STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

ACCESS MONITORING REVIEW PLAN
FOR
CONNECTICUT'S MEDICAID PROGRAM

Submitted to the U.S. Centers for Medicare and Medicaid Services (CMS) pursuant to federal regulations at 42 C.F.R. §§ 447.203(b) and 447.204.

September 30, 2016

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I. OVERVIEW OF ACCESS MONITORING REVIEW PLAN (AMRP)

The Connecticut Department of Social Services (Department or DSS), Connecticut's single state Medicaid agency, prepared this Access Monitoring Review Plan (Plan or AMRP) to ensure that individuals have sufficient access to Medicaid services, in compliance with federal requirements. The Connecticut Medical Assistance Program (CMAP), which includes Connecticut's Medicaid program and Children's Health Insurance Program (CHIP) serves approximately 750,000 people, ensuring that members have access to the health services that they need. Meaningful access to necessary services is essential to promote health and well-being and to fulfill the mission and vision of the DSS' Division of Health Services (DHS), which is the DSS division primarily responsible for administering CMAP.

DSS Mission Statement

Guided by shared belief in human potential, we aim to increase the security and well-being of Connecticut individuals, families, and communities.

DHS Mission Statement

The Division of Health Services [within DSS] works in partnership with stakeholders across the health care delivery system to ensure that eligible people in Connecticut receive the supports and services they need to promote self-sufficiency, improved well-being and positive health outcomes. We ensure that the delivery of these services is consistent with federal and state policies.

DHS Vision Statement

The well-prepared and professional staff of the DSS Division of Health Services manages an effective health care delivery system for eligible people in Connecticut that promotes:

- *well-being with minimal illness and effectively managed health conditions;*
- *maximal independence; and*
- *full integration and participation in their communities.*

DSS is committed to ensuring that the people we serve can access the services they need. In partnership with the Centers for Medicare and Medicaid Services (CMS), the people we serve, Medicaid providers, and other stakeholders, DSS will continue to monitor access, research and evaluate means to further improve access, and implement such strategies as appropriate.
On November 2, 2015, the U.S. Centers for Medicare and Medicaid Services (CMS) published a final rule to adopt new access regulations, codified at 42 C.F.R. §§ 447.203(b) and 447.204. These regulations implement existing federal statute at section 1902(a)(30)(A) of the Social Security Act (also codified at 42 U.S.C. § 1396a(a)(30)(A)). That federal law requires state Medicaid programs to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Specifically, federal regulations at 42 C.F.R. §447.203(b)(1) through (b)(5) require state Medicaid programs to prepare an Access Monitoring Review Plan (AMRP) that includes specified data, member and provider input, standards and analysis, and focuses on several key categories of Medicaid services. As detailed in those requirements, this Plan uses a range of means of measuring access, all of which should be considered and analyzed in full context of CMAP, as the Plan is amended over time. This Plan focuses on the service areas specified in the regulation. Specifically, this Plan analyzes: provider network capacity; utilization of services (based on claims data); rates and utilization with Medicare and neighbor state Medicaid programs; inquiries, complaints, and appeals from members and providers; mystery shopper results; and member surveys.

This Plan represents Connecticut's first issuance of an AMRP. DSS plans to review and refine this Plan and its analysis over time. DSS welcomes feedback from CMS, providers, members, and other stakeholders in support of continuing to improve access to services, as well as means of monitoring and ensuring continued access to Medicaid services.

II. CONNECTICUT OVERVIEW[(a)]

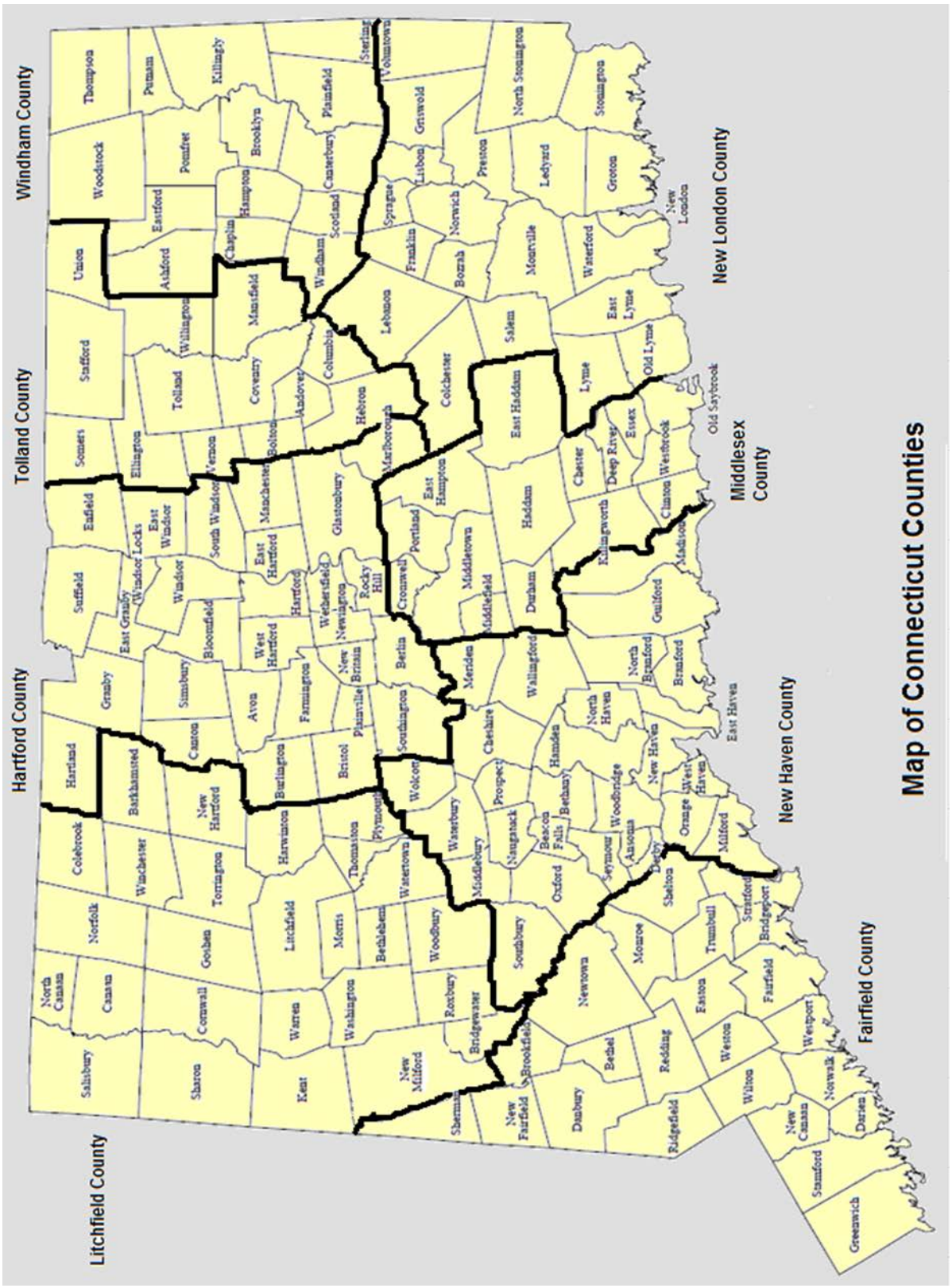
Connecticut is the third smallest state in land area at 5,543 sq. mi (14,357 km^2). It was the 29th most populous state, according to calendar year (CY) 2014 data, and, with a density of 739/sq mi (285/km^2), the fourth most densely populated of the 50 states. According to 2014 data, Connecticut's geodetic center is Cheshire, which is in New Haven County. Connecticut's capital city was Hartford, and according to CY 2014 data, the most populous city was Bridgeport. Connecticut's width measured 70 miles (113 km) and its length is 110 miles (177 km). The state is divided into 8 counties as noted in the Table 1 below. Note that Connecticut counties primarily reflect geographic descriptors, and do not represent regional government structures.

Table 1: Connecticut Towns by County

Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County
Bethel	Avon	Barkhamsted	Chester	Ansonia	Bozrah	Andover	Ashford
Bridgeport	Berlin	Bethlehem	Clinton	Beacon Falls	Colchester	Bolton	Brooklyn
Brookfield	Bloomfield	Bridgewater	Cromwell	Bethany	East Lyme	Columbia	Canterbury
Danbury	Bristol	Canaan	Deep River	Branford	Franklin	Coventry	Chaplin
Darien	Burlington	Colebrook	Durham	Cheshire	Griswold	Ellington	Eastford
Easton	Canton	Cornwall	East Haddam	Derby	Groton	Hebron	Hampton
Fairfield	East Granby	Goshen	East Hampton	East Haven	Lebanon	Mansfield	Killingly
Greenwich	East Hartford	Harwinton	Essex	Guilford	Ledyard	Somers	Plainfield
Monroe	East Windsor	Kent	Haddam	Hamden	Lisbon	Stafford	Pomfret
New Canaan	Enfield	Litchfield	Killingworth	Madison	Lyme	Tolland	Putnam
New Fairfield	Farmington	Morris	Middlefield	Meriden	Montville	Union	Scotland
Newtown	Glastonbury	New Hartford	Middletown	Middlebury	New London	Vernon	Sterling
Norwalk	Granby	New Milford	Old Saybrook	Milford	North Stonington	Willington	Thompson
Shelton	Hartford	Norfolk	Portland	Naugatuck	Norwich		Windham
Sherman	Hartland	North Canaan	Westbrook	New Haven	Old Lyme		Woodstock
Stamford	Manchester	Plymouth		North Branford	Preston		
Stratford	Marlborough	Roxbury		North Haven	Salem		
Redding	New Britain	Salisbury		Orange	Sprague		
Ridgefield	Newington	Sharon		Oxford	Stonington		
Trumbull	Plainville	Thomaston		Prospect	Voluntown		
Weston	Rocky Hill	Torrington		Seymour	Waterford		
Westport	Simsbury	Warren		Southbury			
Wilton	Southington	Washington		Wallingford			
	South Windsor	Watertown		Waterbury			
	Suffield	Winchester		West Haven			
	West Hartford	Woodbury		Wolcott			
	Wethersfield			Woodbridge			
	Windsor						
	Windsor Locks						

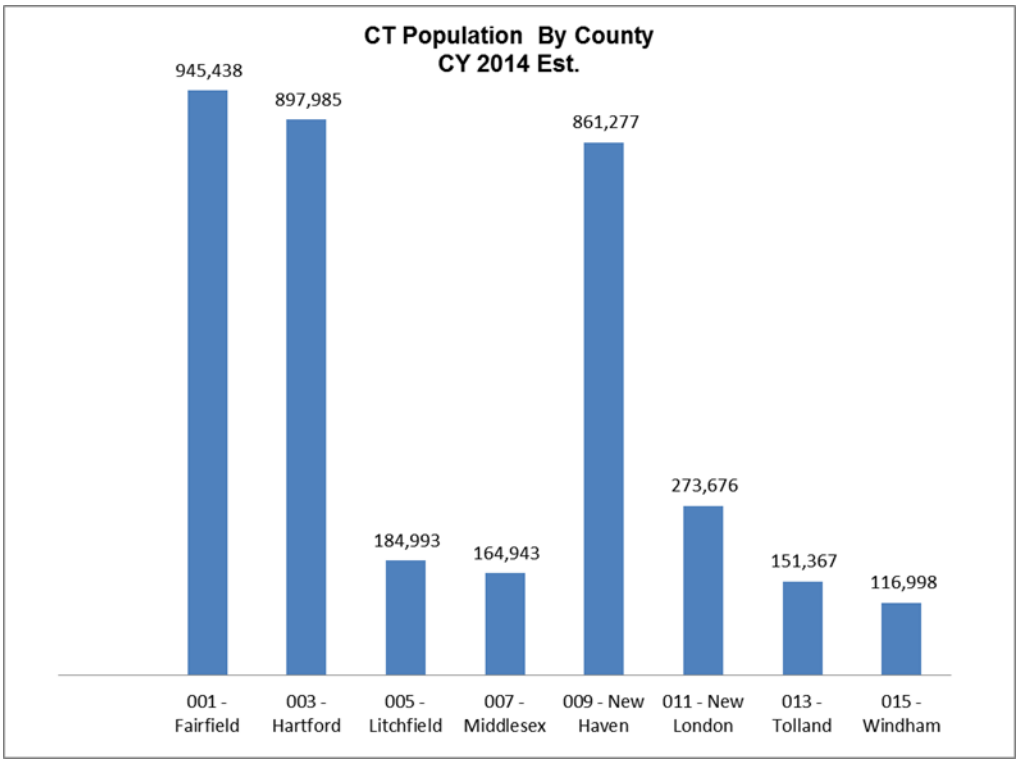
Department of Economic and Community Development, 2016. http://www.ct.gov/ecd/cwp/view.asp?a=1106&q=250994

Fig. 1 Map of Connecticut Towns by County



In 2014, there were an estimated 3,596,677 people residing in Connecticut; with the greatest number, over 945,000, residing in Fairfield County, and the least number, just under 117,000, residing in Windham County. [(1)]

Figure 2. CT Population by County (CY 2014 Estimates)



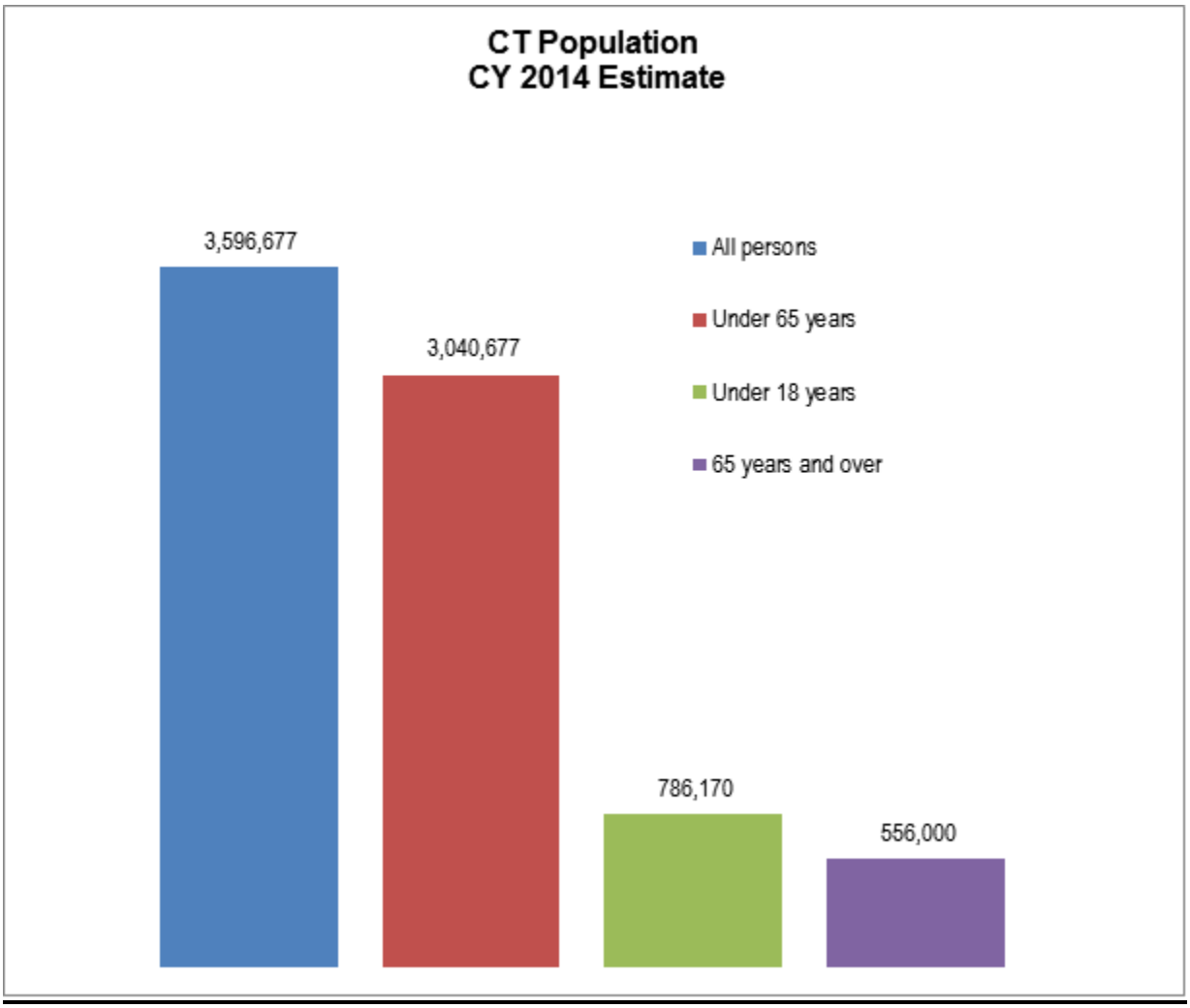
Connecticut Population Density by County [(2)] is shown in Table 2, below.

Table 2. CT Population Density by County (CY 2014 Estimates)

CY 2014 Population Density per Square mile	CT County
1,196	Hartford
1,130	Fairfield
999	New Haven
376	Middlesex
363	Tolland
355	New London
224	Windham
196	Litchfield

In 2014, children under the age of 18 accounted for 21.9% of Connecticut's population, while individuals ages 18-64 accounted for 63.0% and those age 65 and over accounted for 15.1%. Refer to Figure 3 for the breakdown.

