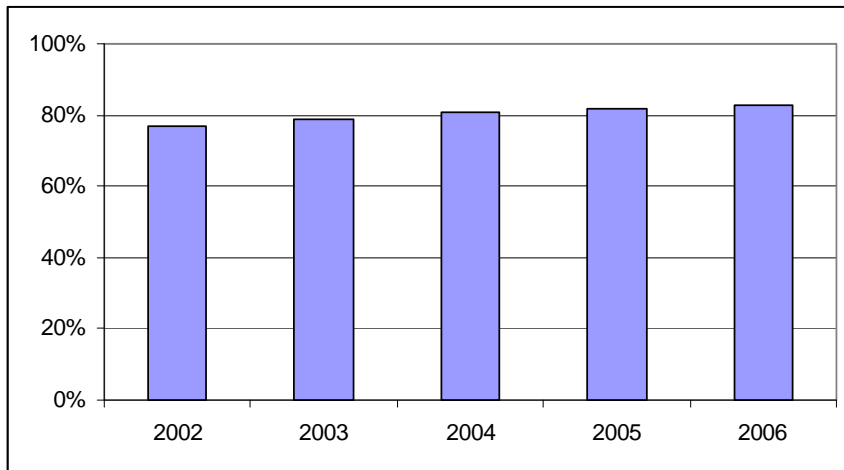
Story Behind Measure 3

The participation ratio represents the percentage of children receiving at least one well child visit, regardless of whether the child was enrolled for the full or part of the year. Improvement has been realized over time due to concerted effort by HUSKY MCOs to educate parents about the periodicity schedule (AAP recommended schedule for check-ups) and postcard reminders to parents of when children are due for their regular check-ups. Follow-up “overdue” reminders are also sent if claims data doesn’t show a billing for the check-up. This report is based n Federal specifications therefore allows for comparison with other State’s Medicaid and SCHIP programs.

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Performance Measure 4

Immunization Rate (Combined HUSKY A & B)

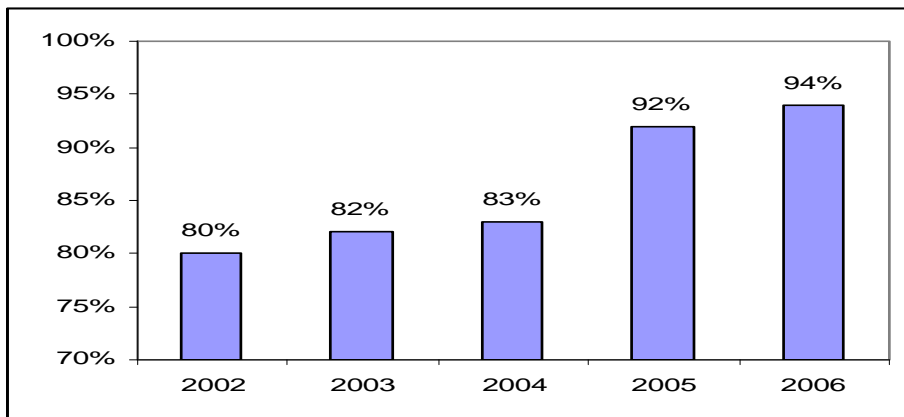


Story Behind Measure 4

The chart above shows the percentage of children who are fully immunized as of their second birthday. The overall rate for HUSKY A and B is 83% which is the same as the statewide rate for all CT 2 year olds. Connecticut has a good immunization rate due to efforts by the Connecticut Immunization Registry System (CIRTS) to outreach to providers and families as well as HUSKY MCO postcard reminder mailings to families when children are due for their immunizations.

