Federal Fiscal Year 2001
ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Connecticut
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name(s): HUSKY

SCHIP Program Type:
____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
X Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

Contact Person/Title: Rose Ciarcia

Address: 25 Sigourney Street, Hartford, CT 06106

Phone: (860) 424-5139 Fax: (860) 424-4959

Email: Rose.Ciarcia@po.state.ct.us

Submission Date: March 13, 2002

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

A. Program Eligibility

1. Removal of the Six (6) Month Residency Requirement

Effective 2/13/2001, the six (6) month Connecticut residency requirement was removed from the state funded portion of HUSKY (Medicaid and SCHIP).

This change was made to be in compliance with federal law.

2. Presumptive Eligibility.

Effective 10/1/01, Presumptive Eligibility (PE) for Children was instituted. Certain qualified entities are now allowed to determine Medicaid eligibility for children. Although Presumptive Eligibility is not used in the HUSKY B (SCHIP) program, when PE is utilized, more cases are referred to HUSKY B (SCHIP). This change was made to increase access to health care for Connecticut's children.

3. Self-Declared Income Verification

Effective July 1, 2001, family income can be self-declared by the applicant/recipient in both the HUSKY A (Medicaid) and the HUSKY B (SCHIP) program. This change was made to streamline eligibility and increase access to health care for Connecticut's children.

4. Ex-Parte Renewals

Effective July 1, 2001, renewals of ongoing eligibility for HUSKY A (Medicaid) and HUSKY B (SCHIP) can be processed using information already verified from other Department programs.This change was made to streamline eligibility and increase access to health care for Connecticut's children.

5. Crowd-out penalty reduced.

Effective July 1, 2001 the Crowd-out penalty was reduced from six (6) to two (2) months in the HUSKY B (SCHIP) program. This was done to reduce the waiting time to families who drop insurance without good cause and then apply for HUSKY B (SCHIP).

6. Expansion of HUSKY A (Medicaid) to adults.

Effective January 1, 2001, HUSKY A (Medicaid) was expanded to cover parents and certain other adult caretaker relatives who live with their dependent children if family income is at or below 150% of the federal poverty level. For those families with income in excess of 150% of the federal poverty level, the children would still be screened for eligibility under either HUSKY A (Medicaid—when family income

is up to 185% of the federal poverty level) or HUSKY B (SCHIP—when family income exceeds 185% of the federal poverty level). This change was made to increase access to health care for adults of dependent children.

7. Family Medicaid coverage groups, name change.

Effective January 1, 2001, all family Medicaid coverage groups were renamed to include the term HUSKY. This was done to help remove a perceived welfare "stigma" to the family Medicaid program.

8. Foreign Born Adopted Children.

Effective July 1, 2001 foreign born children adopted by American parents meet the citizenship and Connecticut residency requirements to be eligible for HUSKY A (Medicaid) or HUSKY B (SCHIP). This change was made to be in compliance with federal law.

9. U. S. Census Income Disregarded.

Effective February 1, 2001, income earned by temporary employees of the U.S. Census Income was disregarded from consideration in the HUSKY A (Medicaid) and HUSKY B (SCHIP) program. This change was made to encourage individuals to accept employment with the U.S. Census (as encouraged by the federal government) as earnings would not jeopardize eligibility for the HUSKY program.

B. **Enrollment Process**

NC

C. Presumptive Eligibility

See 1.1, A, above.

D. Continuous Eligibility

NC

E. Outreach/marketing campaigns

Three major changes affecting outreach and marketing during FFY 2001 involved:

- The $3.9 million **Connecticut Community Healthcare Initiative (CCHI),** integrating HUSKY (SCHIP/Medicaid) outreach with Healthy Start prenatal care services and outreach;
- **A back-to-school broadcast media campaign** funded by the Robert Wood Johnson Foundation; and
- **Expansion of parental coverage** in Medicaid to 150% of the federal poverty level.

Overview:

✓ The Connecticut Community Healthcare Initiative essentially re-defined the state's approach to community-based health coverage outreach by combining and enhancing this service with the Healthy Start system of prenatal care and case management for Medicaid-eligible women. The first contract period for the combined initiative ran from November 2000 through December 2001, and the Department of Social

Services is currently working to extend the initiative in 2002. CCHI encompasses 15 contractors (municipal health departments, private health centers, and private human service agencies) providing HUSKY and Healthy Start outreach and Healthy Start case management services. While Connecticut had community-based outreach contracts before CCCI, it was a major change to join forces with Healthy Start to create an integrated service model.

- ✓ The back-to-school media campaign was a major shot in the arm for Connecticut's HUSKY Plan. Consisting of state-of-the-art TV and radio spots saturating the Hartford media market, the month-long campaign (August 15-September 15, 2001) generated thousands of calls and applications and helped propel HUSKY into the marketing mainstream.

- ✓ Expansion of Medicaid coverage of parents and relative caregivers earning up to 150% of FPL took effect January 1, 2001, representing an complementary and helpful outreach message for HUSKY. This did not impact SCHIP as a whole, although the broadened outreach message undoubtedly reached many parents of teenagers covered by SCHIP-reimbursed Medicaid expansion.

More on these factors in Section 2.4, Areas of Special Interest; and Section 3.1, Successes and Barriers

F. Eligibility Determination Process

Self-Declared Income Verification
See self-declared income change described in 1.1, A, above. The self-declared income process is an eligibility determination process change.

Forms
Forms used in the HUSKY B (SCHIP) eligibility determination process have also been changed to streamline the process. For example, the income calculation sheet has been changed so that the income screen can be done quicker. (See Section 2.6 as this form is used in the referral process between the SPES (Single Point of Entry Servicer) and the Department's regional offices.)

Screening Process
The screening process at the SPES (Benova) has also been changed to gather more information at time of initial screening and not wait until the application is returned to the eligibility worker. This shortens the time needed to confirm eligibility for the program.

Procedures
Effective October 2001, applications received by the SPES that appear HUSKY A (Medicaid) eligible—with no other programs active—are sent directly to the DSS Central Office Central Processing Unit for granting, as opposed to being sent directly to a DSS regional office for processing. Once the case is granted by the Central Processing Unit, the case is transferred to the appropriate regional office for case maintenance. This process is scheduled to end December 31, 2001. This change was made to centralize and streamline the application process and to also assist in processing an influx of applications received due to an enrollment media campaign.

G. Eligibility Redetermination Process

See ex-parte renewal process describe in 1.1, A, above.

A. Benefit structure

NC

B. Cost-sharing policies

NC

C. Crowd-out policies

NC

D. Delivery system

There was a change in ownership of one of the HUSKY participating health plans. Effective October 1, 2000, Preferred One changed ownership from HealthChoice of CT to FirstChoice of CT.