Figure 3. CT 2014 Population Breakdown by Age



[a] **Connecticut** breakdown is based on data obtained from *Table 18, Area Measurements: 2010; and Population and Housing Unit Density: 1990 to 2010 (PDF). United States Summary: 2010, Population and Housing Unit Counts (Report) (United States Census Bureau). September 2012. Table 19, Population by Urban and Rural and Type of Urban Area: 2010 (PDF). United States Summary: 2010, Population and Housing Unit Counts (Report) (United States Census Bureau). September 2012.* and the Center of Population Project. National Geodetic Survey. Archived from the original on November 18, 2010. Retrieved January 30, 2009. http://www.ngs.noaa.gov/INFO/COP/ct_links.htm

Connecticut Towns by County Table 1 and Figure 1 was developed using data from Department of Economic and Community Development, 2016. http://www.ct.gov/ecd/cwp/view.asp?a=1106&q=250994

(1) **CT Population** (Fig. 2 and Fig. 3) Data is based on data from the 2014 U.S Census Bureau State and County QuickFacts. http://www.census.gov/quickfacts

(2)**Connecticut Density by County** (Table 2) Data from http://www.usa.com/rank/connecticut-state--population-density--county-rank.htm

Overview of CT Health Status

By most measures, based on reported and surveyed data, Connecticut residents are healthier on average than the nation as a whole. At 80.8 years, Connecticut has the third highest life expectancy among the 50 states. When surveyed, only 14.3% of CT residents reported they had "fair or poor health." The nationwide average was 17.8%, with states ranging from 11.7% - 25.8%. Connecticut adults self-reported lower rates of major depression (6.6% U.S., 6.0% CT), mental illness (18.3% U.S., 16.4% CT) and the 4th lowest rate of suicide nationwide. This data should be taken in context with Connecticut's 2014 economic status. While Connecticut's median income is 30.8% higher than the national average, its level of income disparity between the top 1% of earners and the remaining 99% of earners ranks among the highest in the country. Health expenditures under employer-based insurance and Medicaid/CHIP are higher than the national average (respectively, 6.8% and 28.9% in Federal Fiscal Year 2011). Note that Medicaid/CHIP expenditure data predates many of the interventions of the Affordable Care Act, and also Connecticut's transition from capitated managed care arrangements to a managed fee-for-service approach through Administrative Services Organizations (ASOs). The following table (Table 3) outlines important indicators of Connecticut residents' health outcomes:

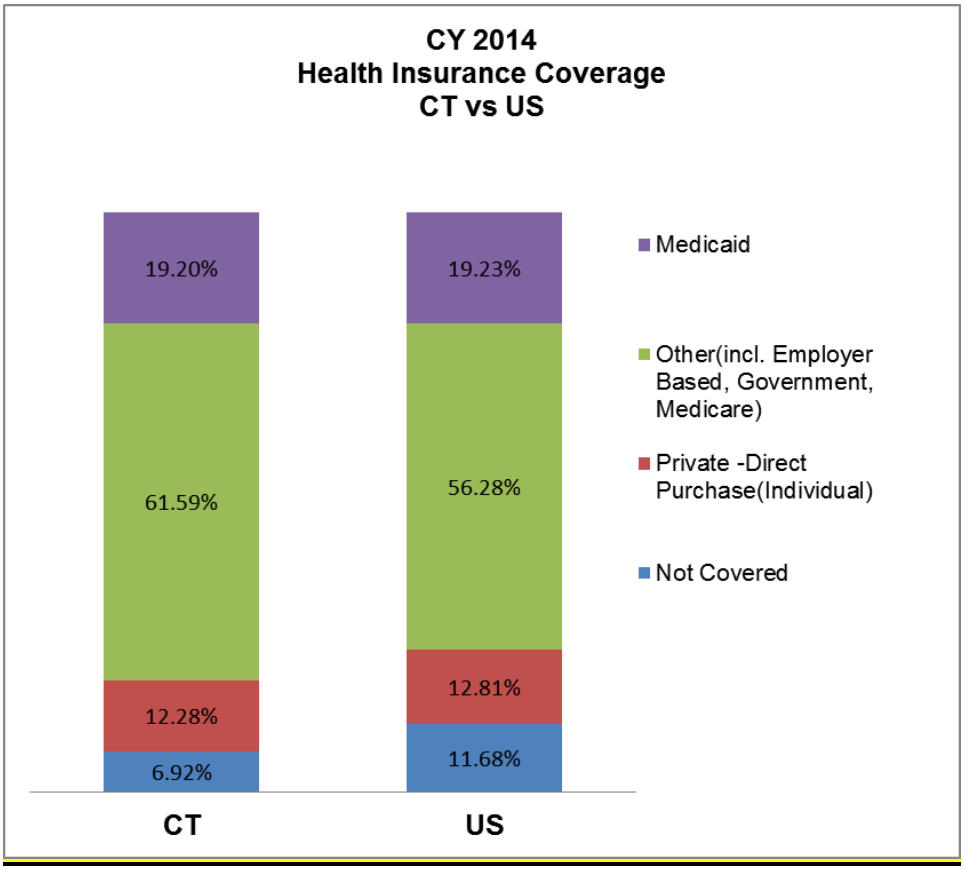
Table 3: Comparison of Health Outcomes

Comparison of Health Outcomes (2014 unless otherwise noted)	**U.S.**	**CT**
Percentage of adults who:		
Smoke	17.4%	15.4%
Are overweight or obese	64.1%	60.4%
Participate in any physical activities or exercise	76.3%	79.4%
Birth outcomes		
Pre-term	9.6%	9.2%
Low birth weight	8.0%	7.6%
2013 Infant mortality rate (per 1,000)	6.0	4.8
Percentage of individuals reporting:		
Annual dental visits	64.4%	74.9%
Adults 65+ who have had all teeth extracted	14.9%	10.9%
Cancer rates per 100,000		
Age adjusted invasive cancer rate	440.3	477.1
Cancer deaths	166.4	152.0
Asthma and Diabetes		
Asthma	13.5%	14.1%
Diabetes	10.5%	9.2%
2013 Deaths due to diabetes per 100,000	21.2	14.8
Cardiovascular Disease		
Adults with cardiovascular disease	6.7%	5.9%
Deaths due to heart disease per 100,000	167.0	145.6
Individuals Reporting Dependence or Abuse of:		
Alcohol		
Ages 12-17	2.8%	2.7%
Age 18+	6.9%	7.7%
Illicit Drugs		
Ages 12-17	3.5%	3.3%
Age 18+	2.6%	2.8%
Opioid Deaths rate per 100,000	9.0	15.2
Episodes of major depression		
Ages 12-17	11.0%	9.7%
Age 18+	6.6%	6.0%
2013-2014 Rate of adults reporting having mental illness	18.3%	16.4%
Incomes & Poverty Rates		
Median Income	$53,657	$70,161
Poverty Rate	14.8%	13.4%

CT Health Insurance Coverage [(3)]

In CY 2014, Connecticut had a high rate of individuals covered by commercial based insurance plans, as compared to the national average. The rate at which individuals were covered by Medicaid was comparable to the national average. Based on 2014 estimates provided by the US Census Bureau - American Community Survey, 93.1% of Connecticut's population reported some form of health insurance coverage (i.e., government plan, private employment-based, private direct purchase, etc.) as compared to the national average of 89.5%. According to this survey, approximately 19.2% of Connecticut's population was enrolled in Medicaid, which was in line with the national average of 19.2%. Note that Connecticut significantly improved the rate of individuals covered by private insurance, following implementation of a state-based health insurance exchange, and also increased incidence of participation in CMAP through early adoption of and full eligibility expansion.

Figure 4: CY 2014 Health Insurance Coverage – CT versus US



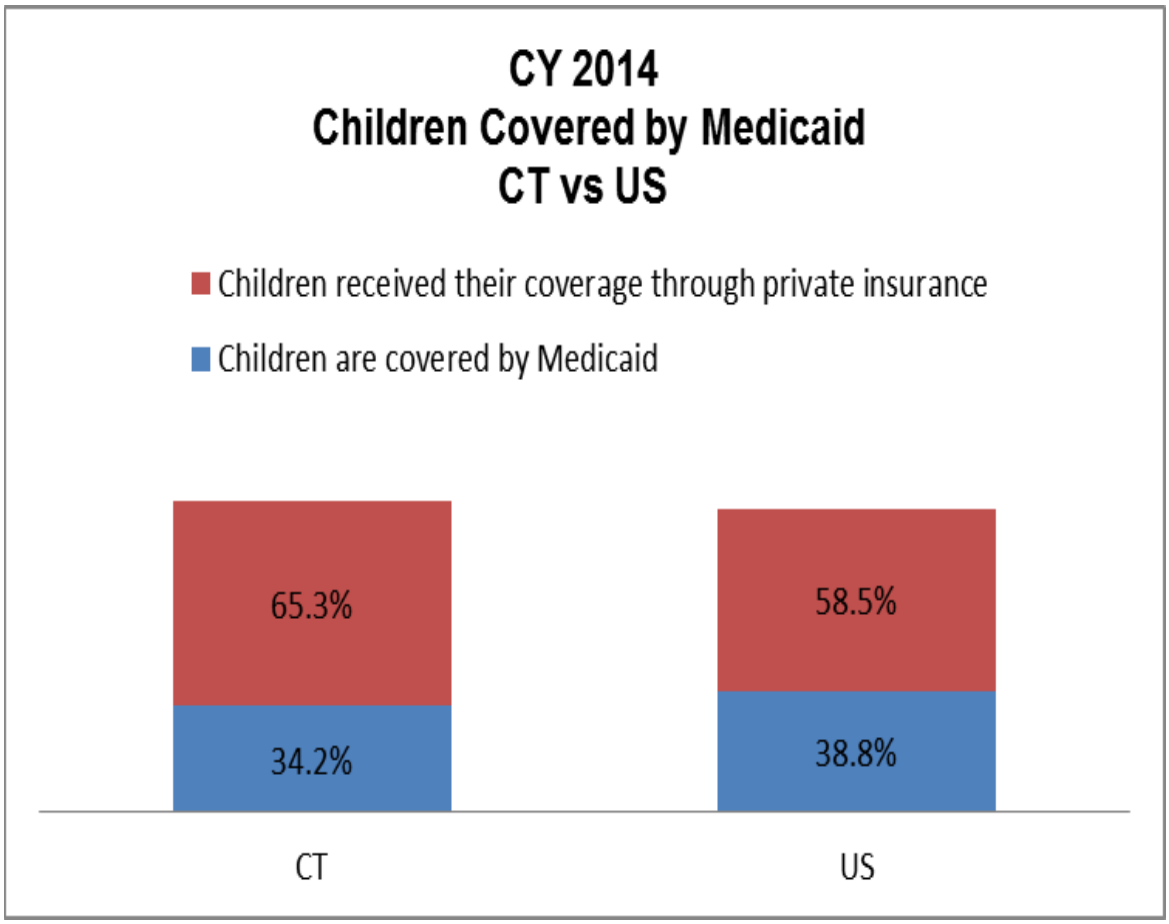
Multiple Coverage Types

Some individuals have multiple types of health insurance coverage at one time to supplement their primary insurance type, or as a result of switching coverage types over the course of the year. Of the population with health insurance coverage in 2014, 79.2% had one coverage type during the year and 20.8% had multiple coverage types over the course of the year. Some types of health insurance coverage were more likely to be held alone, while other types of health insurance coverage were more likely to be held in combination with another type of insurance at

some point during the year. The majority of people with employment-based health insurance or Medicaid coverage had only one plan type during 2014 (79.3% and 67.3%, respectively).

People were more likely to have had more than one coverage type during the year if they had direct-purchase insurance coverage, Medicare, or military health care. In 2014, 58.2% of people with direct-purchase health insurance, 61.9% of people with Medicare, and 60.7% of people with military health care had some other type of health insurance. In CY 2014, Connecticut provided Medicaid coverage to 34.2% of Connecticut's children, compared to national average of 38.7%; and 65.3% of Connecticut children received their coverage through private insurance, compared to national average of 58.5%.

Figure 5: CY 2014 Children Covered by Medicaid – CT vs US



**The percentages above are a comparison of children covered by Medicaid or private insurance only. The figures do not take into account other sources of coverage or children without coverage, thus the percentages do not equal 100%.*

Reference:

[3] **Health Insurance Coverage** data is based on U.S. Census Bureau, 1-year American Community Surveys; Table HIC-4_ACS. Health Insurance Coverage Status and Type of Coverage by State All People: 2013 to 2014; http://www.census.gov/hhes/www/hlthins/data/historical/HIC-acs.html; and on the 2014 US Census ACS Health Insurance Coverage Status Table HI05 Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2014. http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2014/acs-tables.html

III. CONNECTICUT MEDICAL ASSISTANCE PROGRAM (CMAP) OVERVIEW

Pursuant to Titles XIX and XXI of the Social Security Act, the State of Connecticut Medical Assistance Program (CMAP) is a federal-state partnership that includes Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP). CMAP provides healthcare coverage to the following eligibility groups: children and their parents or relative caregivers, and pregnant women (HUSKY A); elderly individuals and individuals with disabilities (HUSKY C); and low income adults age 19-65 without dependent children (HUSKY D).

CMAP also provides coverage to individuals who qualify for a limited benefit coverage group (tuberculosis; family planning) as well as to uninsured children through the CHIP (HUSKY B). The analyses in this Plan exclude the limited benefit and CHIP programs.

Connecticut Medicaid is also referred to as the HUSKY Health Program. The Connecticut Department of Social Services (DSS) is the single state agency that administers the Medicaid program within the state of Connecticut.

CMAP provides coverage for a range of mandatory services, including, but not limited to, inpatient and outpatient hospital services, home health services, family planning services, laboratory services, and transportation to medical care. CMAP also covers an extensive array of optional services, including, but not limited to, eyeglasses and optometry services, behavioral health services, dental services, clinic services, prescription drug coverage, orthotics, prosthetics, and other practitioner services.

Managed Fee for Service Administrative Service Organization (ASO) Model

Prior to 2012, the CMAP provided health coverage for many members (children, pregnant women, parents and caretakers of eligible children coverage groups) through multiple at-risk, capitated Managed Care Organizations (MCOs), while individuals covered under HUSKY C (older adults and individuals with disabilities coverage groups), other than those served by 1915(c) home and community-based services waivers, received little coordination of their services. These arrangements posed many challenges for both members and providers. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for members. Further, this lack of consistency posed challenges for providers who participated in more than one managed care network. Also, providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally, the Department received only incomplete encounter data from the managed care companies, which did not give a complete or accurate view of the use of CMAP services.

By contrast to almost all other Medicaid programs throughout the nation, CMAP no longer utilizes managed care arrangements, under which companies receive capitated payments for serving members. Instead, Connecticut has adopted a self-insured, managed fee-for-service approach. In order to achieve better heath and care experience outcomes, and engagement with CMAP providers, the Department has entered into contracts with ASOs for each of the four major service types:

- Medical (Community Health Network of Connecticut or CHNCT)

- Behavioral Health (Beacon Health Options),
- Dental (BeneCare),
- NEMT (Logisticare).

The structure of each of the ASO contracts supports the Department's desired results. A percentage of each ASO's administrative payments are withheld by the Department pending completion of each fiscal year. To earn these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures. All savings go back into the program instead of contributing to the profit of a managed care organization.

DSS' hypothesis for utilizing an ASO structure:

Centralizing management of services for all CMAP members in self-insured, managed fee-for-service arrangements with Administrative Services Organizations, as well as use of predictive modeling tools and data to inform and to target members in greatest need of assistance, will yield improved health outcomes and member experience, and will help to control the rate of increase in CMAP spending.

Member Supports

The ASOs are responsible for specific services including member support, referrals to providers, utilization management (*e.g.*, prior authorization of services when required), and grievances and appeals.

Predictive Modeling Tools

Employing a single, fully integrated set of claims data which spans all coverage groups and covered services, CMAP takes full advantage of analytic tools to risk-stratify members and to connect those who are at high risk or who have complex health profiles with ASO ICM support. Risk stratification is based on medical and pharmacy claims, member/ provider records, and results from diagnostic laboratory and imaging studies.

Intensive Care Management

The ASOs serve high need individuals with Intensive Care Management (ICM). ICM enables attention to be given to the entire range of a member's needs -from basic needs such as housing stability and food security, to complex medical profiles including chronic disease, behavioral health and oral health conditions. ICM is structured as a person-centered, goal-directed intervention that is individualized to each member's needs.

CMAP's ICM interventions include:

- integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs;
- augment Connecticut CMAP's Person-Centered Medical Home (PCMH) program, through which primary care practices receive financial and technical support towards practice transformation and continuous quality improvement; are directly embedded in the discharge processes of a number of Connecticut hospitals;

- sustain the reduction of emergency department usage, inpatient hospital admissions and readmission rates;
- reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and
- reduce use of the hospital emergency department for dental care, and significantly increase utilization of preventative dental services by children.