Performance Measure 5

Percent of Children Who Qualify for HUSKY that have Insurance



Story Behind Measure 5

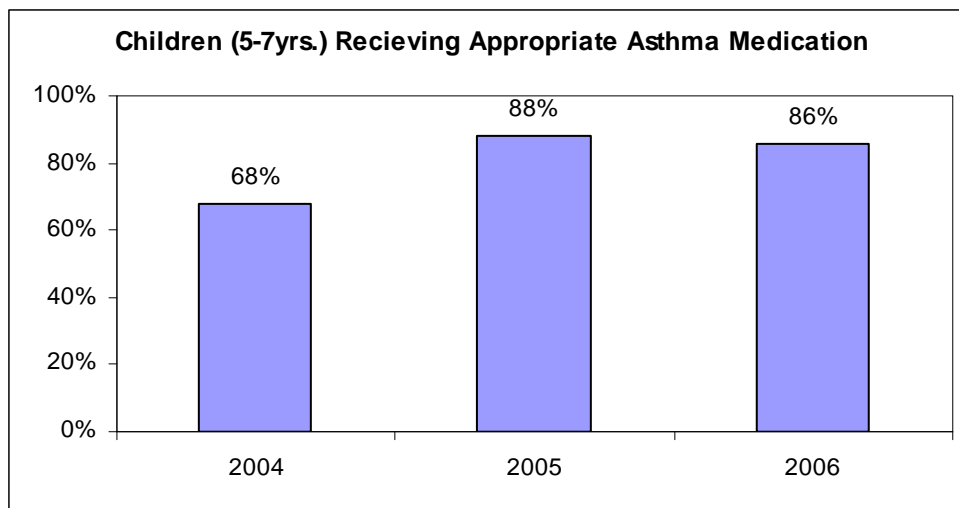
The percentage of children in CT who are under the age of 18 and have insurance (private or public) is represented in Performance Measure 4. These figures are taken from the U.S. Census Bureau's Current Population Survey (CPS).

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During 2007 over one million dollars was granted to local, regional and statewide community agencies as well as schools to increase enrollment in the HUSKY program. More than half the funds were competitively awarded. Enrolling children in HUSKY is the first step toward ensuring their physical and mental health.

Performance Measure 6

% of Children Receiving Appropriate Medication for Asthma



Story Behind Measure 6

The increase from 2004 to 2005 is partially due to a change in the HEDIS definitions on which these rates are based and partially due to focused efforts by the HUSKY MCOs resulting from the addition of appropriate use of asthma medication as a mandatory quality measure for all four MCOs.

Partners and Their Roles:

Contracted partners include the HUSKY Managed Care Organizations (Anthem Blue Care Family Plan; Community Health Network of CT; HealthNet Healthy Options; WellCare Preferred One) who arrange, provide for and reimburse either directly or through arrangements with others, the Medicaid or SCHIP covered services, with the exception of behavioral health services which are currently provided by the CT Behavioral Health Partnership; CT Voices for Children provides EPSDT monitoring; United Way HUSKY InfoLine manages a call-in hotline; ACS provides HUSKY application screening, HUSKY B eligibility determinations and enrollment brokering services (assists clients with and process MCO selection); Mercer Inc. conducts external quality reviews of HUSKY MCOs.

What do you propose to do to improve performance in the next 3-5 years and why?

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1. Disease Management Program (diabetes, cardiac conditions; childhood obesity, asthma) to improve health status of individuals via management of their chronic conditions. Although MCOs currently have various disease management programs in place, there is some variability among them. DSS will be issuing a disease management RFP for competitive procurement of a statewide program that will target education of providers in best practices for the identification and management of various diseases.
2. Medical home pilot - to pilot effectiveness of the medical home model at selected pediatric primary care sites in the delivery of care coordination and case management in addition to the traditional preventative, primary and referral services and the impact on patient quality of care. Currently although some pediatric practices offer components of the medical home model, there is inconsistency and few provide services beyond the traditional check-up, such as care coordination and case management. DPH has committed \$100,000 towards the pilot. Size of the pilot will be dependent on availability of additional funding from HUSKY budget.
3. Pay for Performance program (P4P) – direct provider incentives initially targeting pediatric providers to meet established performance standards related to comprehensiveness of care, with goals including such things as meeting certain targets of percentage of children receiving check-ups, the timeliness of visits, immunizations, etc. Scope of the P4P program will be dependent on available funding in next bi-annual budget.
4. Increase the number of children receiving developmental screens, using a validated tool, at the 9mo., 18 mo., and 24/30mo. visits. This was a recent recommendation by the AAP in order to increase the early identification of issues and thus address those issues earlier. The Department is in the process of changing reimbursement policy to allow providers to bill for the development screen on the same day as the well child visit. The unbundling of codes is expected to provide an incentive for providers to conduct the developmental screen using a validated, standardized assessment tool.