E. Coordination with other programs (especially private insurance and Medicaid)

NC

F. Screen and enroll process

NC

G. Application

The unified Medicaid and SCHIP application was revised in January 2001 to also allow the adult caretaker to apply for himself or herself and/or spouse.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Enrollment increased at a robust rate during FFY 2001. HUSKY A (Medicaid) enrollment of children increased by 5,461, a 3.1 % increase and HUSKY B (separate SCHIP) enrollment increased by 2,329, which reflects a 33.5% increase during the one year period. The increases in HUSKY A and B enrollments was determined by comparing net enrollment data at the beginning of the FFY to net enrollment levels at the end of the FFY.

B.How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

It is difficult to ascertain the actual number or percent of new enrollees that can be credited primarily to outreach. However it is reasonable to assume that most of the increase can be primarily attributed to outreach.

C.Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State. N.A.

D.Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
9.1.1 To increase the number of children in Connecticut with health insurance by expanding Medicaid (HUSKY Part A) coverage and creating a new health insurance	**9.2.1**To increase the number of children covered by health insurance.	Data Sources: The data source for enrollment in HUSKY A (Medicaid) is Connecticut's Eligibility Management System (EMS). The data source of enrollment in HUSKY B is Benova, the SPES. Methodology: Count of increase in net enrollments numbers from data obtained from EMS and Benova.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
health insurance program for previously uninsured children, to be know as HUSKY Part B. **9.1.2** To maximize participation in HUSKY, Parts A and B through outreach, single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.2** To maximize participation in HUSKY Parts A and B.	Progress Summary: During FFY 2001 net enrollment increased by 7,790 children (5,451 in HUSKY A and 2,329 in HUSKY B). Data Sources: Methodology: N/A. Progress Summary: **Outreach—**The HUSKY Healthcare Outreach Partnership. The Department of Social Services (Department) is continuing a multi-level public outreach campaign to inform parents about the availability of children's health coverage, in collaboration with the Connecticut Children's Health Council and Project, Benova (eligibility and enrollment contractor), Infoline, state Medicaid Managed Care Council and other partners in the health and human services field. An initial DSS community-based outreach contracting initiative is transitioning to an integrated HUSKY outreach and Healthy Start prenatal care case management initiative, providing $4 million in funding to 15 contractor agencies statewide. This program complements HUSKY outreach and education in the Covering Connecticut's Kids initiative, funded by the Robert Wood Johnson Foundation and coordinated by the Children's Health Council. In the first 30 months of Connecticut's combined Medicaid/SCHIP program, more than 60,900 applications to the single point of entry servicer (Benova) have been generated by a wide variety of outreach measures. Many additional applications have been received at DSS field offices. The HUSKY Plus Behavioral and HUSKY Plus Physical Centers have actively engaged in outreach within the community, as well as the managed care organizations. The DSS HUSKY Outreach Team, with outreach and education partners, conducted outreach to school health and school lunch personnel; athletic coaches in a pilot project with the CT Interscholastic Athletic Association; through community-technical colleges; through employers such as nursing facilities

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		and home care agencies; with the Department of Labor rapid-response team for employees being laid off; through select media outlets, particularly those serving minority communities; through a grant to the CT chapter of the American Academy of Pediatrics to reach selected medical practices; and myriad other outreach activities and partnerships. **Single Point of Entry (SPES)—**a single point of entry server, Benova, Inc. serves as the HUSKY application center, and has responsibility for HUSKY B eligibility determinations and HUSKY A and B managed care enrollment. Benova also participates in limited outreach efforts. **Presumptive Eligibility—**Implementation at school and community centers began on 10/1/00. The plan is to include Head Start and WIC centers in the near future. As of 9/30/01 over 2,500 children have been enrolled through presumptive eligibility efforts at school and community centers. **Simplified Application Process—**Information and application forms are available through Infoline. Benova is able to accept an application by telephone, print it, and send it to the applicant for verification of income and signature. Both Benova and Infoline offer toll-free telephone numbers. Effective January 2001, the 4-page HUSKY application form has revised and further simplified from its earlier version. **Annual Enrollment**— During FFY 2001 net enrollment increased by 7,790 children (5,451 in HUSKY A and 2,329 in HUSKY B).
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
9.1.2 To maximize participation on HUSKY, Parts A and B through outreach, a single	**9.2.2** Increase the number of insured children 18 or under who are between 185% and 300% of	Data Sources: Benova enrollment files. Methodology: Count of enrollment files. Progress Summary: — During FFY 2001 net

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
point of entry, presumptive eligibility, a simplified application process and annual enrollment.	the federal poverty level.	enrollment in the HUSKY B for children with family income less than 300% increased by approximately 2,000 children.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
9.1.2 To maximize participation in HUSKY Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.2** 1. Expand Medicaid (HUSKY Part A) enrollment of uninsured children 15 – 18 years old that are under 185% of the federal poverty level.	Data Sources: EMS. Methodology: Unduplicated count of Medicaid Expansion recipients during FFY 2001. Progress Summary: During the reporting period, 4,240 children were enrolled in the HUSKY A expansion group. The number of children in the expansion group continues to drop as children get older and age out. During FFY 2000, 9,211were eligible at some point during the year compared to 4,240 during FFY 2001.
9.1.3 To promote the health of children through a health benefit package tailored to the health care needs of children, which includes comprehensive preventive services.	**9.2.3** To promote the health of children through a comprehensive health benefits package. 1. Match or exceed the statewide average of the percentage of children in HUSKY Parts A and B who receive immunizations by age two.	**1. Immunizations:** HUSKY A Data Sources: Administrative Methodology: HUSKY A and HEDIS modified. **See attached.** Progress Summary: During the reporting period, a total of 6,338 two-year-olds (born in CY 1998) met the continuous enrollment criteria. Of that total, 75.3% received all required immunizations. Of that total, 75.8% received immunizations. This represents an increase of 0.5% from the last reporting period. HUSKY B Data Sources: Hybrid. Methodology: HUSKY A and HEDIS 1999 modified for HUSKY B.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		HUSKY B. <u>Progress Summary:</u> During the reporting period of July 1999 – June 2000 a total of 34 members met the criteria to be included in the report. Twenty-four (70.59%) of eligible members were known to be up to date on immunizations. **See attached.** **2. Well-Child Visits:** HUSKY A <u>Data Sources:</u> Administrative <u>Methodology:</u> EPSDT Periodicity Schedule. In Connecticut, it is based on AAP and ACIP Guidelines. **See Attached.** <u>Progress Summary:</u> During the reporting period the total number of individuals eligible for EPSDT was 214,654. Of this group, 180,361 were eligible to receive at least one initial or periodic screening service (Screening ratio = 65.15%). The total number of eligibles that actually received at least one initial or periodic screening service was 96,628 (Participation ratio = 51.36%). These figures represent a decrease of 3,527 eligibles served, as compared to the previous reporting year. The participation ratio likewise decreased (a total decrease of –8.80%) from the previous year. **See Attached.** HUSKY B <u>Data Sources:</u> Administrative, hybrid. <u>Methodology:</u> HUSKY A, HEDIS. <u>Progress Summary:</u> During the reporting period of July 1999 – June 2000, a total of 7,928 HUSKY B enrollees were eligible for well child visits. This represents an increase of 2850 eligible children from the last reporting period. The total percent of recommended