Results

ASO arrangements have substantially improved member outcomes and experience through centralization and streamlining of the means of receiving support. The ASOs act as hubs for member support, location of providers, ICM, grievances and appeals. ASO arrangements have also improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and 'clean claims' are paid completely and promptly through a single fiscal intermediary (Hewlett Packard Enterprises). This promotes participation and retention of providers, as well as enabling monitoring of the adequacy of the networks needed to support a growing population of members.

Medical ASO

Community Health Network of Connecticut (CHNCT) provides medical care coordination for members, member services, network management and data analytics of CMAP medical providers. CHNCT served as a CMAP Managed Care Organization for 16 years. Effective January 1, 2012, CHNCT was selected to serve as the CMAP medical ASO. Operations include: member support services, utilization management, provider support services, and data analytics. Some of the specific functions of CHNCT include:

- operating a call center for members and providers,
- administering the member and provider appeals process,
- assisting in provider selection and appointment scheduling for members,
- offering supports to provider practices that become person-centered medical homes (PCMH), and
- retaining and expanding the provider network.

CHNCT also oversees the Intensive Care Management (ICM) Program. The primary goals of this program include assisting patients in recognizing barriers, optimizing treatment outcomes and self-managing services and supports. ICM programs are available for members with various needs, including but not limited to pregnancy, asthma, complex medical conditions, with or without behavioral health needs, diabetes, sickle cell anemia and transplant services. Furthermore, ICM nurses work with members as well as providers, offering assistance with care coordination, provider coordination, chronic disease and medication management, as well as reducing emergency room visits and missed appointments. ICM teams are nurse-led, geographically grouped, and now include community health workers, with the intent of addressing social determinants of health.

Behavioral Health ASO

Beacon Health Options (formerly known as Value Options) implements the Connecticut Behavioral Health Partnership (CT BHP), which is collaboration among DSS and its sister state

agencies, the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS). The CT BHP is an integrated behavioral health service system for CMAP members, including children and families who are enrolled in CMAP and enrolled under the Connecticut Department of Children and Families (DCF) Limited Benefit program. Beacon Health Options offers many services for members, including:

- Intensive Care Management (ICM): provides specialized care management techniques for members at risk and for members who are encountering barriers to care.

- Peer, Family Peer and Community Peer Support Specialists: provides access to professionals who have direct experience with utilization of the behavioral system and who can relate to members and provide assistance with navigating the system.

- Customer Service Center: provides inbound call triage, assists with scheduling appointments, verifies member eligibility, documents complaints and grievances, assists with transportation needs for behavioral health appointments, and advises members of their rights and responsibilities.

Services provided include clinical mental health and substance use disorder management, work/life support, specialty programs for autism spectrum disorder and depression, and analytics to improve the delivery of care.

Dental ASO

The administrative functions supplied by BeneCare include dental provider network development and management, maintenance of a provider and member call center, prior authorization of services, payment processing, web-based member and provider services, administration of member and provider administrative hearing processes, and dental claim review and utilization management. BeneCare employs a team of dental health specialists who are placed in various communities and are responsible for promoting oral health, reducing barriers to obtaining care, and providing Intensive Care Management (ICM) and referral services for members who have complex dental or medical conditions.

Non-emergency Medical Transportation ASO

The Department has contracted with LogistiCare Solutions, LLC to manage the CMAP Non-Emergency Medical Transportation (NEMT) services.

NEMT services enable members' access to CMAP covered services. Transportation is currently provided for eligible HUSKY A, C and D CMAP members for purposes of non-emergent medical care and routine treatments (i.e. dialysis, methadone). A CMAP member, a relative, caregiver, nurse or doctor may schedule an appointment for transportation for an eligible CMAP member. CMAP members are eligible to receive transportation assistance even if there is a vehicle in their household. The Department reserves the right to limit its payment of transportation to the nearest appropriate provider of medical services. The Department will only pay for the least expensive appropriate method of transportation, depending on the availability of the service and the physical and medical circumstances of the patient. Transportation reservations may be scheduled via telephone or online. Requests for routine transportation must be scheduled at a minimum of forty-eight hours (2 business days) in advance of the requested trip up to five days' notice ahead of the scheduled appointment, and more notice is required for certain types of

transportation (examples are bus passes, mass transit). Requests for urgent transportation are taken twenty-four hours a day, seven days a week by telephone.

Fiscal Agent MMIS Operator

Hewlett Packard Enterprises (HPE) provides MMIS fiscal agent services, including provider credentialing and enrollment, claims processing and payment, Medicare premium buy-in, pharmacy prior authorization, e-prescribing transaction support, and drug rebate collection and submission to manufacturers. HPE also provides operational support of these functions, for example: provider call center; client call center; provider relations representatives; and provider communications, including operation of the www.ctdssmap.com web site, and provider bulletins and newsletters. In addition, HPE supports the CMAP Electronic Health Record (EHR) Incentive program via the CT Medical Assistance Provider Incentive Repository (MAPIR) attestation system and provider representative support. HP also operates the data warehouse via a separate contract administered by Information Technology Services.

IV. ACCESS MONITORING REVIEW PLAN METHODOLOGY

This Plan analyzes the three overall areas identified in the federal access regulations: (1) beneficiary characteristics, (2) provider capacity, and (3) utilization data. The analysis also includes beneficiary satisfaction survey results and access to care complaints and inquiries.

Beneficiary characteristics: Using data from calendar years (CY) 2013 through 2015, DSS examined the characteristics of the beneficiary population, including demographics (age and gender), enrollment data, beneficiary plan characteristics, and the geographic area where members reside. An evaluation of members' access to the enrolled provider network and actual utilization of specific categories of service was added to the member characteristics data in order to provide context to the overall analysis of access to care.

Provider capacity: This analysis focuses on the adequacy of the CMAP provider network. As described above, CMAP is a self-insured, managed fee-for-service program that utilizes an ASO structure to administer program benefits. By utilizing one ASO for each major benefit category (medical, dental, behavioral health, and transportation), the state has substantially improved engagement with the provider community. The ASO structure provides more accurate and detailed information on the providers enrolled under CMAP, since providers are not required to enroll under with multiple managed care organizations. It also provides a uniform fee schedule and has the capacity to promptly reimburse providers through the single fiscal intermediary – Hewlett Packard Enterprises (HPE). This administrative structure promotes participation and retention of providers and enables monitoring of the adequacy of the provider network needed to support enrolled members. Evaluating provider enrollment and network capacity for CY 2013, CY 2014 and CY 2015 provides a baseline for the number of enrolled providers who are available to provide services to the member population covered under CMAP. Changes in enrollment from year to year help to identify trends in the overall network capacity and enable comparison with data obtained from Medicare and commercial payers regarding their network capacity. These data also enable DSS to make observations about whether the CMAP provider network: (1) affords sufficient capacity to meet the needs of the member load in Connecticut and (2) is comparable to other public and private payers.

Utilization data: Utilization data for specific categories of healthcare services was also analyzed. CMAP is uniquely situated in its data analytic strength. Since 2012, CMAP has the benefit of a fully integrated set of claims data across all categories of CMAP services and all covered members. CMAP compiled eligibility, member enrollment, survey results and utilization data for three years of Fee for Service (FFS) paid claims (excluding crossover claims), based on services used by CMAP members and services rendered by enrolled providers. DSS compiled service utilization statistics and provided data in terms of units of service for unduplicated members by age, gender, geographic area and eligibility plan for all categories of service as required under the AMRP regulations. The categories specifically outlined by the AMRP regulations include: primary care services provided by a physician, federally qualified health center (FQHC), clinic and dental providers; physician specialist services, behavioral health services (including routine mental health and substance abuse); obstetric services (including labor and delivery), and home health services. An additional category includes any service for which the state has proposed a rate reduction or reimbursement restructure that could negatively affect access. Analysis related to rate reductions and reimbursement restructures are attached as an appendix to this full Access Monitoring Review Plan as applicable.

Actual utilization data was extracted and summarized for CYs 2013, 2014 and 2015. Utilization trends were calculated based on data extracted for each category, comparing the utilization between CY 2013, CY 2014 and CY 2015 and identified trends over time. Connecticut CMAP analysis of service utilization focused on data by age (child under age 21 versus adult age 21 and over), geographic area (counties), and eligibility group (HUSKY A, C and D) to determine whether CMAP members have sufficient access to care and whether healthcare service utilization has changed over time.

Data Sources

The data needed to identify the number of enrolled members, and the number of enrolled CMAP providers, and all utilization reports, were extracted from DSS' Data Warehouse (DWH). Although the ASOs are charged with providing specific reports and measures related to members, providers and utilization, the DWH is the most comprehensive repository of available member, provider and claims specific data and provided DSS with the quality control needed to ensure that the reports and measures used were consistent with the AMRP requirements. With the raw data in the DWH, DSS designed specific report templates to comply with the AMRP regulation and extracted the necessary data from one single source. Use of the DWH allowed DSS to report enrolled providers on a county level, since this level of detail was included on claims. Lastly, use of the DWH allows DSS the ability to pull the data at any given time, rather than depending on an outside entity to gather and analyze the information.

Quality measure results were extracted from the Healthcare Effectiveness Data and Information Set (HEDIS) measure reports for CY 2013, 2014 and 2015. Mystery shopper survey results were based on a survey performed by an external vendor and access to care complaints data were based on data extracted from each ASO's tracking process. Additional data sources were used in order to make comparisons between the CMAP and Medicare, commercial insurance coverage and coverage provided by neighboring Medicaid programs. These included: Medicare fee schedule(s), neighboring states' Medicaid program's fee schedules, data from the Connecticut Department of Economic and Community Development, the US Census Bureau, the Centers for Medicare & Medicaid Services (CMS) public data set, and the Consumer Report Card on Health Insurance Carriers in Connecticut. Additionally, Qualified Health Plans-Individual Marketplace data, which demonstrates network adequacy, was obtained from an October 2014 presentation to the board of directors of the state's public health insurance exchange / marketplace, Access Health CT (AHCT BOD).

Data Parameters

The following description identifies specific data parameters used when pulling and analyzing data for the AMRP. This description also provides an overview of high-level criteria used to obtain and analyze member, provider and utilization data to determine whether the CMAP program provides sufficient access to care for enrolled members.

Members: The members included in this analysis are unduplicated members for dates of service in calendar years 2013, 2014 and 2015. This analysis focused on members enrolled under the HUSKY A, C and D programs. Due to the inability to specifically isolate and exclude members who qualified for full benefit under both Medicare and Medicaid ("full duals"), full duals were included in the member data. However, the analysis, excluded partial duals (i.e., individuals

whose Medicaid coverage is limited to payment for eligible Medicare cost-sharing). Children/pediatric populations were defined as members 0 to 20 years of age, and adults were defined as members who are age 21 years and older. Data analyses did not incorporate a factor for Incurred but Not Reported (IBNR), which is a type of completion factor frequently used in claims analysis. This completion factor refers to a reserve for services that have been rendered but not yet submitted. Incorporation of an IBNR factor adjusts the claims data to be representative of 100% completion, if the claims run-out period is outstanding. DSS did not adjust for an IBNR factor and instead assumed that the claims run-out period was sufficient.

Providers: The provider analysis focused on in-state independently enrolled providers (solo practitioners and groups), clinics (medical, federally qualified health centers, methadone clinics, and behavioral health clinics) and outpatient hospital providers. The independently enrolled providers included in this analysis were the unduplicated independent performing practitioners who rendered a CMAP service with a date of service during CY 2013, CY 2014, and/or CY 2015, with a claims run-out period set to paid claims through May 1, 2016. This allowed DSS to capture pertinent provider and utilization data for services that were rendered during the time periods outlined above but not paid until a later date due to claims billing lag (the time it takes providers to actually submit a claim), mass claim adjustments made by DSS, and adjusted claims (potentially denied claims that are resubmitted by providers to correct billing issues i.e., adding appropriate modifiers, adding referring provider information).

During the data collection process, DSS considered using the DWH provider universe as well as the claims universe. However, based on mock queries in both areas, DSS decided that it is more appropriate to use only the claims universe because that count of providers reflects those who are actually billing for CMAP services. This ensured that the analysis excluded providers who are: (1) only enrolled as ordering, prescribing and referring providers (OPR providers) which represented approximately 3,000 providers as of June 2016; and (2) enrolled under CMAP, but not actively providing services. An OPR provider is a provider that is not fully enrolled to provide billable services to a CMAP member but provides services to CMAP beneficiaries directly related to non-billable services such as only ordering a service, prescribing or referring for further evaluation and/or treatment. Sections 6401 and 6501 of the Affordable Care Act, codified at sections 1902(a)(77) and 1902(kk) of the Social Security Act, mandated that OPR providers who render services to beneficiaries be enrolled in the CMAP. Inclusion of these types of providers would skew the analysis of the number of enrolled providers of services and would not provide a true representation of the providers enrolled to render billable CMAP services.

This analysis included providers from the following provider categories:

(1) Physician (broken out into primary care, specialists, and obstetrics);
(2) Advanced Practice Registered Nurses;
(3) Physician Assistants;
(4) Certified Nurse Midwives;
(5) Freestanding Medical Clinics;
(6) Freestanding Behavioral Health Clinics;
(7) Medical FQHCs;
(8) Behavioral Health FQHCs;
(9) Dental FQHCs;
(10) Outpatient Hospital Clinics;

(11) Dental Primary Care (general dentists and pediatric dentists);
(12) Behavioral Health Clinicians and groups in independent practice (*i.e.*, licensed psychologists, licensed clinical social worker (LCSW), licensed marital family therapist (LMFT), licensed professional counselor (LPC), and licensed alcohol and drug counselors (LADC)); and
(13) Home Health Agencies.

Utilization: The utilization data included paid claims data for dates of service in calendar years 2013, 2014 and 2015 with a claims run-out period through May 1, 2016. Cross-over claims paid for dually eligible members (i.e., members who are eligible for both Medicare and Medicaid) were excluded from all utilization data since these payments only represent Medicare cost-share expenditures. If a claim for a full dual was not reimbursed under their Medicare primary coverage (due to benefit exclusion or benefit exhaustion) the claim was included in this analysis since that claim would be processed as a straight CMAP claim. Additional parameters utilized for specific categories included the following:

- Medical primary care services were extracted using a specific set of procedure codes identified under the HUSKY Health Increased Payments for Primary Care initiative, Connecticut's modified extension of the payments authorized by Affordable Care Act §1202.
- Dental services were extracted using a specific set of procedure codes commonly used in the dental home setting and included dental office visits codes,
- Behavioral health services were extracted utilizing the behavioral health indicator that is assigned to a claim or detail on a claim at the time of processing based on a set of BH criteria (provider type and specialty, procedure code, and diagnosis code range).
- Other areas were based on specific sets of procedure codes and enrolled provider types.

Description of Measures

In this report, DSS utilized various measures to determine whether the state provides sufficient access to care for enrolled CMAP members. This section provides a general overview of the measures and how they were used in the analysis.

Utilization Trends: As described above, utilization trends were calculated using data extracted for each category by comparing the utilization between CY 2013, CY 2014 and CY 2015. The trend was reported in both a table and figure format to describe the utilization under a specific category as reported by county.

Provider Enrollment Trends: The number of enrolled providers was extracted for CY 2013, CY 2014 and CY 2015 to analyze for increases or decreases. Additionally, provider data were analyzed to obtain a member-to-provider ratio to demonstrate the potential provider network availability for each category of service analyzed by county.

HEDIS Measures: The following HEDIS measures were analyzed for calendar years 2013, 2014 and 2015 to determine (1) if there was a change in the measures reported by the State over time and (2) how the state measured against national standards.

- Adults' Access to Preventive/Ambulatory Health Services (AAP): Members ages 20 and older who had an ambulatory or preventive visit during the measurement year.

- Annual Dental Visit (ADV): The percentage of members 2 to 21 years of age who had at least one dental visit during the year.

- Children and Adolescents' Access to Primary Care Practitioners (CAP): Members aged 12 months to 19 years who had a visit with a primary care provider (PCP) (with different frequencies depending on age range.)

- Prenatal and Postpartum Care (PPC): The percent of deliveries that had one timely prenatal and post-partum visit (shown as two separate rates).

- Well-Child Visits in the First 15 Months of Life (W15): The percent of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34): The percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year.

Mystery Shopper Data

The mystery shopper survey is an anonymous telephone survey that is conducted by external vendors contracted by CMAP medical and dental ASOs to assess access to care for CMAP members. DSS is investigating with the behavioral health ASO whether or not to adopt a similar process to assess access to behavioral health care based on appointment obtainability.

The mystery shopper process involves making calls to various provider types and specialties and asking for an appointment. When an appointment is offered, the survey specialist records the appointment date and indicates that he or she will need to call back to confirm – no appointments are actually booked. Mystery shopper survey results include the number of calls made, number and type of providers that offered appointments, stated reasons why appointments were not given, and the length of time (in days) within which an appointment was offered.

Access to care measured by complaints / inquiries

Another method to evaluate access to care is to capture the nature and volume of complaints and/or inquiries members have regarding their health care services. Members of CMAP are provided information via member handbooks and communication with member services of each applicable ASO regarding the various ways in which they may share their concern. Most member complaints are lodged in the form of a direct phone call made to the behavioral, dental, and medical and/or the NEMT ASO's call center. On a quarterly basis, each ASO generates a call center report that captures information regarding volume and nature of calls received. Behavioral health complaint reports include the number of days until resolution, while dental and medical grievance reports capture the turnaround time it takes to address each complaint and all three reports contain similar subcategories.