Appendix A, Data Development Agenda

The EPSDT (well-child care) reporting specifications are federally required under the Medicaid program so that there is consistency in reporting across all the states. The uniform reporting allows for comparisons to be made across all states. For consistency purposes, DSS decided to use the Medicaid EPSDT reporting specifications for HUSKY B so that we can compare performance amongst the two programs.

Immunization reporting is also based on uniform federal specifications. The report uses HUSKY enrollment data provided by DSS and data from DPH's CIRT system.

Asthma appropriate medication is based on HEDIS specifications. HEDIS provides uniform standards so that comparisons can be made across different states' Medicaid programs as well as across different payers (i.e. commercial vs. Medicaid).

Claims data is the data source used for asthma, EPSDT and well-child reporting. Billing time lags impact the completeness of the data source, which could lead to underreporting if the reports are run too soon after the end of the reporting time period. DSS usually allows a six-month lag to

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allow for claims run-out. Consequently at time of report issuance, the information is usually six to eighteen months old. CIRTS data has similar limitations as claims data related to timeliness of data, that is there is a lag between the date of service and when the data gets uploaded into the system.

Additional data, such as birth certificate and lead data is provided by DPH to DSS or some of our contractors under a memorandum of agreement.

Identification of additional data sources and collection will be explored under the Pay for Performance program and the medical home pilot. This new data will be used in conjunction with existing data to support and evaluate both programs.

Appendix B, Funding Details

Funding Details

The Budget for HUSKY breaks out as follows:

	<u>SFY 06 Exp.</u>
HUSKY A	\$
HUSKY B	\$

HUSKY A expenditures are reimbursed at 50% by the Federal government under Medicaid.

HUSKY B expenditures are reimbursed at 65% by the Federal government under the State Children's Health Insurance Program (SCHIP).

Both HUSKY A and HUSKY B programs are administered through contracts with Managed Care Organizations (MCOs), so we have categorized all funding as contracted to third parties.

Appendix C, Information and Research Agenda

To support the Department's efforts towards utilization of research and data for analysis, measurement and program improvement, the Department is participating in a technical assistance grant from the Centers for Health Care Strategies (CHCS). The CHCS initiative is titled *Return on Investment* (ROI) and provides participants with a tool that can be used to estimate the costs of implementing and operating proposed quality improvement programs, such as disease management programs or other program performance improvements.

DSS staff is also currently participating in a similar CHCS grant related to Pay-for-Performance. Both initiatives provide access to subject matter experts and consultants, research material and literature from other states' experiences and the opportunity to learn directly from other states

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with similar programs. Both initiatives include training on performance and quality measurement.

The Department is also participating in the ABCD (Assuring Better Child Health and Development) Screening Academy through the National Academy for State Health Policy. The intent of this program is “to assist states in improving the delivery of early child development services for low-income children and their families by strengthening primary health care services and systems that support the healthy development of young children, ages 0-3.”

Appendix D, Partners (Optional)

Additional partners include Connecticut Children’s Medical Center, who manages and coordinates HUSKY Plus program services. DSS staff also work closely with other State agencies such as DPH (initiatives such as Medical Home), DCF (related to health care delivery to DCF children); SDE (HUSKY outreach); Children’s Trust Fund (coordination between Health Start and Nurturing Families programs); Commission on Children. Other partnerships include the Hartford Foundation for Public Giving; Children’s Health and Development Institute; Covering Kids and Families; Bridgeport Child Advocacy Coalition on various access and outreach initiative.

Appendix E, What Works (Optional)

Based on the areas where improvement has been noted, it appears that education and aggressive outreach to families is effective for a portion of the HUSKY population. Family outreach coupled with provision of information and data to providers (such as list of patients due for check-ups or immunizations) improves results.