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		well child visits received was 77.2% (screening ratio), which is an increase of 14.2% from the previous reporting year. The total percent of children receiving well child visits was 60.6% (participant ratio). This represents an increase of 4.6%. **See Attached.**
OTHER OBJECTIVES/HUSKY PLUS		
9.1.4 To assist those children enrolled in HUSKY B who have special health care needs, to receive appropriate care through two supplemental plans (HUSKY Plus).	9.2.4 To assist children with special physical and behavioral needs through HUSKY Plus. 1. 100% of referrals to HUSKY Plus to have eligibility determinations within 21 days. 2. Track the percentages of referrals to HUSKY Plus accepted or denied. 3. 100% of children with the following conditions will receive care according to	1. <u>Data Sources:</u> Administrative; medical records. <u>Methodology:</u> Two HUSKY Plus Data Collection Tools (1 administrative, 1 medical record audit), as adapted from the HUSKY Plus Medical Audit Form 2000. See Attached. <u>Progress Summary:</u> An aggregate total of 140 children were referred to HUSKY Plus Physical (120) and HUSKY Plus Behavioral (20) during the specified time period. Eligibility for HUSKY Plus was determined within 21 days for 127 of the referrals (93%). Eligibility determination exceeded 21 days for 9 (7%) children who were referred to HPB. Since the last reporting period, the rate of timely eligibility determination has improved (+14.60%) while the rate of late eligibility determinations has decreased (-15.60%). See Attached Data Compilation Sheet. 2. <u>Data Sources:</u> Same as above. <u>Methodology:</u> Same as above. <u>Progress Summary:</u> An aggregate total of 125 (92%) of those referred were accepted into the HUSKY Plus programs. This represents an aggregate increase of 79 children accepted into HUSKY Plus. HPP accepted 114 (91.2%) children, while HPB accepted 11 (64.7%) children and denied 6 children. See Attached.

	individual needs and professional guidelines: • Cerebral Palsy • Cystic Fibrosis • Major Depression	3. <u>Data Sources:</u> Same as above. <u>Methodology:</u> Same as above. <u>Progress Summary:</u> A total of 16 (13%) of HUSKY Plus enrollees carried a diagnosis of cerebral palsy, cystic fibrosis, or major depression. In HPP there were two enrollees who were diagnosed with cystic fibrosis and 13 enrollees who were diagnosed with cerebral palsy. HPB had one enrollee who was diagnosed with major depression. See Attached.
9.1.5 To design the HUSKY Plus program in a way that will maximize coordination between HUSKY B and HUSKY Plus, by integrating basic health care needs into the care provided for intensive health care needs and, whenever possible, building upon the existing therapeutic relationships with Title V providers.	9.2.5 To maximize coordination between HUSKY B and HUSKY Plus. 1. 100% of children in HUSKY Plus who receive case management. 2. 100% of children in HUSKY Plus, who were formerly	1. <u>Data Sources:</u> Same as above. <u>Methodology:</u> Same as above. <u>Progress Summary:</u> An aggregate total of 119 (95%) of children enrolled in HPP and HPB received case management services. HPB provided case management services to 9 (81.8%) enrolled children; HPP provided case management services to 109 (95.6%) enrolled children. The Lead Case Management Coordinator was identified for 108 (99%) HPP children and 9 (90%) HPB children, for an aggregate total of 117 (98.3%). This represents an aggregate improvement ratio of +5.1% from the previous reporting year. The HUSKY B representative who was assigned to the case management team was identified for 110 (96.5%) HPP children and 9 (81.8%) HPB children, for an aggregate total of 119 (95.2%). This represents an aggregate improvement ratio of +8.8% from the previous reporting period. <u>Global Plan of Care (GPC):</u> A GPC was completed for 87 (78%) HPB and HPP children within 30 days of eligibility determination for HUSKY Plus [HPP = 103/(90%) HPB = 9/(81.8%)]. This represents an aggregate improvement ratio of +5%. Reference was made to Individual Education Plans and Individual Family Service Plans for 91% of children with a completed GPC. Detailed information on specific services provided such as Birth to Three program, Early Learning Centers, Speech and Occupational

	covered by Title V, who will continue to have the same specialty provider.	therapies, etc. was consistently provided in the GPC. Progress notes referring to the GPC treatment goals were documented in 80% of the records with a GPC. See Attached. 2. Data Sources: Same as above. Methodology: Same as above. Progress Summary: In HPP six enrollees had previous Title V services. Of these, three (50%) continued to use the same specialty provider(s). See Attached.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Attachments to the SCHIP Annual Report 2001 include:

- ☐ HUSKY A Utilization Reports Submitted to Medicaid Managed Care Council
  - ☑ Fourth Quarter of 2000
  - ☑ First Quarter of 2001

- ☑ HUSKY B Annual Utilization Report (7/1/00 – 6/30/01)

- ☑ HUSKY B Quality Improvement Program Report

- ☑ HUSKY Plus External Quality Review (10/1/00 – 9/30/01)

- ☑ Children's Health Council (CHC) Reports
  - ☑ Children's Health Council (CHC) Children with Special Health Care Needs – Executive Summary (December 2000)
  - ☑ Children's Health Council (CHC) Children with Special Health Care Needs – Survey to Assess Access to Care and Satisfaction (December 2000)
  - ☑ CHC Report: Access, Utilization, and Quality of Care in the HUSKY Program (November 2000)

- ☑ CHC Report: Many Children New to HUSKY Part A Receive Well-Child Care Soon After Enrollment (April 2001)
- ☑ CHC Results in Brief: Many Children New to HUSKY Part A Receive Well-Child Care Soon After Enrollment (April 2001)
- ☑ CHC Issue Brief: More Children Receive Well-Child Care in Connecticut: EPSDT Participation in FFY 2000 (May 2001)
- ☑ CHC Issue Brief: EPDST On-Time Visit Rates: Fourth Quarter 2000 (July 2001)
- ☑ CHC Issue Brief: EPDST On-Time Visit Rates: First Quarter 2001 (October 2001)

☑ Consumer Assessment of Health Plans Survey

- ☑ Blue Care Family Plan
- ☑ PHS, Inc. (Health Net) 2000 Survey
- ☑ Community Health Network
- ☐ First Choice – Preferred One

☑ DPH Lead Screening Report

☑ Immunizations Report

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A.If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out. N.A.