Stakeholder Engagement

On March 11, 2016, DSS presented an overview of the new federal access regulations and DSS's overall approach to preparing the AMRP to the Medical Assistance Program Oversight Council (MAPOC), which is the state's legislatively-constituted oversight committee for CMAP and is established in state law at section 17b-28 of the Connecticut General Statutes. MAPOC's membership includes legislators, providers and provider trade associations, sister state agencies, and advocates for CMAP members. DSS will continue engaging with MAPOC and other stakeholders to ensure that it receives robust feedback from a variety of perspectives.

DSS also plans to formally engage with the Behavioral Health Partnership Oversight Council, as well as with various stakeholder and grassroots groups including, but not limited to: the Money Follows the Person Steering Committee, the Consumer and Family Advisory Committee of the Connecticut Behavioral Health Partnership, the Hartford-based Caring Families Coalition, the New Haven-based Christian Community Action Kitchen Cabinet, to seek feedback on the Plan. Further, DSS also plans to solicit recommendations from all of the above groups about additional stakeholders from whom to seek comments on the Plan.

On July 26, 2016, DSS published public notice for comment of the AMRP in the Connecticut Law Journal, Connecticut's state register, and held a public comment period of 30 days that ran from July 26, 2016 to August 25, 2016. DSS posted the draft AMRP to the state's website, http://www.ct.gov/dss/amrp and circulated notice of the comment period to the Connecticut Law Journal, posted notice about the ARMP and solicitation for comments on each of the ASO's respective websites, and the MAPOC list-serv. Additionally, DSS presented an overview of the posted AMRP at the September 9, 2016 MAPOC meeting and accepted additional comments.

DSS received one substantive comment about the draft AMRP prior to the conclusion of the public comment period (August 25, 2016). That comment was presented by the dental ASO and consisted of a few suggested edits to the narrative as well as a suggestion on how to pull and interpret the provider data differently. Due to only receiving one substantive comment about the draft AMRP prior to the conclusion of the posted public comment period DSS decided to extend the deadline for submission of comments to September 9, 2016, which coincided with the DSS presentation about the AMRP to MAPOC. Two additional formal comments were submitted on behalf of school-based health centers (SBCHs) enrolled in Connecticut's Medicaid program. The main focus of the comments submitted on behalf of the SBHCs suggested including data outlining the specific locations of school based health center locations and stated that the current fee schedule structured coupled with other agency's cuts (such as the CT Department of Public Health) creates a challenging landscape for sustaining current levels of care provided by SBHCs. Additional comments were made during the MAPOC presentation, many of which focused on the limited number of providers (for all payers) in less densely populated geographic areas of the state, especially Windham County. DSS reviewed the comments submitted and where possible updated the AMRP. Comments at the MAPOC meeting also included discussion about SPA 16-0023 (the Access Analysis for SPA 16-0023 is included as an appendix to this Plan).

As DSS has informally advised CMS, the state is currently in the process of establishing a Medical Care Advisory Committee (MCAC) that meets the requirements in federal regulations at 42 C.F.R. § 431.12. DSS will continue to provide CMS with updates as the MCAC is

established. However, as described above, DSS has engaged in stakeholder engagement through MAPOC prior to finalizing and submitting this Plan.

V. DATA AND ANALYSIS

CMAP Members

CMAP coverage is available for residents meeting various eligibility criteria. These programs are referred to as HUSKY plans, both as an acronym for "Healthcare for Uninsured Kids and Youth" and in honor of the University of Connecticut's sports mascot. HUSKY Health refers collectively to the Medicaid eligibility groups and the State's CHIP program. The majority of CMAP members fall into three HUSKY programs; additionally, members eligible for specific service programs fall under the umbrella term "Limited Benefit".

A brief description of members eligible under the HUSKY programs is included below:

- HUSKY A – Coverage groups for eligible children, parents, relative caregivers, and pregnant women.
- HUSKY B (CHIP) – Children under age 19 in households with income between 201% and 323% of the federal poverty level qualify under either band 1 or band 2. CHIP is excluded from the ARMP because it is separate from Medicaid.
- HUSKY C – Coverage groups for Aged, Blind and Disabled individuals.
- HUSKY D – Coverage groups for low-income adults aged 19 through 64 who do not have dependent children, who do not receive federal Supplemental Security Income or Medicare and who are not eligible for another coverage group.
- Limited Benefit - Limited coverage provided for: DCF behavioral health for non-HUSKY children (coverage is limited to selected community based behavioral health services); residents who have a tuberculosis diagnosis; residents who need treatment for breast and cervical cancer; and coverage for certain family planning and related services.

Since this Plan relates to access in Medicaid, not CHIP, and excludes Limited Benefit plans, the discussions that follow will examine the members in HUSKY A, C and D only.

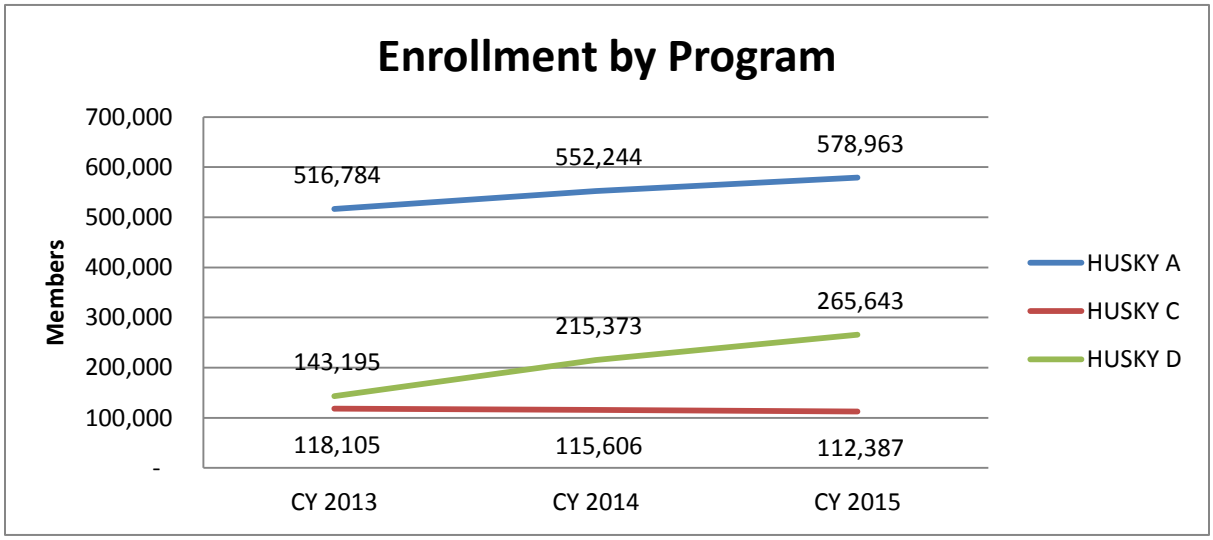
The unduplicated count of Medicaid members in Connecticut in CY 2014 is shown below in Table 4. Nearly two-thirds of members were covered by the HUSKY A plan, approximately one quarter was covered by HUSKY D, and the remaining 13% were HUSKY C members.

Table 4: 2014 Enrollment by Program

CY 2014	Count	% of Total
HUSKY A	552,244	62.5%
HUSKY C	115,606	13.1%
HUSKY D	215,373	24.4%
Total	**883,223**	**100.0%**

HUSKY A and D enrollment increased significantly in the three-year span from CY 2013 through 2015, as shown in Fig. 6 below. HUSKY D experienced an 85.5% increase in enrollment, and HUSKY A increased by 12.0% over the three year period. These increases were largely due to the implementation of the Medicaid expansion to low-income adults up to 133% of the federal poverty level under Section 2001 of the Affordable Care Act effective on January 1, 2014. Connecticut was the first state to implement partial expansion in April 2010. During that same period, enrollment in HUSKY C, Connecticut's program for individuals who are aged 65 or older, are blind or have a disability, remained relatively stable with a slight decrease (4.8%) over time.

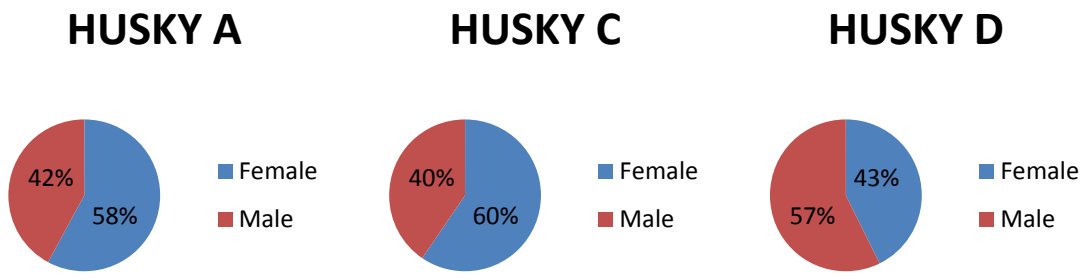
Fig. 6: Enrollment by Program CY 2013 through CY 2015



Gender

Overall, there were slightly more female members (54.4%) in the HUSKY A, C and D plans combined. However, of the three plans, HUSKY D has a higher proportion of males, as shown in Fig. 7 below.

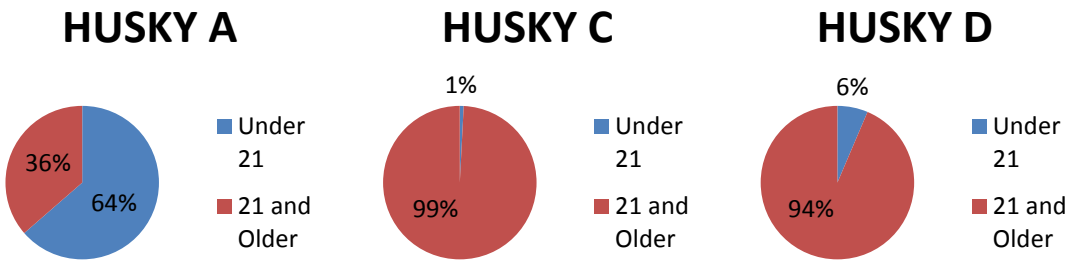
Fig. 7: Program by Gender



Age

While nearly 58.6% of the participants in the combined HUSKY plans are age 21 or older, age distribution varies widely among HUSKY A, C and D. In CY 2014, 63.6% of HUSKY A members were children, compared to 6.4% of HUSKY D members and 0.8% of HUSKY C members (Fig. 8).

Fig. 8 Program by Age



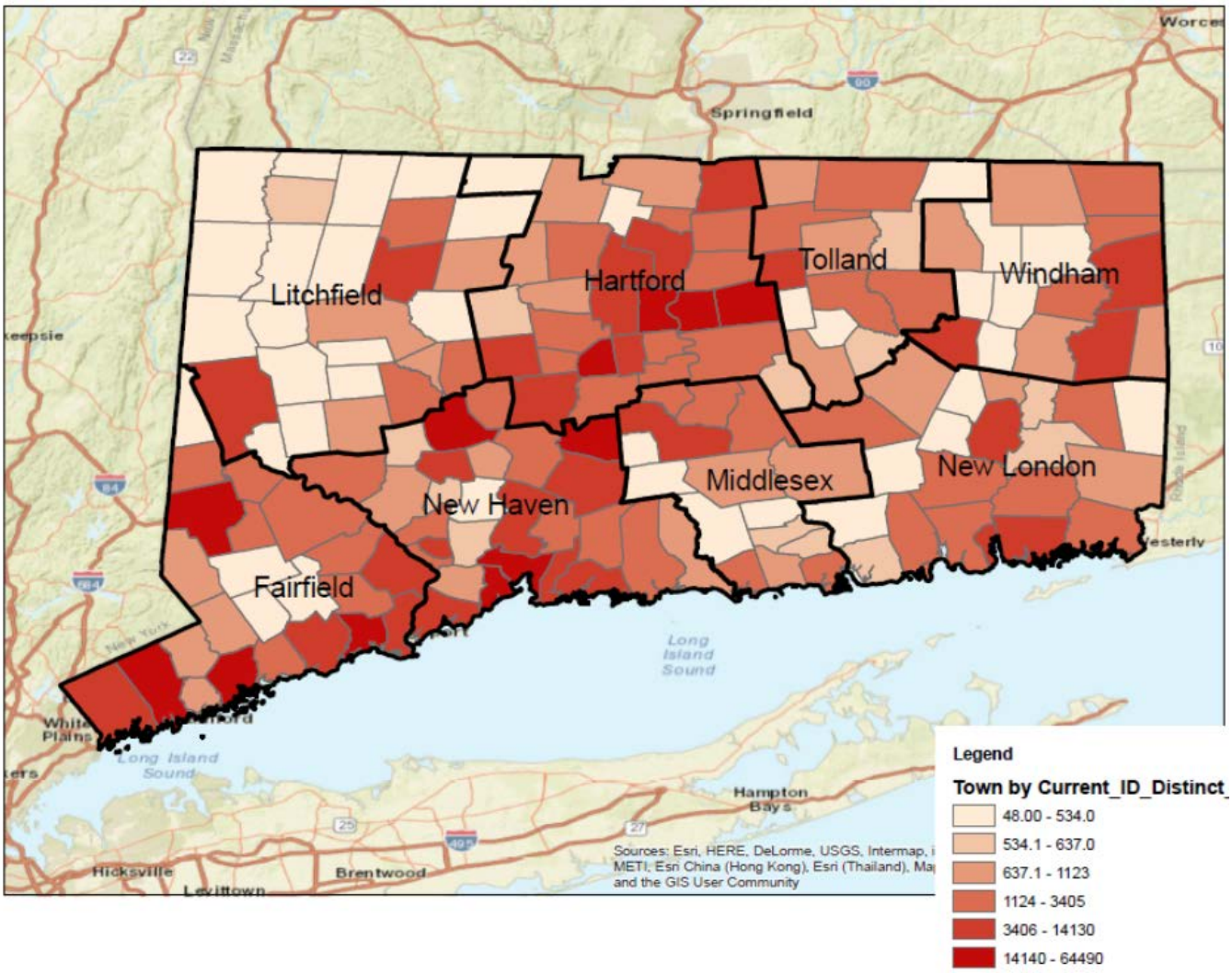
County

Connecticut has eight counties. These are largely geographic subdivisions and are not associated with any regional government structure. As shown in Table 5, in CY 2014 the largest number of CMAP members resided in New Haven County, the third most populous county in the state. A small proportion (approximately 1%) resided out-of-state (1,999) or did not have a county of residence on file (1). The CMAP program covers some members who are legal residents of Connecticut, but are living in another state due to the need for specialized medical or behavioral health care that is not available in Connecticut.

Table 5: 2014 Enrollment by County by Program

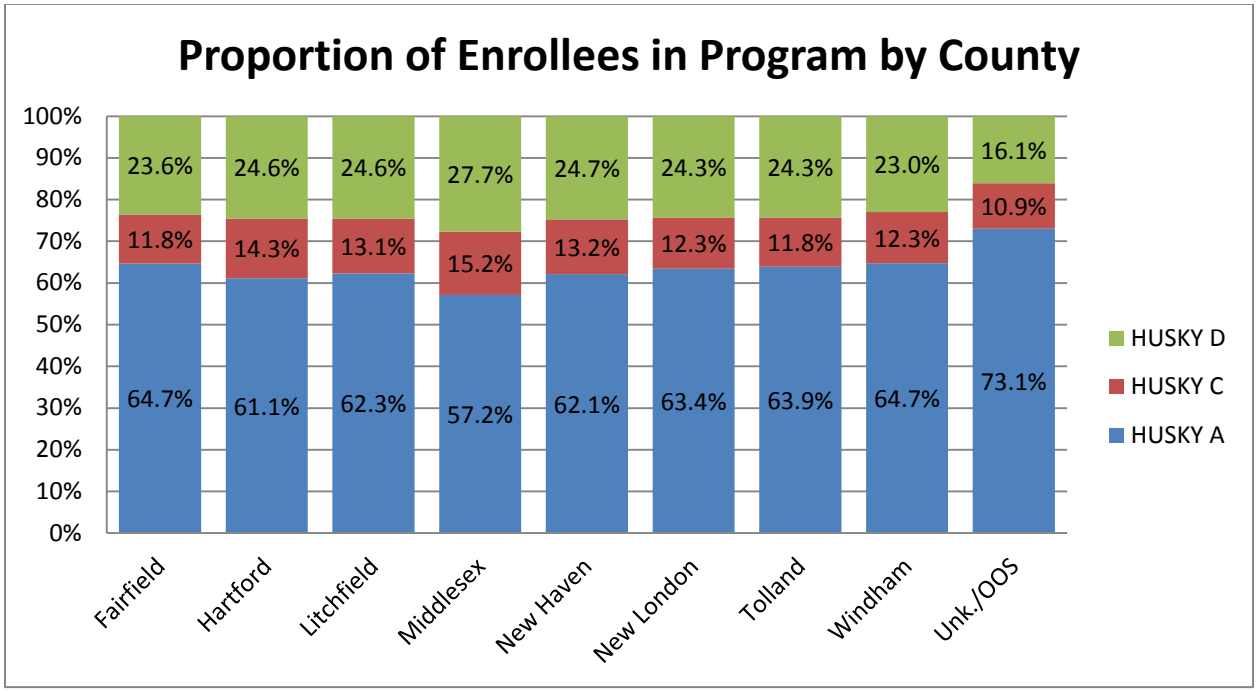
County	HUSKY A	HUSKY C	HUSKY D	Total
Fairfield	128,701	23,387	46,901	198,989
Hartford	150,664	35,212	60,646	246,522
Litchfield	23,045	4,845	9,103	36,993
Middlesex	16,258	4,313	7,866	28,437
New Haven	154,314	32,770	61,400	248,484
New London	42,402	8,205	16,228	66,835
Tolland	13,417	2,475	5,106	20,998
Windham	21,982	4,182	7,801	33,965
Total	**552,244**	**115,606**	**215,373**	**883,223**

Figure 9: Map of CT Counties and Members (2014)



As shown in Fig. 10, the proportions of members in each program by county are fairly consistent across the state. However, those with an unknown or out-of-state residence tend to be more likely to be in enrolled in HUSKY A.