B.How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults

_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s). N.A.

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults

_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Connecticut defines crowd-out as the displacement of commercial health insurance resulting from the availability of public funding. To guard against the crowd-out phenomena, Connecticut instituted a waiting period before children who dropped employer-supported health care benefits can be enrolled into the SCHIP program (HUSKY B). There are several exceptions to this six-month (2 months as of 7/1/01) waiting period, including self-employment, loss of employment, death of parent, and financial hardship (as defined as a family paying more than 10% of gross income on health insurance premiums).

B. How do you monitor and measure whether crowd-out is occurring?

To monitor whether crowd-out is occurring, we track the number of applications denied due to having dropped insurance within the last 6 months (2 months as of 7/1/02). There is no way to track the number of parents who did not apply because they believed their children would not qualify because they are currently insured or because they dropped coverage during the crowd-out period and waited till the crowd-out period ended before applying.

Generally, crowd-out is a confusing area. It is difficult for some parents to understand that crowd-out does not apply if they are paying for health coverage on the private market. It also does not apply if a child will be

eligible for Medicaid. So it is likely that some applications are deterred. In this light, crowd-out accomplishes the goal of avoiding the supplantation of employer sponsored insurance by SCHIP.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

During FFY 2001, only 45 children were denied HUSKY B (separate SCHIP program) eligibility due to having dropped employer-sponsored insurance within 6 months of application (2 months eff. 7/01). An additional 875 children were denied due to having employer-sponsored insurance coverage at the time of application

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Six months (2 months eff. 7/01) of ineligibility for HUSKY B after dropping employer sponsored insurance coverage. Data Source: Benova application activity reports including denials because of existing insurance. As seen by the large number of denials due to currently being insured (875 children in FFY2001) parents are not dropping insurance until after a determination has been made that hardship conditions are met. Benova staff, upon applicant request, will conduct an assessment to determine if financial hardship can be met.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The back-to-school media campaign was a very successful outreach endeavor, consisting of state-of-the-art TV and radio spots which saturated the Hartford media market, the month-long campaign (August 15-September 15, 2001) generated thousands of calls and applications and helped propel HUSKY into the marketing mainstream. Early measures of the success of the media campaign are a near doubling in call volume to the HUSKY hotline and applications received by Benova, Inc. However, due to our multi-faceted approach to outreach, no one activity can be fully credited.

The crux of this campaign has been grass-roots, community-based outreach through schools, health centers, community meetings, fairs, events, worksites, and other venues identified by DSS, statewide partners and community contractors. Just as often, HUSKY outreach brings the message to professionals who work with parents through a 'key informant' model--these are the known and trusted people in health, education, human services and other fields who are already in the community and who can vouch for the program and provide follow-up assistance. The emphasis on grass-roots, community-based outreach has been acknowledged as especially important in reaching minority communities and newcomer/immigrant populations.

Community-based outreach services are provided by 15 contractors in the Connecticut Community Healthcare Initiative; by community health educators from the Connecticut Children's Health Council and Children's Health Project; by the DSS HUSKY Outreach Team; by Benova Inc., the HUSKY B eligibility contractor; and by other partner organizations working in the health and human services field. Community contracts were infused with the principles of consumer input and cultural competence, to ensure that diverse consumers of health care and health insurance help inform outreach and case management programs.

As a government-sponsored program, it was especially important as HUSKY got off the ground to access local community networks that already have the contacts and buy-in with parents. This helps cut through the stigma

factor and provides on-scene application assistance to surmount such barriers as fears of immigrant parents about public charge (primarily a Medicaid eligibility barrier).

At the same time, the higher-than-usual income audience for SCHIP (HUSKY B) has indicated the need to complement the community-based approach with more 'mainstream' outreach tactics. The higher-income audience is not as likely to use, for example, community health centers or need hands-on application assistance from an outreach worker. These parents may be more likely to respond to a television ad or video presentation or a newspaper ad or article than a community health representative's personal outreach. This factor was amply demonstrated by the **2001 back-to-school media campaign.**

Outreach themes of interest during FFY 2001

- **Application boom**--Outreach fueled a major upswing in HUSKY applications over the fiscal year and beyond. By the close of FFY 2001, applications for 98,580 children had been received by Benova, our single point of entry servicer and HUSKY B eligibility contractor since July 1998. This represented an **84% increase** in the federal fiscal year (compared to 53,399 applications received as of September 30, 2000). Additional applications were received directly at DSS offices.

- **HUSKY B enrollment increase**--the number children enrolled in HUSKY B (SCHIP) at the end of FFY 2001 was **up by 33.5%** over October 1, 2000. At the end of FFY 2001, 9,262 children were enrolled. [By the end of calendar 2001, enrollment in HUSKY B had risen to 10,566 children, a jump of 1,304 in only three months, with another 3,706 applications pending.]

  Note: Besides HUSKY B, SCHIP has made an impact in Connecticut by enabling coverage of older teenagers through Medicaid expansion, beginning in October 1997.

  While HUSKY B enrollment is still dwarfed by Medicaid enrollment--and most applications continue to be for Medicaid-eligible children--the rate of increase in HUSKY B enrollment is a significant and welcome trend.

- **Impact of media marketing**--Recent application and enrollment gains can be attributed in large part to the **back-to-school media campaign,** which combined paid media (TV and radio ads); earned media (guest editorials, news releases); and extensive community outreach from mid-August to mid-September 2001. Upon application by the Connecticut Children's Health Council with DSS support, the Robert Wood Johnson Foundation selected Connecticut as one of several media markets to receive what was essentially a grant for professional film-quality TV ads, radio ads and extensive support from a Washington-based advertising agency. Preparation for the campaign and a kickoff news conference ensued over the summer, and the saturation effect of the month long ad campaign is regarded as a prime reason for the surge in hotline calls, applications and enrollments. A key factor was the inclusion of a phrase in the ad materials--to the effect that families can earn $50,000--*and even more*--to help break through the stereotype that HUSKY is only for families with low incomes. In addition, a 30-second public service announcement featuring Governor John G. Rowland and children and teenagers at a Hartford child care center was provided to Connecticut movie theater chains. While not a paid, saturation placement, a number of calls were probably generated from this initiative.

- **Impact of presumptive eligibility**--Launched in late 2000, presumptive eligibility has caught on in Connecticut as a major contributor to HUSKY A coverage gains. A description of PE activity is elsewhere in this report.

- **Outreach often means application assistance**--Outreach combined with application assistance is reported to be a critical service at the community level, especially for people with limited English proficiency. In fact, the contractual definition of outreach was expanded to include application assistance, when appropriate for the parent. This personal touch at the local level has been a distinctive feature of HUSKY outreach through the Connecticut Community Healthcare Initiative. As noted above, this may be less of a factor in the HUSKY B market but is acknowledged to be a critical piece of outreach for children's health coverage overall. This also means that one of our tasks is to help contractors strike a productive balance between outreach/education/marketing and appropriate level of application assistance, rather than focusing on 'one-size-fits-all' application assistance at the expense of broader outreach efforts.