Figure 10: Enrollment by Program by County



Member and Provider Input

The medical, behavioral, and dental ASO call centers assist members with various complaints and inquiries, including, but not limited to, benefits, services, access to care issues, as well as any other concerns they wish to address. A member may file a written or verbal complaint (or grievance) or both, to express dissatisfaction with anything or any quality of care or service delivery from a provider, a medical, behavioral health, or dental ASO employee. Verbal complaints, including clinical and non-clinical matters, and is usually received by the involved ASO Call Center. ASO Call Centers track and forward all such complaints to a quality management unit for review. Acknowledgement of the complaint, including confirmation that the issue is being researched, is made to the member. Additionally, members are informed of their right to make a complaint, grievance and/or appeal regarding a denial of goods/services. Members are also provided contact information (phone, mail, fax, and/or e-mail) for the various ASOs, including direct contacts for DSS and the Connecticut Office of Healthcare Advocate.

Each ASO has a defined process for addressing access to care issues and employs specific interventions. The following outlines the process used by each ASO, including specific examples of interventions:

Medical ASO

Within 2 weeks of enrolling in HUSKY, all members receive a Welcome Brochure summarizing all the services available through the CMAP, important contact information including the

Member Engagement Call center and other ASO Call Center contacts together with their unique HUSKY ID card Through the Welcome Brochure, members are directed to the HUSKY Health website, where the user will find detailed information about CMAP and what it has to offer including a provider directory lookup feature to find providers by a number of search criteria. Members can also find the on-line member handbook that provides specific information about covered benefits, rights and responsibilities, important contact information, choosing a primary care provider, special programs, community services, how to appeal a denial of service and basic information about how to apply or renew coverage.

CHNCT Member Engagement Services Call Center is available to members Monday through Friday 8 a.m. to 6 p.m. Member Engagement helps members:

- Find a provider and make appointments
- Choose or change a Primary Care Provider (PCP)
- Learn about covered services and how to get them
- Learn about special programs they can use
  Find resources in their community that can help them
- Facilitate complaint resolution

Member Engagement Services can communicate with members in the language of the member's choice

Members and CMAP providers have the right to file a grievance (expression of dissatisfaction) with CHNCT. CHNCT's Call Center receives and logs all member and provider grievances. Those issues not amenable to a first call resolution process are forwarded to the QM team for research, evaluation, and follow-up as needed.

On a monthly basis, a committee that includes staff from Provider Relations, Member Services, QM, and Health Services reviews and trends all member and provider grievances. By categorizing the grievances by issue type, CHNCT is able to differentiate isolated problems from issues that are more systematic in nature and determine if process improvements are necessary.

Upon initial contact, when a complaint is received regarding a member having difficulty finding a provider, (for example, a dermatologist, ENT or neurologist), the Member Engagement (ME) representative will locate a provider and assist in scheduling an appointment during that contact. If the ME representative is unable to find a provider in a timely fashion, the next step is to refer the member's inquiry to the Member Engagement Escalation Unit (EU). These are longer tenured, more experienced representatives who have established relationships with many providers throughout the state. The EU is able to assist with locating provider types that may be more difficult to access.

When a request for a specialist is received from a member, the first step the EU will take is to contact the member's Primary Care Provider (PCP) to:

- Establish if this is a medical concern the PCP feels comfortable addressing and a referral to a specialist may not be necessary.

- Determine if the PCP feels the referral is medically necessary and will submit any referral or clinical information a specialist may request prior to scheduling an appointment with the member.

- Decide, with the PCP or with the member, if an alternative specialist may be able to meet the member's needs. For example, a member may be referred to a podiatrist rather than a dermatologist for conditions such as plantar warts or athlete's foot.

Once this information is received, the EU representative will work with the member to locate a provider and schedule an appointment. In addition, the EU may contact the member after the appointment to obtain feedback on the visit and help ensure any recommended follow up care is obtained. The EU was successful in making appointments with the appropriate providers on all the grievances referred to them for the first quarter of 2016.

If a provider has an access to care complaint they may forward such complaint through the ASO, HPE or directly to DSS. All complaints are researched and responded to in writing. Appropriate action is taken if necessary.

Behavioral Health ASO

Beacon Health Options tracks access through calls, grievances, and monitoring of utilization trends. A recent and specific example pertained to members who were requesting medication assisted treatment (MAT) for substance use disorders. The initial introduction can take place when the member is in detox. However, the member will need follow up once he is in the community. In this particular case, access was limited because, due to the Substance Abuse and Mental Health Services Administration's (SAMSHA) extensive MAT provider requirements, only a few providers in the community currently offer this level of treatment. The behavioral health ASO reached out a provider who agreed to serve CMAP members. Currently, this provider has been overwhelmed and the behavioral health ASO has reached out to mental health (MH) and substance abuse (SA) providers throughout the state, via a focus group, to discuss barriers to MAT. Another focus group has been scheduled with state providers to continue the discussion around access. A SA workgroup, comprised of the behavioral health ASO staff, Advanced Behavioral Health (a local ASO), Community Health Network of Connecticut (the medical ASO), Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), has also been established to further explore ways to mitigate this specific MAT barrier. Provider webinars are being planned and the behavioral health ASO is working with St. Francis Hospital to establish the "one shot program," where members will get their initial introduction free; however, this initiative is on hold pending more provider buy-ins.

Dental ASO

BeneCare addresses all complaints individually. Although aggregate data is reported externally in a format that is consistent across all ASOs, the information is also given to their Quality Improvement Committee to identify trends. Complaints are addressed immediately with the member unless further investigation is required. All complaints are categorized into three levels based on severity, urgency and level of intervention needed to resolve the complaint. Policy and procedures have been constructed to ensure all complaints are addressed through a thorough and systematic approach. A Level 1 complaint is the most routine/administrative type

of complaint. A level 3 complaint, the most serious type of complaint, may include but is not limited to physical altercations, inappropriate/sexual contact with a patient, treatment that leads to an emergency condition, etc. and requires immediate investigation and intervention.

The dental ASO's policy and procedure for these types of issues requires staff to take certain actions immediately, based upon the level assigned during handling of the complaint. All complaints are thoroughly documented. Note that, when low level complaints (level 1) occur repeatedly for a given provider, the dental ASO's internal process identifies these trends and intervenes accordingly. Investigative measures are also taken when an office is flagged for multiple complaints or for complaints made regarding patient infectious disease control safety practices. Office inspections are conducted when such complaints are logged or offices may be selected at random to undergo the Occupational Safety and Health Administration's (OSHA) standards for sterilization and HIPAA compliance. If there are noted deficiencies, then the office is given thirty days to correct deficiencies. If warranted, the office may be reported to the authority that has jurisdiction over the violation.

Non-Emergency Medical Transportation

Logisticare monitors transportation providers' performance before, during and after each trip. The expectation is that each trip is safely completed on-time and that all aspects of the service are delivered with compassion and respect. If the CMAP member believes that the quality of service is less than desired, Logisticare will investigate and respond. Members are able to submit information regarding specific issues or complaints via an on-line form (through the WeCare feedback system) or by contacting the NEMT ASO via phone. The WeCare feedback system sends a member's question or concern to the appropriate person quickly and effortlessly in order to follow up and make the necessary changes for member's future experiences.

Grievance Reports

While each ASO's process is slightly different, the core principles governing access complaints are consistent across ASOs. Access complaints are addressed immediately upon receipt and are resolved as timely as possible based on the nature of the access complaint. In addition to each ASO's current processes to address the most common access issues, the medical ASO has launched several initiatives focusing on projecting, trending, and developing interventions to mitigate future access trends. These initiatives include, but are not limited to, member and provider focus groups, tracking and trending of member and provider complaints and provider network analyses to name a few. An analysis of provider complaints across the ASOs revealed an insignificant percentage of access related issues; therefore, access issues are identified through member complaints, mystery shopper surveys and other surveying protocols, rather than through provider complaints. There are several reports maintained by the ASOs that capture the volume and nature of concern that provide a baseline and an opportunity to monitor and improve areas of concern regarding access to care.

Table 6. 2014 CMAP Grievance Report

January – December 2014			
	Medical ASO	Behavioral Health ASO	Dental ASO
Total Grievances	501	113	202
Total Member Months	2,396,454	2,354,933	2,354,933

Table 7. Dental ASO Call Center Report

Provider Access	#	Reporting Period	2014Q4
No access: location, closed panel, selection, no par prvdr in area, etc.		Program:	CTDHP
PCD	0		
Specialist	0	Total MM	2,354,933
Clinic	0		
Other	0		
Total	0		
Delayed access/ wait time to appt.		Total Grievances	202
PCD	0		
Specialist	0		
Clinic	0		
Emergency/Urgent Appointment	0		
Total	0		
Quality of Provider Services	#		
Provider conduct/professionalism (clinician or staff)			
Complaint regarding the condition of office/facility	0		
Inappropriate care/disagreement	48		
Bias	0		
Cultural	0		
Assistance with specialist referral	0		
Privacy violation	0		
Language barrier	0		
Handicapped accessibilityandicap	0		
Other	143		
Total	191		
Quality of ASO Services	#		
Quality of ASO customer Service Representatives	0		
Member materials	0		
Interpreter services (lack or quality)	0		
Referal/Authorization issue	0		
Care Coordination (ICM)	0		
Provider search engine information	0		
Website - Provider Portal	0		
Website - Customer Portal	0		
Total	0		
Financial	#		
Member Billed	0		
Cost share	0		
Premium	0		
Total	0		
Other	#		
Fraud - member	0		
Fraud -provider	0		
Behavioral Health	0		
Medical	0		
Pharmacy	0		
Transportation	0		
ID Card (lost or misuse)	0		
Other (Benefit Limitations)	2		
Other (Claim Payment Issue)	3		
Other (DSS Appeal/NOA Process)	1		
Other (DSS Lack of Response)	0		
Other (CTDHP Communication Issue)	0		
All Others	5		
Total	11		

Table 8. Medical ASO - – Member Grievance Report Q4 2014

Provider Access	#	Reporting Period	2014Q4
No access: location, closed panel, selection, no prvdr in area, etc.		Program:	HUSKY
PCP	25		
Specialist	73	Total MM	2,396,454
Hospital	0		
Other provider type	0		
Total	98		
Delayed access/ wait time to appt.		Total Grievances	501
PCP	16		
Specialist	11		
Hospital	1		
Other	1		
Total	29		
Quality of Provider Services			
Assistance with specialist referral	6		
Bias	7		
Condition of office/facility	2		
Handicap	0		
Inappropriate care/disagreement	151		
Language barrier	0		
Privacy violation	1		
Provider Conduct/professionalism (including staff)	59		
Refused to see Member due to lack of photo ID/Card	0		
Total	226		
Quality of ASO Services			
Automated Calls	1		
ICM	2		
Interpreter services (lack or quality)	1		
Member materials	0		
Nurse Advice Line	1		
Provider search engine information	49		
Quality of ASO customer service	3		
Referral/authorization issue	0		
Total	57		
Financial			
COB	0		
Cost share	1		
Member billed	11		
Premium	0		
Total	12		
Other			
Behavioral Health	5		
Dental	24		
Fraud - Member	8		
Fraud - Provider	4		
Others	0		
Pharmacy	4		
Transportation (NEMT)	34		
Total	79		

Table 9. Behavioral Health ASO – Member Grievance Report Q4 2014

Annual Number of Complaints/Grievances by Reason

	2011	2012	2013	2014
Complaint with VO staff/process	**7**	**8**	**27**	**23**
Provider	5	3	21	18
Adult Member	-	2	4	2
Youth Member	2	3	2	3
Clinical Issues	**26**	**41**	**43**	**49**
Provider	-	-	1	3
Adult Member	14	32	33	36
Youth Member	12	9	9	10
Access Issues	**3**	**11**	**10**	**41**
Provider	1	1	2	7
Adult Member	-	10	5	29
Youth Member	2	-	3	5

Mystery Shopper Survey

The primary goal of the mystery shopper survey was to evaluate CMAP member's access to medical and dental professionals. Conducted by telephone, the mystery shopper survey, which is, seeks to document the experience of a CMAP member in contacting provider offices. The survey provides a baseline and an opportunity to monitor and improve areas of concern. Areas monitored include sufficiency of access by provider type, length of time for appointment offered, and reasons why there isn't appointment availability. Mystery shopper survey results enable DSS to track trends. Additionally, the dental mystery shopper survey results are used to issue corrective action plans to offices that are not making appointments within identified standards or are providing incorrect information to members.

Table 10. Medical ASO Mystery Shopper Results

CT Medicaid Access Review Plan **Mystery Shopper Results** **Medical Services** **Survey Date: CY 2015**						
Medical Apointment Availability						
Provider Type	Number Surveyed		Accept new patients		Accept new patients and new HUSKY patients	
	Number of Providers Contacted	Surveys Completed	%yes	%no	%yes	%no
Adult PCP	325	177	73.45%	26.55%	49.15%	50.85%
Child PCP	173	120	80.83%	19.17%	71.67%	28.33%
OB/GYN	200	132	72.73%	27.27%	65.15%	34.85%
Cardiologist	91	74	72.97%	27.03%	67.57%	32.43%
ENT	32	30	63.33%	36.67%	43.33%	56.67%
TOTAL:	821	533				

Table 11. 2014 Dental ASO Mystery Shopper Results

CT Medicaid Access Review Plan **Mystery Shopper Results** **Dental Services** **Survey Date: CY 2014**					
Dental Appointment Availability					
Provider Type	Surveys Completed	Accept new patients		Accept new patients and new HUSKY patients	
		%yes	%no	%yes	%no
General & Pediatric	667	97.15%	2.85%	88.61%	11.39%
Endodontist	13	92.31%	7.69%	79.92%	23.08%
Oral Surgery	65	90.77%	9.23%	83.08%	16.92%
Orthodontist	63	98.41%	1.59%	95.24%	4.76%
All Practices	808	96.66%	3.34%	88.49%	11.51%

The mystery shopper results shown in tables 10 and 11 indicate the percentage of enrolled providers willing to accept new patients who are members of CMAP. This information can provide some indication, stratified across provider types, of whether changes in coverage, policy or rates have impacted appointment availability. Based on the 2015 medical mystery shopper

results, nearly half of enrolled adult PCPs who were identified as accepting new patients reported that they will accept CMAP members. Further, over 70% of enrolled pediatric PCPs were identified as accepting new patients.

Provider Network

The following section describes (1) the network sufficiency standards used by each of the ASOs, (2) the overall provider network under the CMAP program and (3) enrollment trends for CY 2013, CY 2014 and CY 2015. To the extent possible, based on available data, network capacity under CMAP was compared to network capacity under other public and private payers. As previously discussed, this section focused on provider types that are linked to the specific areas required under the access regulations.

ASO Provider Network Sufficiency Standards

Under contract with DSS, each ASO is responsible for recruiting and retaining a sufficient provider network. Provider sufficiency standards are identified for each ASO and vary according to service category (medical, dental and behavioral health) to reflect specific needs.

Medical ASO: The medical ASO (CHNCT) measures provider network sufficiency via a GEO-access standardized report. The GEO-access report is performed semiannually (or more often, as requested by DSS) and defines network sufficiency as at least one primary care provider within 15 miles of a CMAP member's home zip code and at least one specialist provider within 20 miles of a CMAP member's home zip code. A primary care provider is defined as a practitioner actively enrolled as one of the following provider types and specialties: physician, advanced practice registered nurse (APRN), or physician assistant with a specialty in adult health, family nurse practitioner, family practitioner, general pediatrician, general practitioner, geriatric practitioner, internal medicine, medical physician assistant, nurse practitioner (other), pediatric adolescent medicine, pediatric nurse practitioner, physician assistant, preventive medicine, primary care nurse practitioner, primary care physician assistant. A specialist is defined as a practitioner actively enrolled as a provider type and specialty other than the types and specialties noted as primary care.

In addition to the GEO-access report, the medical ASO utilizes an outside firm to conduct a mystery shopper survey with the primary goal of evaluating CMAP members' ability to obtain medical appointments and to understand if self- identifying as a CMAP member impacts the ability to obtain an appointment with an office that identified as having an appointment slots available. Additionally, the medical ASO reviews CMAP membership levels to determine if additional outreach and retention efforts are warranted in a specific region.