- **Emphasis on re-enrollment**--Just as community-based outreach and application assistance supports front-end enrollment, it can help parents understand and follow through with **annual renewal process.** HUSKY has a problematic attrition rate. DSS and our partners are addressing this problem on a number of fronts, including the Continued Access for Connecticut's Families initiative. There is an increasing role for our outreach network in assisting parents with reminder information, encouragement and hands-on assistance to renew coverage for their children.

Some highlights of direct outreach activities by CT DSS

- **Fatherhood Initiative of Connecticut - Statewide Collaboration Service Providers--**Participated in several service provider network meetings to educate fathers about the importance of having health insurance and how to apply for the HUSKY Plan.

- **Rapid Response - Partnership with the Department of Labor--**Conducted HUSKY presentations state-wide to employees who are being dislocated from their employment using a one-stop service model. Dislocated workers often cannot afford health insurance even where it's possible to continue their benefits under COBRA. In addition to information on unemployment benefits, employees are provided with valuable information on free or low-cost health insurance for their children, in some cases, themselves.

- **Business Outreach--**Initiated collaborative relationship with various small businesses through the Chamber of Commerce, the Spanish American Merchants Association, the Capital Region Black Chamber of Commerce and the Small Business Administrations' Small Business Development Centers.

- **Health Care Providers - Human Resources--**Provided HUSKY information and materials to employees during open enrollment. Part -time and per diem employees are targeted since they are not eligible for employer-sponsored health insurance due to their total work hours.

- **Schools--**Conducted HUSKY training sessions to school health personnel, including dental hygienists, school nurses and social workers. Provided HUSKY materials to school lunch personnel for inclusion in the school lunch application; linked school lunch application responses to HUSKY eligibility contractor. Added HUSKY hotline number to parents' school health reporting form.

- **Community Based Agencies--**Ongoing HUSKY training and presentations to health care, child care, human service providers as result of legislative changes to the HUSKY Plan.

- **Movie Theaters--**Provision of Governor's HUSKY 30-second public service announcement in 35mm-format to movie theater chains.

Some highlights of outreach activities by CT DSS contractors in the Connecticut Community Healthcare Initiative

The Connecticut Community Healthcare Initiative encompasses the Healthy Start prenatal care/case management program and public outreach/education for HUSKY and Healthy Start. In the outreach area, CCHI replaced and expanded the first round of DSS community-based outreach funding. A request-for-proposals issued in 2000 resulted in 15 contracts with coverage areas matching the 15 DSS regional and subregional offices. Each contractor focused on schools and other priority target areas that included employers, faith communities and community organizations. Some representative, selected highlights:

- **Bridgeport**--Billboards and bus shelter ads present color photo of two children with HUSKY slogan 'Healthy Kids, Bright Futures,' message about availability of low-cost or free coverage for children and teens, toll-free hotline number and website address.
- **Bristol**--Linkage with school principals' 'cabinet' results in HUSKY outreach staff working with every school, including pre-packaged HUSKY application kits for school nurses who identify uninsured children.
- **Danbury**--Developed trilingual (Portuguese-Spanish-English) HUSKY publication for schools, including distribution through school lunch program as part of extensive school outreach program; also reached out to Spanish-speaking and Portuguese-speaking church groups.
- **Hartford**--'Business outreach package' focuses on area municipal health departments' re-licensing process for food establishments and HUSKY information for uninsured employees.
- **Manchester**--Program identified impressive 90 faith-based organizations for collaboration in HUSKY outreach; linkage with WIC, VNA, Literacy Volunteers, other programs helping reach newcomer populations, including from Ghana, Pakistan, India, Asian/Pacific Islander.
- **Meriden**--Hospital/health center as outreach contractor provides smooth referral from medical providers for application assistance; community health fair and other events blend screenings with HUSKY informational opportunities.
- **Middletown**--Innovative bilingual pamphlets and flyers support community and business outreach by linking themes of prenatal care, affording needed health care and personalizing outreach staff and services they provide.
- **New Britain**--Bilingual application assistance facilitates HUSKY enrollment and referral to related health services; community outreach targeted employees of grocery stores as part of business outreach.
- **New Haven**--Business outreach initiative reached over 450 employers, including license renewal packets to food service establishments, while flyers covered all schools and a dozen churches agreed to dissemination of outreach materials.
- **Norwalk**--Business outreach focusing on seasonal employers like landscape contractors and small and minority-owned business; outreach also focusing on dispelling fear of accessing government health programs on part of Haitian, Latino, other newcomers.
- **Norwich**--Extensive outreach with school nurses, social workers, parent volunteers in large region; faith-based outreach includes linkage with parish nurses and professionally-designed church flyer notices.
- **Stamford**--Outreach to neighborhood organizations assisting recent immigrants and underserved minority populations; 'Every Child Matters' program links school nurses with DSS office to facilitate applications for uninsured schoolchildren.
- **Torrington**--Outreach to temporary employment agencies, information for posting in Wal-Mart employee staff rooms, consignment stores, Salvation Army, food banks and soup kitchens covered.
- **Waterbury**--Extensive community outreach includes diners, flu and immunization clinics, gas stations, convenience stores, fathers' groups, doctor offices, fast food outlets, temporary employment agencies.
- **Windham**--Large employers, public housing, town halls, libraries, family resource centers, school nurses and social workers, PTOs among outreach priorities.

Note: The application assistance services of CCHI contractors as a component of outreach often link directly with local DSS offices, where applications are directly sent. Consequently, much of the work of CCHI

contractors is not reflected in number of hotline calls or applications received by the single point of entry servicer.

Measuring effectiveness of Connecticut's outreach program

Two primary measures of outreach effectiveness are calls to customer information hotlines and applications for health coverage. Both measures showed impressive increases during FFY 2001.

Incoming calls to HUSKY Health Infoline, the main call center, showed a pattern of steady growth. In October 2000, calls numbered 1,824. In September 2001, calls numbered 3,891.

The crescendo occurred in August 2001, when 4,286 calls were received. During the last quarter of FFY 2001 (July-September 2001), HUSKY Health Infoline handled 10,202 calls, nearly double the number of calls from the same period the previous year. Most of the dramatic increase in calls at this time may be attributed to the back-to-school media campaign described above.

Receipt of applications, driven primarily by outreach, also showed a significant increase during FFY 2001. Applications on behalf of 45,181 children were received by Benova, the HUSKY single point of entry servicer--an 84% increase over the number at the beginning of the federal fiscal year.

By the end of FFY 2001, cumulative 'children-applied-for' mark was nearly 100,000 since the opening of HUSKY as a combined Medicaid-SCHIP program in mid-1998. Additional applications were received directly by DSS regional offices.

Looking at 'how callers heard about HUSKY,' as reported by HUSKY Health Infoline for January through June 2001, by far the highest number of calls were attributed to friend/family/word of mouth (2,370). This compares to 1,485 calls in this category for the same period in 2000. This nebulous category of positive word-of-mouth continues to be the most common outreach indicator, although it is probable that the work of many individual outreach activities is also reflected here. The hotline staff do not spend inordinate time quizzing callers about which particular source may have prompted a call since the main purpose of the hotline is to engage parents about the program and how to apply. Moreover, marketing principles note that it usually takes multiple, sometimes altogether different, call-to-action 'hits' before a target audience takes the critical step to respond. However, the word-of-mouth call totals do show that people vouching for HUSKY is absolutely vital.

Next categories were Department of Social Services (713); unknown [it should be noted that our call center does not badger people if they don't immediately know where they heard about the program](574); 211 Infoline (471); flyer/brochure/poster (466); newspaper/magazine/phonebook (446); doctor (345); schools (336); clinic/hospital (244); employer/temp agencies (234); Department of Motor Vehicles registration renewal insert (213). There were 34 additional categories.

Moving to the final quarter of FFY 2001 (July September 2001), the 'how heard of' categories begin with the surprising 'Used Before' category (1,769), perhaps an indicator of the attrition factor in HUSKY coverage. Next came television (1,753), a clear result of the back-to-school media campaign and, to a lesser extent, the movie theater ad project mentioned above. Word-of-mouth was third at 1,522 calls.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

In both the HUSKY A and B programs, the largest enrollment increase during calendar year 2001 was seen among the Caucasian population. In HUSKY B enrollment growth was 69% for Caucasians compared with

46% for African-Americans and 55% for Latinos. In HUSKY A enrollment growth was 18% for Caucasians; 3% for African-Americans and 7 % for Latinos. It's unclear at this point if the higher rates, or any portion of the increase, for Caucasians can be attributed to outreach or if they were affected by economics or uninsured rates among those populations.

C. Which methods best reached which populations? How have you measured effectiveness?

We do not currently have this information.

2.5 Retention:
A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

A number of things have been done to increase retention in the HUSKY program. The most significant one has been to secure a grant from the Robert Wood Johnson Foundation to study and evaluate the Department's processes related to retention and recommend process improvements to increase retention in the program.

Phase one of the grant has been completed and a number of process improvements have been identified. Phase two of the grant will involve submission of an implementation plan that will result in the elimination of the identified retention barriers. Our hope is that phase two will also be approved by the Robert Wood Johnson foundation so that funding can be secured to implement identified improvements.

Improvements that have already been made to increase retention include the following:

*a monthly special mailing to all HUSKY A households that contain at least one person who will be losing eligibility for HUSKY A due to the expiration of CE. This mailing includes a special notice and application. When the application is returned, ongoing eligibility is reviewed for both HUSKY A and HUSKY B. This special mailing started in May 2001, and continues to date. The process is currently done manually, but will eventually be automated. Thus far, approximately 8,000 applications have been mailed out through this process;

*the HUSKY logo was placed on redetermination envelopes, replacing the State seal. This was done in an effort to reduce a perceived "welfare" stigma to the program and to ensure that renewal forms would be forwarded by the post office (regular department mail is not forwarded) to clients who failed to report changes of address;

*prefilled applications will soon be sent out at time of HUSKY A (Medicaid) renewals to simplify the redetermination process;

*a "Change of Address" post card is being developed to streamline the process of reporting a new address when a client moves.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

____ Follow-up by caseworkers/outreach workers
____ Renewal reminder notices to all families
__X__ Targeted mailing to selected populations, specify population (HUSKY A children nearing the end of their continuous eligibility period).
____ Information campaigns

__X__ Simplification of re-enrollment process, please describe (Use of the 4 page simplified HUSKY application/renewal form for Medicaid redeterminations in place of the longer 8 page Medicaid form).

____Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe

____ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, these measures are being used for the Medicaid SCHIP expansion as well as for regular Medicaid eligible children.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Some of the efforts that we have implemented that we find to be effective at ensuring that eligible children stay enrolled are use of a HUSKY logo envelope that allows for post office forwarding of renewal notices; self-declaration of income and use of a simplified renewal form. Please see 3.1 D below.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Benova discontinuance reports show a small percentage of children losing eligibility due to having other insurance. During FFY 2001, eligibility for HUSKY B was discontinued for 221 children. Eligibility for 66 of these children was discontinued at time of redetermination. The other 166 were discontinued prior to the redetermination, either due to Benova learning about the insurance directly from the family or from the HUSKY B managed care organization in which the children were enrolled.

We do not know much about insurance coverage of those who do not reenroll in HUSKY B. The assumption is that a significant portion do not return their HUSKY B renewal form because they have obtained other insurance for their children and therefore no longer need HUSKY B coverage

.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, the same application and redetermination procedures are used for Medicaid (HUSKY A) and SCHIP (HUSKY B) with the exception of pre-filling of applications for Medicaid (HUSKY A). Currently, if the client calls DSS to apply for HUSKY, the application is not pre-filled prior to sending it out to the client. Under HUSKY B (SCHIP), the application is pre-filled by Benova based on the responses given over the phone by the client. Also, at time of renewal, Benova sends out a pre-filled application to the client for review, signature, and return to Benova to complete the renewal process. For HUSKY A (Medicaid) a blank HUSKY application/renewal form is sent to the client for completion of their renewal. We are in the process of changing the HUSKY A renewal process to send out pre-filled renewal applications. This should be implemented in January 2002.

Also, effective October, all new HUSKY A applications, once identified as such by the SPES (Benova), are sent by Benova to the Central Processing Unit at the Central Office of DSS. (Only HUSKY A applications with no other active programs are sent to the Central Processing Unit.) Once the Central Processing Unit receives the application, the case is granted HUSKY A (Medicaid) by the Central Processing Unit and transferred to the Department's regional office for case maintenance. This process was devised to centralize and streamline the referral process from the SPES to HUSKY A and to streamline the workflow for the DSS regional offices.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

As HUSKY A (Medicaid) children near the end of their eligibility—primarily towards the end of their CE period—a special mailing is sent out to capture the child and screen them for ongoing HUSKY A and B eligibility. The special mailing includes a special notice and an application form. The form is returned to the SPES (Benova) who conducts an eligibility screen, similar to the process used for new applications, with the exception being that these children are currently HUSKY A eligible. If HUSKY A eligibility is identified, the renewal form is sent to the assigned DSS caseworker who then makes the necessary update to the EMS to renew coverage. This CE identification mailing is currently done manually each month and is scheduled to be automated in the near future.