Dental ASO: The dental ASO (BeneCare) is responsible for measuring and analyzing the dental provider network enrolled under CMAP. The provider access standard is measured with a network analysis tool, GeoAcess, which measures CMAP member to dental provider distances. Network access statistics include providers that are currently accepting new patients, so a realistic baseline of access can be established. The results are examined to identify areas that could use improvement. Access is defined by maintaining one primary care dental provider within a 20 mile radius of a CMAP member. Provider capacity is measured using in-house

reporting which examines CMAP member and provider enrollment data to develop the appropriate county-based metrics. Capacity is measured by a ratio of 2,000 CMAP members to one primary care dental provider (general dentist and pediatric dentist) and one member to 4,000 dental specialists. Dental provider availability is measured with the mystery shopper analysis, which is performed once annually by an external organization that generates specific reporting about these results. Provider availability is defined as a provider's capability to accept appointments in a given timeframe (current contractual standard is 56 days).

Behavioral Health ASO: A GeoAccess methodology standard is used at least quarterly to assess behavioral health provider sufficiency. Sufficiency standards for the behavioral health provider network are defined as follows:

- in urban locations: 1 behavioral health provider within 15 miles,
- in suburban locations: one behavioral health provider within 25 miles, and,
- in rural locations: one provider within 45 miles.

Behavioral health service gaps are also tracked and identified in a variety of other ways using a variety of data sources including:

- tracking and trending information on services requested but not available;
- requesting the Contractor's advisory committee to identify services that are needed but unavailable;
- monitoring penetration rates by age, location and ethnic/minority; monitoring consumer-reported satisfaction with access to services;
- conducting mystery shopper surveys;
- monitoring population growth; and,
- utilizing findings of other local research, such as assessments done by the MCOs, Community Collaborative, Managed Service Systems and Local Mental Health Authorities (LMHAs).

CMAP Providers by Category

Federally Qualified Health Centers (FQHC) and Outpatient Hospitals (Clinics)

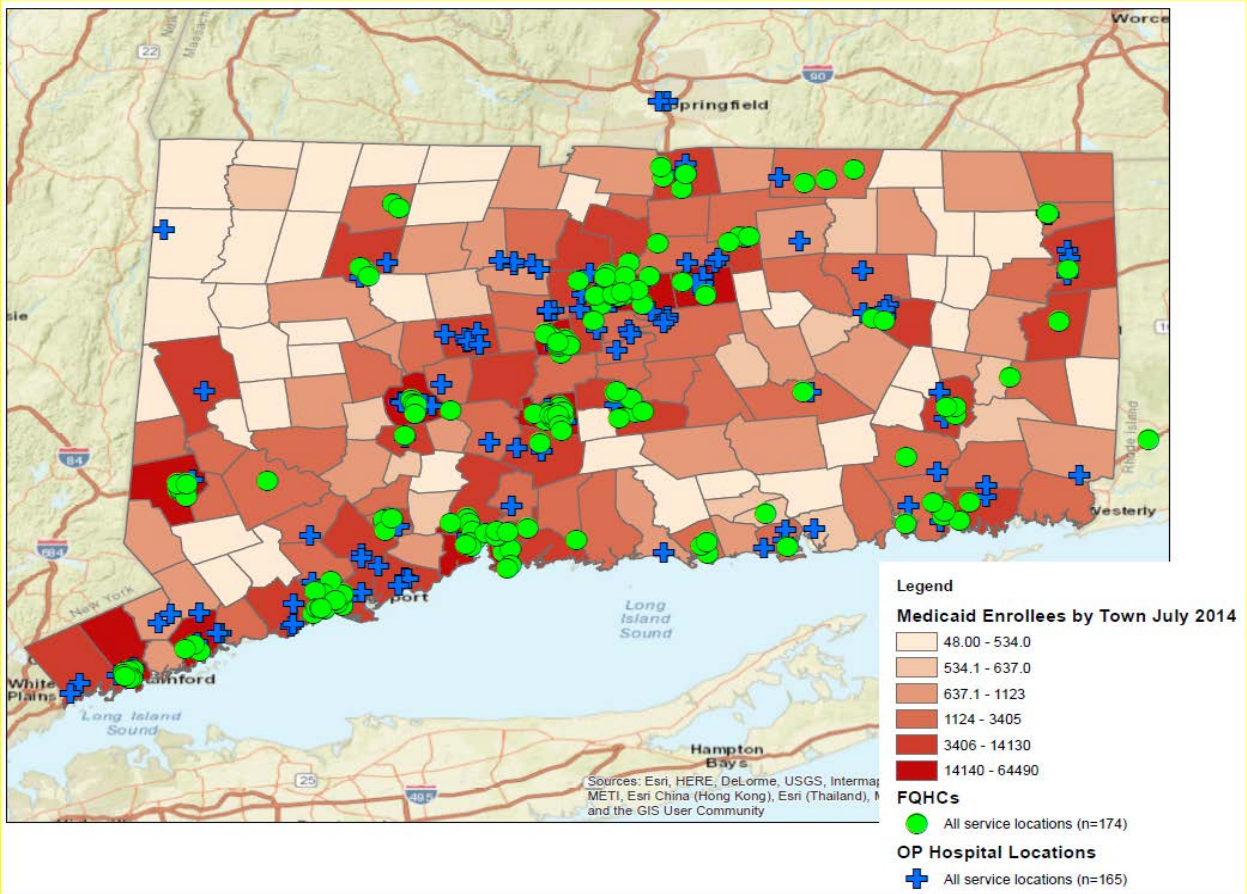
Connecticut residents have access to primary care services in a variety of settings from various provider types including Federally Qualified Health Centers (FQHC), outpatient clinics/departments operated by enrolled hospitals (will be referred to as outpatient hospitals), free-standing medical clinics, and independent physicians (both solo practitioners and group practices), advanced practice registered nurses, certified nurse midwives, and physician assistants. The services provided in a FQHC include medical services, dental services, and behavioral health services. The FQHCs enrolled under CMAP enroll with one main provider location in addition to multiple service sites, including, but not limited to, additional full-service and satellite locations, mobile sites, school-based health centers, and homeless shelters.

During calendar year 2014, there were fifteen medical FQHCs, thirteen behavioral health FQHCs and twelve dental FQHCs enrolled in CMAP, with 204 service sites. Please note that the service sites included in the map below (Figure 11) do not represent all the service locations currently run by CT enrolled FQHCs and instead focus on the stationary sites and exclude mobile clinics and homeless shelters.

Additionally Connecticut's residents were able to obtain primary care services in outpatient hospital settings. Outpatient hospitals enrolled under CMAP routinely provide primary care services, dental services, psychiatric services, and obstetric care through their various clinic departments included under the outpatient hospital license.

During calendar year 2014, there were 40 outpatient hospital clinics enrolled in CMAP, with 168 service location sites. The map below does not display all of the service locations for outpatient hospitals. Instead, it focuses on primary care service locations throughout the state. Additionally, our current mapping software shows only one service location when different hospitals share the same street address; this explains the difference between the number above of 168 service locations and the 165 service locations shown on the map below. The following map of CT provides the number of CMAP members by town as compared to the locations of the FQHC and outpatient OP Hospitals enrolled in CMAP. The enrollment data as of July 2014 was extracted from the DSS data warehouse. July 2014 was chosen since it is the midpoint of CY 2014. The list of FQHC and outpatient hospital locations was compiled using each facility's website and information on each facility's licensed that was obtained through the CT Department of Public Health website (https://www.elicense.ct.gov/). The service locations depicted below are all of the physical address locations where a member may receive a health service (i.e., business office related addresses were excluded).

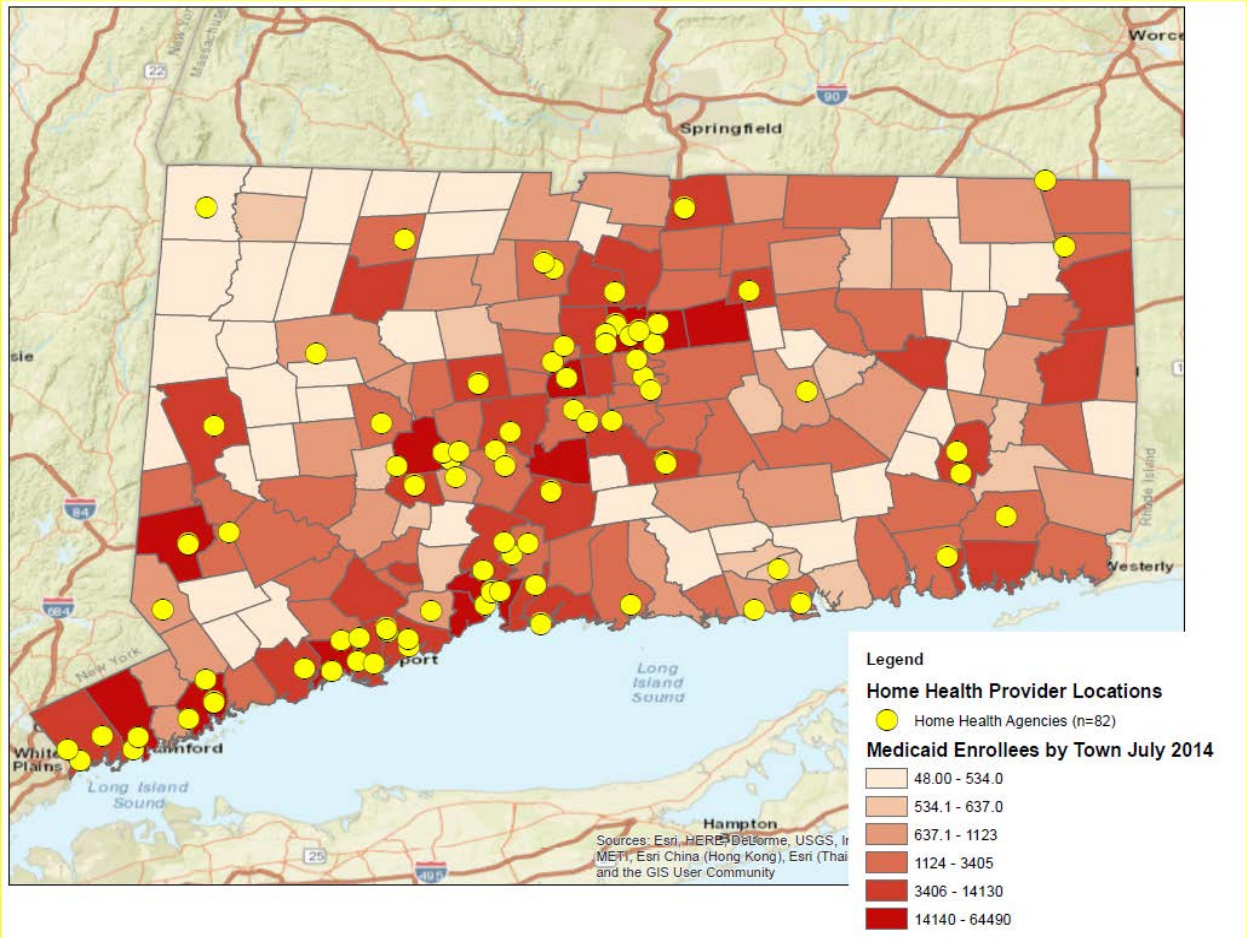
Figure 11: CT Members and FQHC / Outpatient Hospital Service Locations



Home Health Agencies

There were 82 Home Health Agencies enrolled in CMAP serving CMAP members. CT Home Health agencies provide skilled nursing services, home health aide services, medication administration services, and rehabilitation services. In contrast to the Medicare program that reimburses for home health services through a per episode payment rate, CMAP will reimburse for home health services for as long as such services are deemed medically necessary, pursuant to 17b-259(b) of the Regulations of Connecticut State Agencies. The practical difference is that when medically necessary, CMAP covers home health services for many years, whereas Medicare typically covers home health services for a much shorter length of time. The map below does not include certain satellite locations.

Figure 12: CT Home Health Agencies



Statewide Count of Connecticut CMAP Performing Providers – Medical

For the purpose of the AMRP, CMAP uses a members-to-provider ratio to measure the availability of primary care providers to provide services to the CMAP population, dividing the number of members in each county by the number of performing providers who provide services

in each county. For example, if there were 100 members and 2 performing providers, the members to provider ratio would be 50 members to one provider. A low ratio indicates a greater level of providers relative to the population, while a high ratio indicates that there are a fewer providers. The members-to-provider ratio was used to identify counties where the ratio diverges from the statewide average.

The following tables and charts, show the number of providers or organizations that provided selected categories of service as individuals, and the member ratios by county for overall health care services and for the selected services. The selected categories of services are:

- primary care, with the subsets of medical and dental primary care,
- physician specialist services,
- behavioral health services, and,
- prenatal and postnatal obstetric care, which includes labor and deliveries.

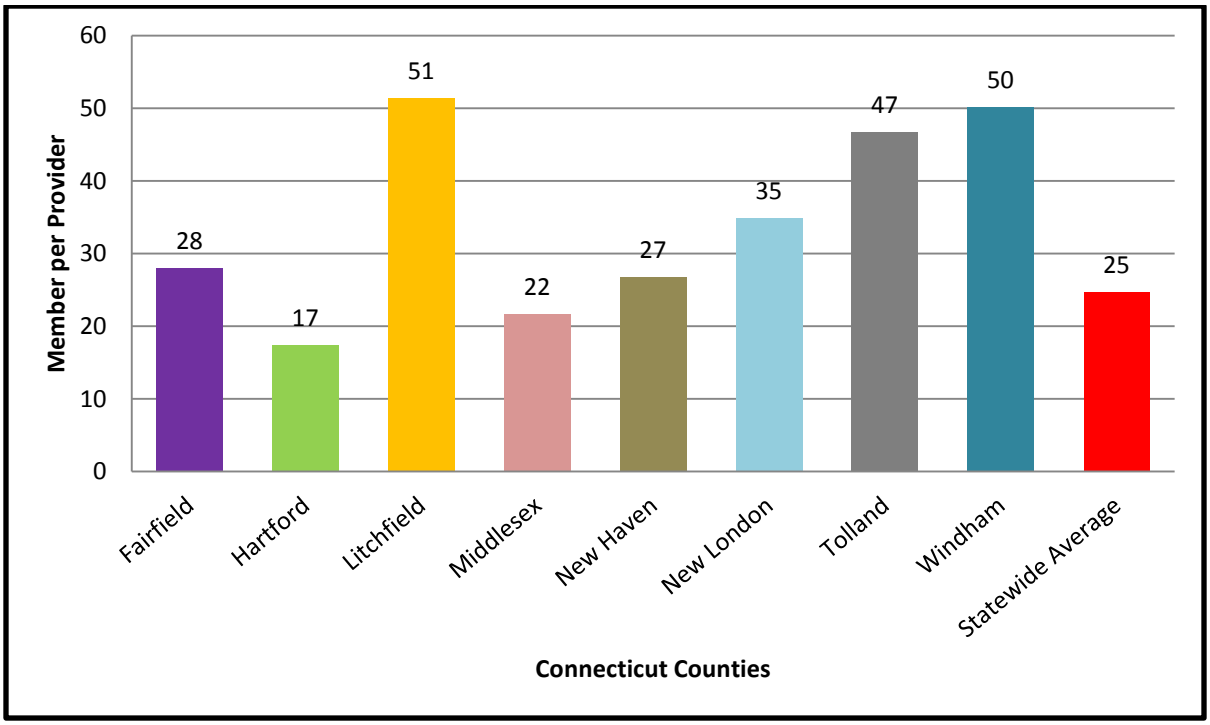
The provider categories of home health, medical outpatient hospital and dental outpatient hospital were excluded from this analysis due to discrepancies within the data collected for those categories. Out-of-state providers and members with unknown residencies are also excluded from this analysis.

Performing providers are used for this analysis instead of billing providers in order to demonstrate actual access to healthcare for all members within each Connecticut county. Billing providers are providers who submit claims for services to the CMAP program's fiscal intermediary and are paid directly by MMIS. Performing providers are providers rendering services to CMAP members through independent or group billing providers. Each performing provider is counted for each service category by county, which means performing providers might be counted more than once if there is an overlap in providing services by category and/or by county. The members are unduplicated HUSKY A, C, and D members enrolled in CMAP anytime period during CY 2014. The data presented below in Table 12 shows the statewide count of performing providers per county, while Figure 13 shows the members-to-provider ratio for CY 2014 based on where the members reside by county. The subsequent tables display data from CY 2013, through CY 2015, in order to compare the availability of performing providers in each county over an extended period of time. The remaining graphs will only include member-to-provider data from CY 2014.