Also, when income changes are reported and the HUSKY A case would be otherwise ineligible if not for CE, the application is copied and sent by the DSS regional office to the SPES (Benova). Benova then creates a tickler file to track, identify, and contact (if necessary) families as they near the end of the CE period so that HUSKY B eligibility grant can be coordinated with the termination of the HUSKY A coverage so that there is no gap in coverage.

As a HUSKY B (SCHIP) child loses eligibility (e.g. when a drop in income occurs) the case is referred to the appropriate DSS regional office for the processing of HUSKY A. The case will remain active in the HUSKY B program until the case is granted HUSKY A, so that no gap in coverage occurs. If income increased on an active HUSKY B case, the child stays active in the same HUSKY B income band until the HUSKY B renewal comes due

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, the same delivery systems are used in the Husky A (Medicaid) and the HUSKY B (SCHIP) programs. However, not all managed care organizations are in both HUSKY A and HUSKY B. All managed care plans in both programs do access the same provider networks within each plan.

2.7 Cost Sharing:

A.Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Not during the time period covered by this evaluation.

B.Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

Not during the time period covered by this evaluation.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

The Connecticut Department of Social Services currently has available to it several sources of information concerning quality of care received by SCHIP enrollees. The table below summarizes a few of the major information sources:

Program	Data Source	Type of Data	Results
HUSKY A (Medicaid)	MCOs through contractor	Encounter data	Problems with completeness but data are good enough for EQRO (Qualidigm) to use as input for quality audits and for Children's Health Council (CHC) to use in tracking EPSDT visits and other analyses.
HUSKY A (Medicaid)	MCOs directly to department	Aggregate utilization reports	Reports are useful to department in monitoring MCO performance & its impact on member access.
HUSKY B (separate SCHIP)	MCOs through EQRO Contractor to department	Aggregate utilization reports	Reports are useful to department in monitoring MCO performance & its impact on member access.
HUSKY A (Medicaid)	MCOs directly to department	Aggregate utilization reports	Reports are useful to the Medicaid Managed Care Council in monitoring DSS's administration of program.
HUSKY B (separate SCHIP)	MCOs through EQRO Contractor to department	Aggregate utilization reports	Reports are useful to the Medicaid Managed Care Council in monitoring DSS's administration of program.
HUSKY A (Medicaid)	External Quality Review Organization (EQRO), Qualidigm	Operational audits	Audits are useful to department in monitoring MCO operations and their impact on members.
HUSKY A (Medicaid) & HUSKY B (separate SCHIP)	Children's Health Council (CHC) contractor, Children's Health InfoLine (CHIL)	Reports of call center activity, case review meetings.	Reports on volume and types of calls received, plus case review meetings with department staff highlight and give early warning on impending access or quality issues.
HUSKY A (Medicaid)	DSS Appeals Tracking	Grievance / Fair Hearing Tracking Log and Reports.	Allows department to schedule timely Fair Hearings, analysis allows department to monitor trends in client problems with access and quality.
HUSKY A (Medicaid)	Department of Public Health (DPH)	Reports on immunizations, blood lead level screens & birth certificate match.	Allows department to monitor delivery of immunizations, lead screens, and prenatal care.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

By contract and through monthly meetings with the managed care organizations (MCOs) the department has established a series of quarterly reports covering these very subjects.

In so far as is possible the methodology for each report is based on the National Committee for Quality

Assurance (NCQA) Health Employer Data Information Set (HEDIS) specifications, thereby allowing the department to compare the SCHIP program against the benchmark of HEDIS reports for other states and commercial HMOs.

In addition, the Children's Health Council (CHC) uses encounter data to monitor the timeliness of well-child visits, including well-baby care, and provides detailed feedback to MCOs concerning children who have not received well child visits on time. HUSKY MCOs are required to contract with the Connecticut Department of Public Health's (DPH) Connecticut Immunization Registry and Tracking System (CIRTS). CIRTS provides a centralized means for HUSKY PCPs to report on the immunization status of children enrolled in the HUSKY Program. In turn, PCPs are able to query CIRTS regarding the immunization status of children new to their practice. Annually, CIRTS reports aggregate immunization data to the MCOs and the department.

As a backstop and look behind to the above data sources for monitoring the quality of care received by SCHIP enrollees, the department has commissioned the EQRO to do focussed studies of the content of well child visits, maternal and prenatal care, discharge planning in behavioral health, and to evaluate the HUSKY Plus Behavioral and Physical Health programs. The department works closely with the Bureau of Community Health in DPH to monitor access to dental care. The department is also carrying initiatives with Yale University to monitor and assess outcomes of behavioral health treatment for children in HUSKY and the use of psychotropic medications by children in HUSKY.

CHC conducted a consumer satisfaction survey of children with special health care needs as defined by the Balanced Budget Act that the department commissioned. In addition, HUSKY MCOs conducted consumer surveys of their HUSKY members as required by their contracts with the department. In both cases, the surveys are based on the Consumer Assessment of Health Plans Survey (CAHPS), thereby allowing for benchmarking to surveys in other states.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The department plans to continue its current activities as described above for monitoring and assessment of the quality of care received by SCHIP enrollees. New initiatives include a match of HUSKY enrollment with birth certificates for the purpose of assessing prenatal care and birth outcomes, reporting on access and quality of care provided to children with special health care needs as required by the department's waiver under section 1915(b) of the Social Security Act, and working with the DPH to improve the ability of DPH's immunization, blood lead level screening, vital records, WIC, and Title V data bases to interface with data contained within the HUSKY Program for the purposes of better monitoring and tracking the quality of care received by HUSKY Program members. The Department in conjunction with the CHC and the MCOs established an EPSDT Revitalization Workgroup to work with providers and consumers to improve the quality and access to well-child care for children birth to 21 years in age.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.
Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

N.A.

B. Outreach

FFY 2001 was a banner year for outreach. Connecticut's participation in a back-to-school broadcast media campaign funded by the Robert Wood Johnson Foundation, coupled with the efforts of Connecticut's Covering Kids Initiative (also funded by RWJF) and the Connecticut Community HealthCare Initiative outreach efforts resulted in increased application and enrollment activity. Please see section 1.1 E. above.

C. Enrollment

N.A.

D. Retention/disenrollment

Several successful efforts targeting retention were implemented during this FFY, the most successful efforts being self-declaration of income; ex-parte verification and use of HUSKY logo envelopes in place of DSS envelopes. After implementation of these initiatives, discontinuance rates at time of renewal dropped from 37% to 33% in HUSKY A and from 53% to 39% in HUSKY B.

E. Benefit structure

N.A.

F. Cost-sharing

N.A.

G. Delivery system

N.A.

H. Coordination with other programs

N.A.

I. Crowd-out

N.A.

J. Other

N.A.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

SECTION 4. SCHIP PROGRAM FINANCING

4.1

	Federal Fiscal Year 2001 Costs	Federal Fiscal Year 2002 Costs	Federal Fiscal Year 2003 Costs
Benefit Costs			
Insurance Payments			
Managed Care [1]		A	B
	11,988,281	17,883,900	22,744,800
per member/per month rate x # of eligibles	93,824	133,445	166,794 C
Fee for Service	-	-	-
Total Benefit Cost			
	11,988,281	**17,883,900**	**22,744,800**
Administrative Costs			
Personnel	414,152	650,075	836,062
General Administration	736,705	890,367	
			1,084,418
Contractors/Brokers [2]	36,013	69,328	82,463
Claims Processing [3]	121,008	290,640	402,550
Outreach/Marketing [4]	24,154	86,690	121,707
Other	-	-	-
Total Administration Cost [5]			6
	1,332,032	**1,987,100**	**2,527,200**
10% Administrative Cost Ceiling			
	1,332,032	1,987,100	2,527,200
Federal Share	865,821		
		1,291,615	1,642,680
State Share	466,211	695,485	884,520
TOTAL PROGRAM COST	6	6	6
	13,320,313	**19,871,000**	**25,272,000**

[1] Includes HUSKY B and HUSKY Plus programs. Does not include MCHIP expenditures.
[2] Prorated portion of actual and estimated expenditures for Benova (enrollment broker).
[3] Prorated portion of MMIS claim processing costs.
[4] FY 2001 and FY 2002 are estimated based on prorated projection of SFY 2001 and SFY 2002

expenditures.
[5] Represents actual dollars claimed in FFY 2001 and estimated claim up to 10% administrative cap in FFY 2002 - 2003. Dollars are consistant with 10% administrative costs under CHIP.
[6] Does not include MCHIP expenditures.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

N. A.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

_X___State appropriations
_____County/local funds
_____Employer contributions
_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No, we do not expect any changes.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	HUSKY A	HUSKY B
Provides presumptive eligibility for children	_____No ___X___Yes, for whom and how long? For children under 19 yrs. PE covers from the date of application through the end of the following month.	___X___No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ___X___Yes, for whom and how long? Three months of retroactive eligibility from the month of application for adults and children.	___X___No _____Yes, for whom and how long?
Makes eligibility determination	___X___State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	_____State Medicaid eligibility staff ___X___Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months	Specify months
Has joint application for Medicaid and SCHIP	_____No ___X___Yes	_____No ___X___Yes
Has a mail-in application	_____No ___X___Yes	_____No ___X___Yes
Can apply for program over phone	_____No ___X___Yes	_____No ___X___Yes
Can apply for program over internet	___X___No _____Yes	___X___No _____Yes
Requires face-to-face interview during initial application	___X___No _____Yes	___X___No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	___X___No _____Yes, specify number of months What exemptions do you provide?	_____No ___X___Yes, specify number of months (2 months as of 7/1/01; 6 months prior to 7/1/01) What exemptions do you provide? (exemptions include: self employment; loss of insurance due to loss of employment or death of a parent; exhaustion of lifetime maximums; financial hardship).

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage regardless of income changes	_____No __X___ Yes, specify number of months (12 months) _____ Explain circumstances when a child would lose eligibility during the time period (move out of state, death, incarceration)	_____No __X___Yes, specify number of months (12 months) Explain circumstances when a child would lose eligibility during the time period period (move out of state, death, incarceration, eligible for Medicaid)
Imposes premiums or enrollment fees	__X___No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No __X___Yes, how much? Who Can Pay? ___ Employer _X_ Family _X__ Absent parent _X__ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	__X___No _____Yes	_____No __X___Yes
Provides preprinted redetermination process	__X___ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __X___ Yes, we send out form to family with their information and: _X_ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

There are several differences between the redetermination and initial application processes, primarily due to the redetermination being a more streamlined process. Information that was verified at the time of application, which does not change (e.g. social security number) does not require re-verification during redetermination. Additionally, during redetermination ex-parte information can be used as verification.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher

185 % of FPL for children under age 19.
____% of FPL for children aged _____
____% of FPL for children aged _____

C. Medicaid SCHIP Expansion

Less than or equal to 185% of the FPL for children under age 19
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

Greater than 185% of the FPL for children under age 19 (band one);
235% to 300% of the FPL for children under the age of 19 (band two);
Over 300% of the FPL for children under the age of 19 (band three).

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

See table 6.2 below

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)?

____ Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90.00/mo. and $30.00 and 1/3 of the remainder in limited circumstances.	$ Same as Title XIX.	$ 90.00/ mo.
Self-employment expenses	$ Reasonable costs as defined in Title XIX policy.	$ Same as Title XIX.	$ Reasonable costs as defined in policy SCHIP policy.
Alimony payments Received	$ N/A	$ N/A	$ N/A
Paid	$ N/A	$ N/A	$ N/A
Child support payments Received	$ 100/mo.	$ Same as Title XIX.	$ Same as Title XIX.
Paid	$ N/A	$ N/A	$ N/A
Child care expenses	$ 200/ mo./child under 2 years of age, $175/mo./child over age 2 and for an adult.	$ Same as Title XIX.	$ Same as Title XIX.
Medical care expenses	$ N/A	$ N/A	$ N/A
Gifts	$ Cash contributions from non-legally liable relatives or friends disregarded if received irregularly, and if less than $30/quarter.	$ Same as Title XIX.	$ Same as Title XIX.
Other types of disregards/deductions (specify)	$ PASS plans; and a standard deduction for income derived from room and board. Please note: certain types of income are considered excluded income (not income disregards or deductions) and are not counted in determining eligibility.	$ Same as Title XIX. Please note: certain types of income are considered excluded income (not income disregards or deductions) and are not counted in determining eligibility	$ Same as Title XIX. Please note: certain types of income are considered excluded income (not income disregards or deductions) and are not counted in determining eligibility

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

X No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

X No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

X No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program N/A

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

__X_ No ___ Yes

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage

Effective Jan 1, 2003 the Department is planning to restructure coverage for parents of Medicaid eligible children in families with incomes between 100% and 150% of the federal poverty level. Parents will be eligible for the HUSKY B program with the same benefit and co-payment structures that are currently provided to HSUKY B eligible children. The monthly premium rate for adults will be $30.00.

B. Employer sponsored insurance buy-in

DSS is planning to expand coverage through employer-sponsored-insurance buy-in. The purpose of the ESI buy-in program is to encourage employees to purchase dependent coverage through their employer by offering premium subsidies to employees. The level of subsidy will be based on family income and household size. To qualify for the subsidy, the insurance package offered by the employer must meet certain benchmark levels of coverage.

C. 1115 waiver

D. Eligibility including presumptive and continuous eligibility

E. Outreach

F. Enrollment/redetermination process

G. Contracting

H. Other