Table 12: Total Statewide Count of Connecticut CMAP Performing Providers for Medical Services, Dental Services, Behavioral Health, Prenatal and Postnatal Obstetric Care, Calendar Year 2014 by County

Connecticut Counties	Statewide Count of Performing Providers
Fairfield	7,098
Hartford	14,183
Litchfield	719
Middlesex	1,310
New Haven	9,266
New London	1,914
Tolland	450
Windham	677
Total	35,617

Figure 13: CMAP Health Care Members-to-Provider Statewide Average <u>for Medical Services, Dental Services, Behavioral Health, Prenatal and Postnatal Obstetric Care</u>, Calendar Year 2014



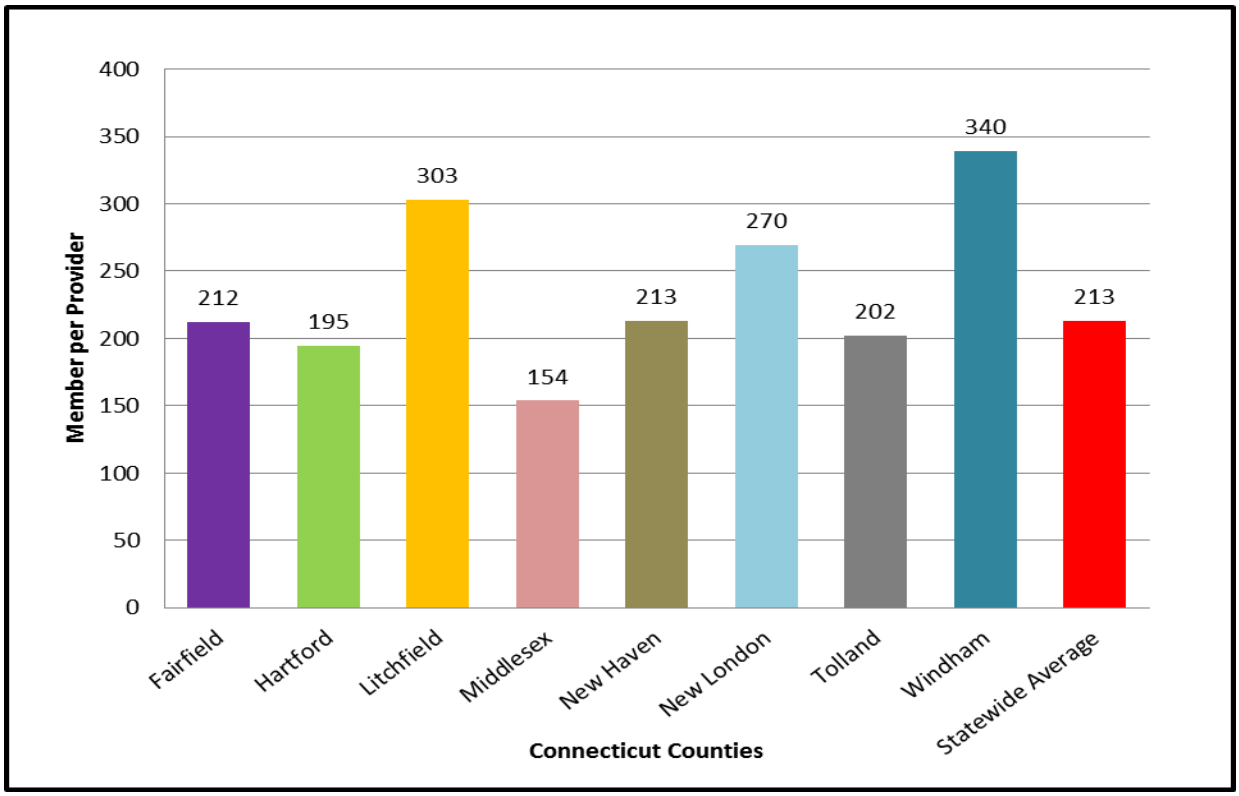
Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2014 through December 31, 2014 of paid claims through May 2016.

As shown in Fig.13, the member-to-provider ratios by county ranged from 28 to 92 members per provider among health service providers (i.e., medical and dental primary care providers, physician specialists, performing providers within medical, dental and behavioral health federally qualified health centers, behavioral health and prenatal and postnatal obstetric care providers), with the average overall ratio of 50. The counties of Windham and Litchfield have the highest ratios while Middlesex has the lowest member-to-provider ratio. Overall, Middlesex has the lowest amount of members at 3% of the member population, followed by Windham and Litchfield with about 4% of the member population. However the number of providers in Middlesex appears to be twice as many as Windham. For all other counties, the member-to-provider ratio is within the average.

Table 13: Counts of CMAP Physicians, Advanced Practice Registered Nurses and Physician Assistants, Calendar Years 2013 through 2015

Physicians, APRNs and Physician Assts.	**Statewide Performing Provider Count**		
	CY 2013	**CY 2014**	**CY 2015**
Provider County			
Fairfield	986	939	1,077
Hartford	1,475	1,265	1,318
Litchfield	129	122	136
Middlesex	195	185	192
New Haven	1,367	1,167	1,290
New London	288	248	276
Tolland	103	104	112
Windham	99	92	89
Statewide Total Performing Providers	4,642	4,122	4,490

Figure 14: CMAP Health Care Members-to-Provider Statewide Average of CMAP Physicians, Advanced Practice Registered Nurses and Physician Assistants, Calendar Year 2014



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2014 through December 31, 2014 of paid claims through May 2016.

Figure 14 above shows the number of members to one provider in each Connecticut County, within the category of Physician, Advanced Practice Registered Nurses and Physician Assistants for primary care. For this particular category of providers, the overall average ratio is 213 members to one provider and ranges from 154 to 340 members per provider. The counties of Fairfield, New Haven and Tolland are close to the statewide average. Meanwhile, New London with the two hundred and seventy members per provider is higher than the statewide average. Meanwhile, Hartford County, with only one hundred and ninety-five (195) members to one provider, though in close proximity, falls slightly below the overall ratio. Similar to Figure 14 above, the counties of Litchfield and Windham have the highest ratio of members to one provider.

Table 14: Counts of CMAP Physician Specialists, Calendar Years 2013 through 2015

Physician Specialists	**Statewide Performing Provider Count**		
	CY 2013	**CY 2014**	**CY 2015**
Provider County			
Fairfield	1,077	1,676	1,493
Hartford	1,421	1,681	1,395
Litchfield	90	121	109
Middlesex	132	169	151
New Haven	1,565	1,877	1,624
New London	368	414	360
Tolland	42	56	51
Windham	75	92	73
Statewide Total Performing Providers	4,770	6,086	5,256

Figure 15: CMAP Health Care Members-to-Provider Statewide Average of CMAP Physician Specialists Calendar Year 2014

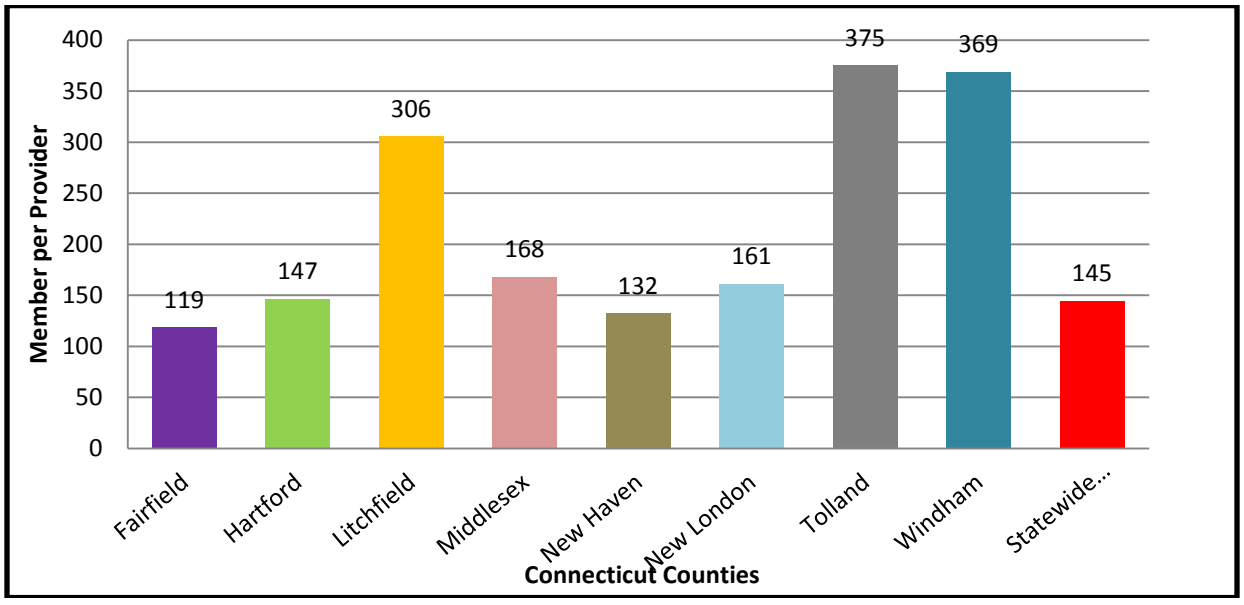


Figure 15 above shows the number of members to one provider in each Connecticut County, within the category of Physician Specialist. The category of Physician Specialists included cardiology, dermatology, orthopedic, urology, allergy, pulmonary, neurology and gastrostomy. From the data presented, the overall average ratio is 145 members to one provider, with counties ranging from 119 to 375. Hartford County has a ratio in close proximity to the statewide average. The counties of Litchfield, Tolland and Windham have more rural areas with fewer specialists available. In comparison, Hartford County had 1,681 performing providers in calendar year 2014. Fairfield County had the lowest ratio of 119, showing the greatest availability of specialists. As shown in Table 14, only 121 performing providers provided services in Litchfield, 56 performing providers in Tolland and 92 performing providers in Windham in calendar year 2014.

Table 15: Counts of CMAP Medical Federally Qualified Health Centers, Calendar Years 2013 through 2015

Medical Federally Qualified Health Centers	**Statewide Performing Provider Count**		
	CY 2013	**CY 2014**	**CY 2015**
Provider County			
Fairfield	135	144	131
Hartford	93	88	67
Litchfield	8	9	16
Middlesex	116	122	126
New Haven	114	120	105
New London	10	10	13
Windham	29	24	25
Statewide Total Performing Providers	505	517	483

Figure 16: CMAP Health Care Members-to-Provider (per Site of Service) Statewide Average of CMAP Medical Federally Qualified Health Centers, Calendar Year 2014

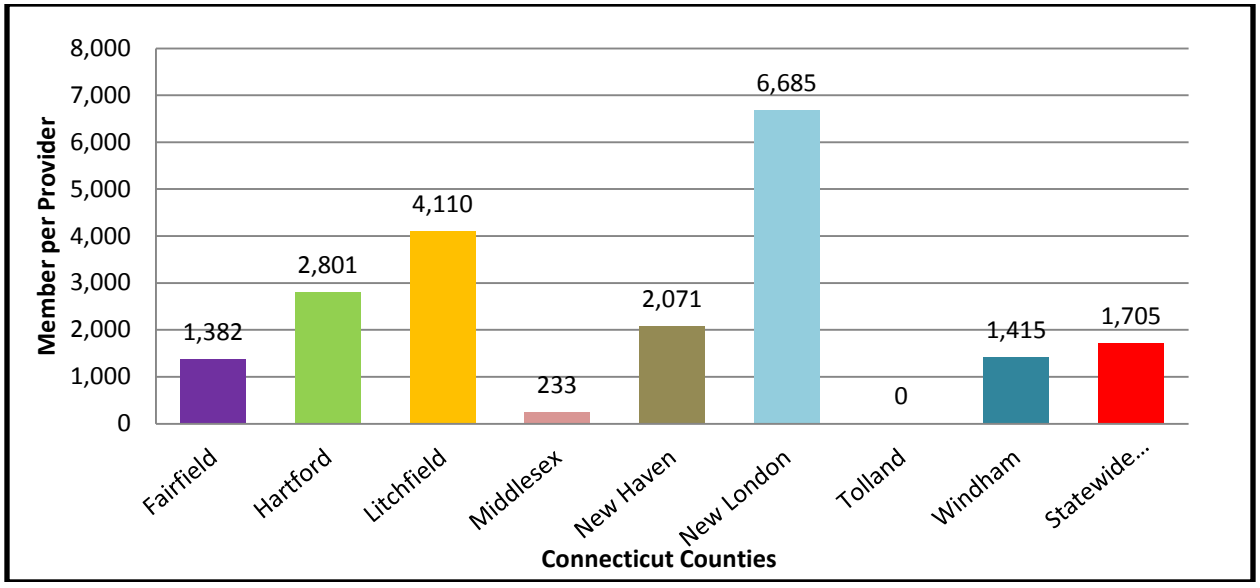


Figure 16 above shows the number of members per provider in each Connecticut County, in the category of Medical Federally Qualified Health Center (FQHCs) services of for primary care. In the case of FQHCs, the number of performing providers includes the number of performing providers at each FQHC site. The overall average ratio is 1,705 members to one provider, ranging from 0 to 6,685. Windham County has a ratio that is the closest to the statewide average, of 1,415. The counties of Litchfield and Windham New London higher ratios have spikes within the ratio, due to the low amount limited number of FQHC service sites within those particular counties. In comparison, Middlesex County had 233 members per one service site in calendar year 2014. Tolland County had no data of FQHC service sites, therefore, had the ratio of 0, however, members in that county have still has availability access to physician and other practitioner groups and outpatient hospitals.

Table 16: Counts of CMAP Independent Dental Practitioners, Calendar Years 2013 through 2015

Independent Dental Practitioners	**Statewide Performing Provider Count**		
Provider County Description	**CY 2013**	**CY 2014**	**CY 2015**
Fairfield	263	284	306
Hartford	394	412	396
Litchfield	39	38	41
Middlesex	52	44	47
New Haven	298	342	345
New London	68	69	59
Tolland	30	30	30
Windham	24	15	21
Statewide Total Performing Providers	1,168	1,234	1,245

Figure 17: CMAP Health Care Members-to-Provider Statewide Average of CMAP Independent Dental Practitioners, Calendar Year 2014

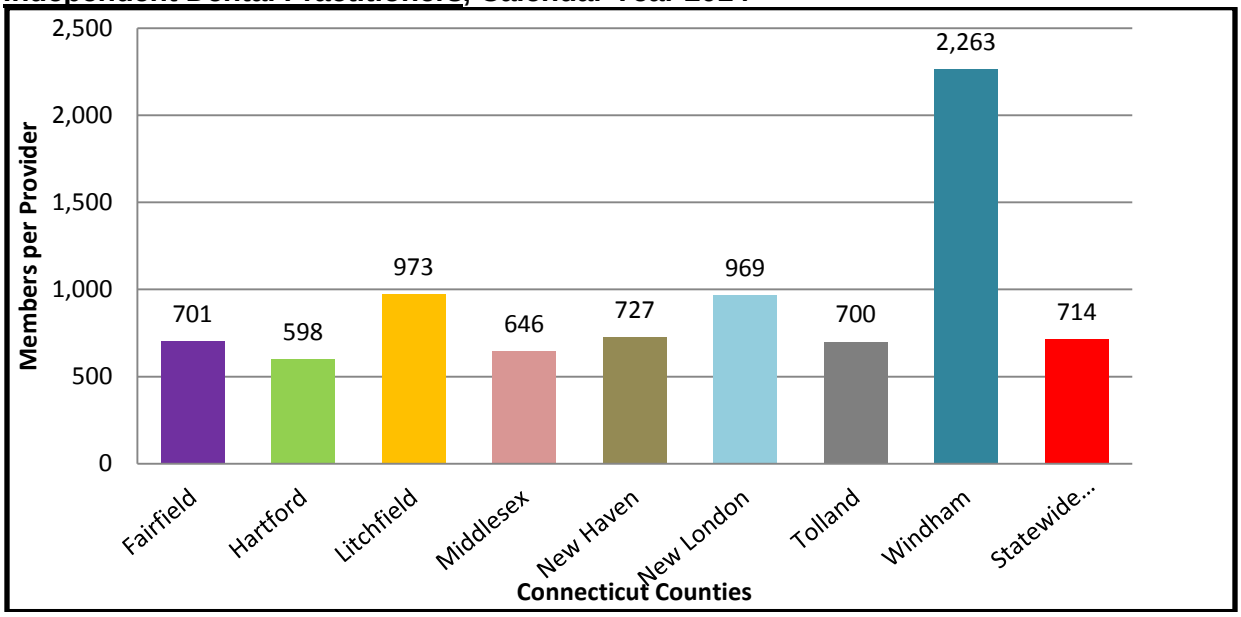


Figure 17 above shows, by county, the number of members per provider in the category of Individual and Group Independent Dental Practitioners. The statewide average ratio is 714 members per provider, with a range from 598 to 2,263. Windham County has the highest ratio at 2,263 due to the limited number of dental practitioners available in this particular county. At 701 and 700, Fairfield, New Haven and Tolland had ratios that were in closest to the statewide average, members per providers. Hartford County had 598 members per one provider, showing greater availability in calendar year 2014.

Table 17: Counts of CMAP Dental Federally Qualified Health Centers, Calendar Years 2013 through 2015

	Statewide Performing Provider Count		
Provider County Description	**Calendar Year 2013**	**Calendar Year 2014**	**Calendar Year 2015**
Fairfield	18	18	22
Hartford	33	28	29
Litchfield	5	5	5
Middlesex	34	29	26
New Haven	27	37	36
New London	17	19	17
Windham	7	5	9
Statewide Total Performing Providers	141	141	144

Figure 18: CMAP Health Care Members-to-Provider Statewide Average of CMAP Dental Federally Qualified Health Centers, Calendar Year 2014

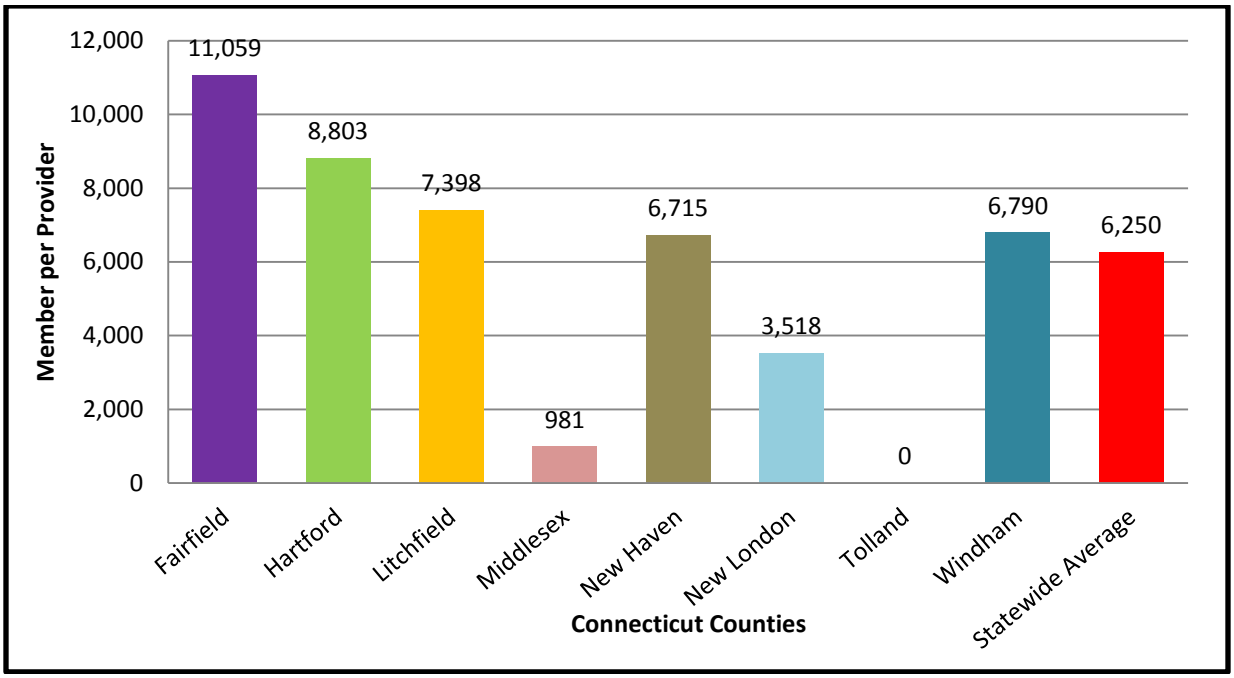


Figure 18 shows the number of members per provider in each county, within the category of Dental Federally Qualified Health Center (FQHCs) services of primary care. In the case of FQHCs, the number of performing providers is accounted for per site of service. The statewide average ratio is about 6,205 members per provider, with individual county numbers ranging from 0 to 11,059. New Haven County has a ratio that is the closest to the statewide average of 6,715. Fairfield, Hartford and Litchfield counties have the highest ratios, due to the low number of FQHC service sites within those counties. In comparison, Middlesex County had 981 members at one service site in calendar year 2014. The Tolland County had no FQHC service sites, therefore, had the ratio of 0.

Table 18: Counts of CMAP Behavioral Health Independent Practitioners, Calendar Years 2013 through 2015

Behavioral Health-Independent Practitioners	**Statewide Performing Provider Count**		
Provider County Description MAP	**Calendar Year 2013**	**Calendar Year 2014**	**Calendar Year 2015**
Fairfield	334	450	569
Hartford	539	699	886
Litchfield	71	91	110
Middlesex	103	171	210
New Haven	515	649	872
New London	191	255	322
Tolland	107	110	135
Windham	48	54	75
Total Performing Providers	1,908	2,479	3,179

**BH Independent Practitioners include psychologist, psychiatrists, LCSW, LMFT, LPC, drug and alcohol counselors, APRNs and physicians (including groups), and board-certified behavioral analyst (BCBA).*

Table 19: Counts of CMAP Behavioral Health Clinics, Calendar Years 2013 through 2015

	Statewide Performing Provider Count		
Provider County Description MAP	**Calendar Year 2013**	**Calendar Year 2014**	**Calendar Year 2015**
Fairfield	178	174	176
Hartford	113	162	185
Litchfield	33	41	55
Middlesex	10	39	37
New Haven	180	246	245
New London	48	54	42
Tolland	31	33	38
Windham	31	26	40
Total Performing Providers	624	775	818

**BH clinics include methadone clinics, medical clinics and behavioral health clinics*

Table 20: Counts of CMAP Behavioral Health Enhanced Care Clinics, CY 2013 – 2015

Behavioral Health-Enhanced Care Clinics (ECC)	**Statewide Performing Provider Count**		
Provider County Description MAP	**Calendar Year 2013**	**Calendar Year 2014**	**Calendar Year 2015**
Fairfield	21	39	45
Hartford	198	204	223
Litchfield	19	17	17
Middlesex	28	20	3
New Haven	157	156	111
New London	52	47	41
Tolland	9	8	11
Windham	26	3	2
Total Performing Providers	510	494	453

Figure 19: Members-to-Provider Ratio for CY2014 for Behavioral Health Services

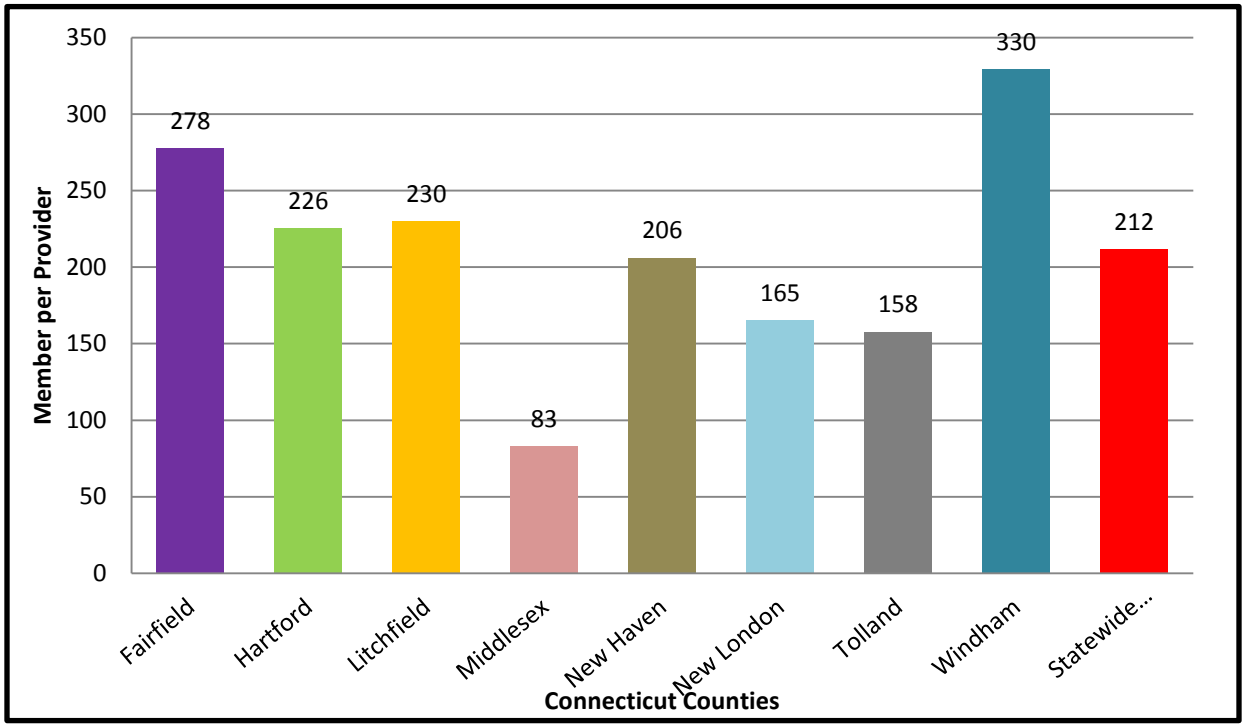


Figure 19 shows the number of members per provider in each county, within the category of Behavioral Health. The statewide average ratio is 212 members per provider, with ratios for individual counties ranging from 83 to 330. New Haven County has a ratio in close proximity to the statewide average. Windham County has the highest ratio at 330, due to the small number of behavioral health providers in that county. In comparison, Middlesex had an 83 ratio of members to providers in calendar year 2014, showing the greater availability of providers per members within that county.

Table 21: Counts of CMAP Behavioral Health Federally Qualified Health Centers, Calendar Years 2013 through 2015

Behavioral Health Federally Qualified Health Centers	**Statewide Performing Provider Count**		
Provider County Description	**Calendar Year 2013**	**Calendar Year 2014**	**Calendar Year 2015**
Fairfield	56	56	49
Hartford	33	38	38
Litchfield	11	9	11
Middlesex	106	112	118
New Haven	126	143	156
New London	66	83	80
Windham	20	17	20
Statewide Total Performing Providers	418	458	472

Fig. 20: Members-to-Provider Ratio by CMAP for Behavioral Health Federally Qualified Health Center, Calendar Year 2014

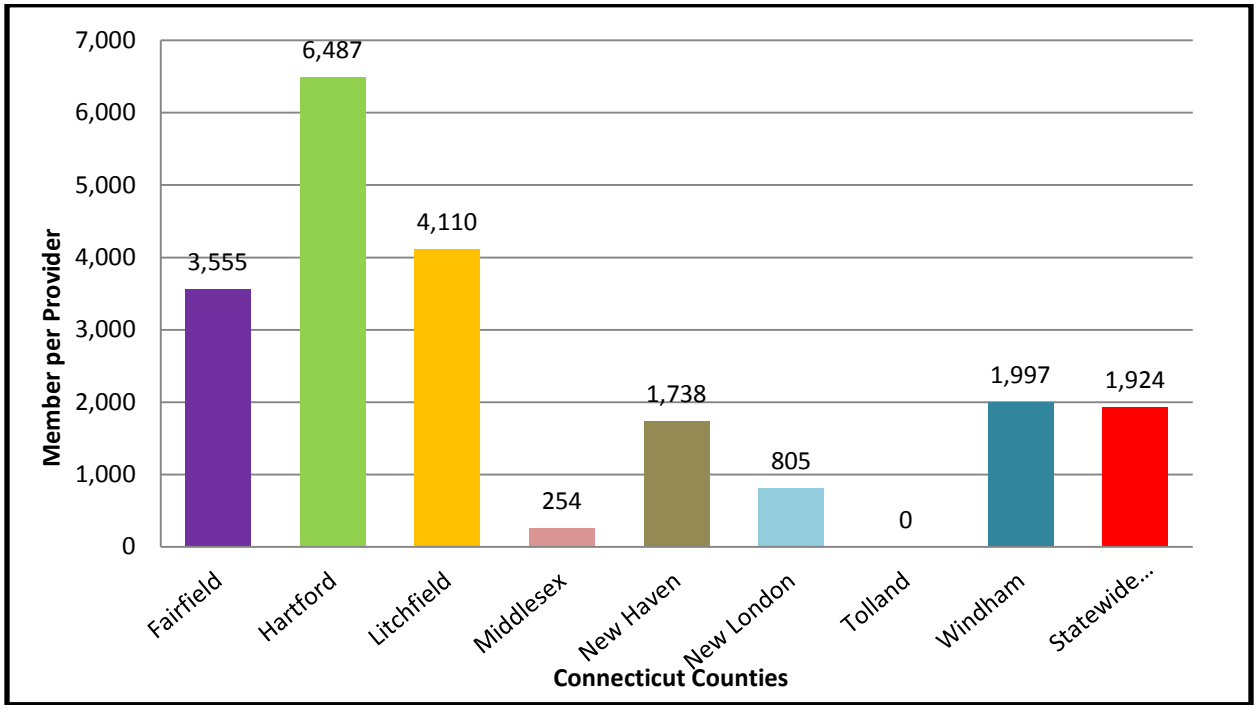


Figure 20 above shows the number of members per provider in each county, in the category of Behavioral Health Federally Qualified Health Center (FQHCs) services. In the case of BH FQHCs, the number of performing providers is counted per site of service. From the data presented, the statewide average ratio is about 1,924 members to one provider, ranging from 0 to 6,487. Windham County has a ratio of 1,997, the closest to the statewide average, Fairfield, Hartford and Litchfield Counties have higher ratios, due to the low number of BH FQHC service

sites within those counties. However, services are available from other BH providers in those counties. In comparison, Middlesex County had 254 members per one service site in calendar year 2014. Tolland County had no FQHC service site, therefore, had the ratio of 0. However, other behavioral health services are available to members in that rural county.

Table 22: Counts of CMAP Prenatal and Postnatal Obstetric Care, CY 2013 through 2015

PRENATAL AND POSTNATAL OBSTETRIC CARE	Statewide Performing Provider Count		
Provider County Description	**Calendar Year 2013**	**Calendar Year 2014**	**Calendar Year 2015**
Fairfield	3,211	3,238	2,980
Hartford	9,372	9,534	9,809
Litchfield	244	254	294
Middlesex	243	302	350
New Haven	3,693	4,368	4,355
New London	597	616	666
Tolland	201	90	63
Windham	343	321	389
Statewide Total Performing Providers	17, 904	18,723	18,906

Figure 21: Members-to-Provider Ratio by CMAP for CY2014 for Prenatal and Postnatal Obstetrics

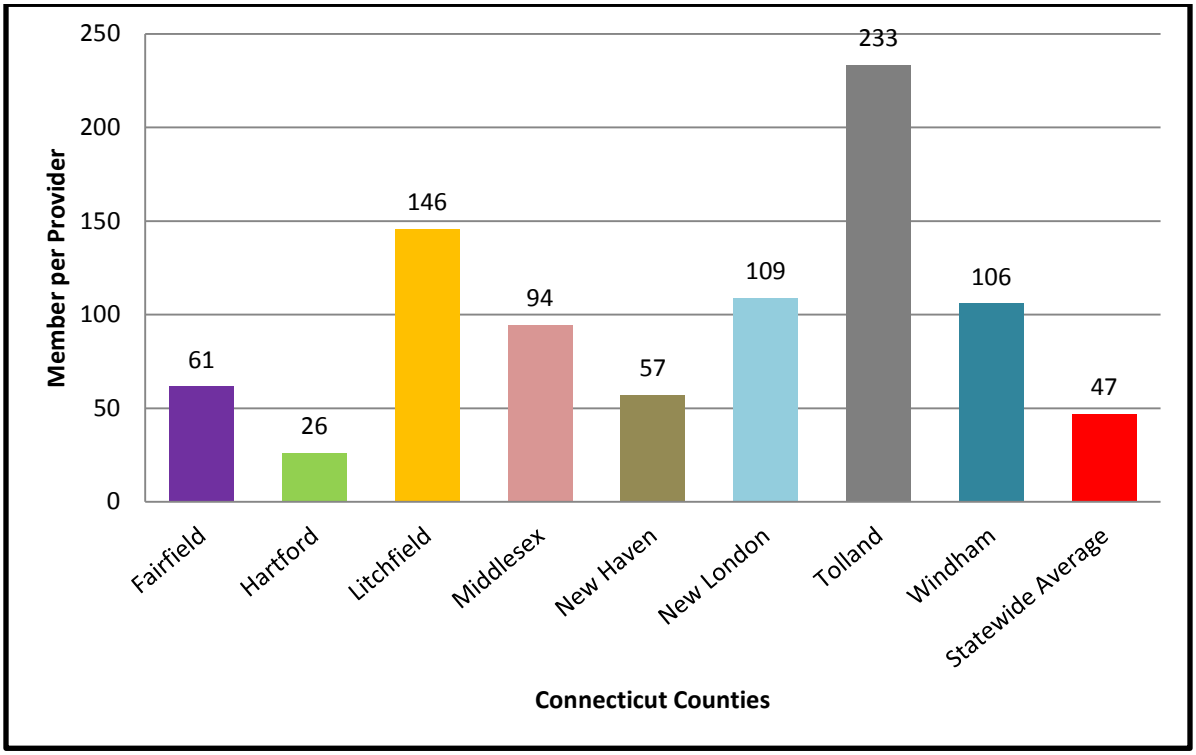


Figure 21 shows the number of members per provider in each county, in the category of prenatal and postnatal obstetrics. For this particular graph, we included the age range of the

recipient from ages fifteen (15) to forty-four (44). This rand of child-bearing year for women was referenced from, data found from the 2015 "National Vital Statistics Reports, Births: Final Data for 2014", created by the Center for Disease Control and Prevention (http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12.pdf). The statewide average ratio is 47 members per one provider, with ratios for individual counties ranging from 26 to 233. New Haven County had a ratio of 56, which is in close proximity to the statewide average of 47. The counties of Litchfield and Tolland had the fewest prenatal and postnatal obstetric providers per member. Hartford County had the greatest availability of providers per members, with a ratio of 26 members per one provider in calendar year 2014.

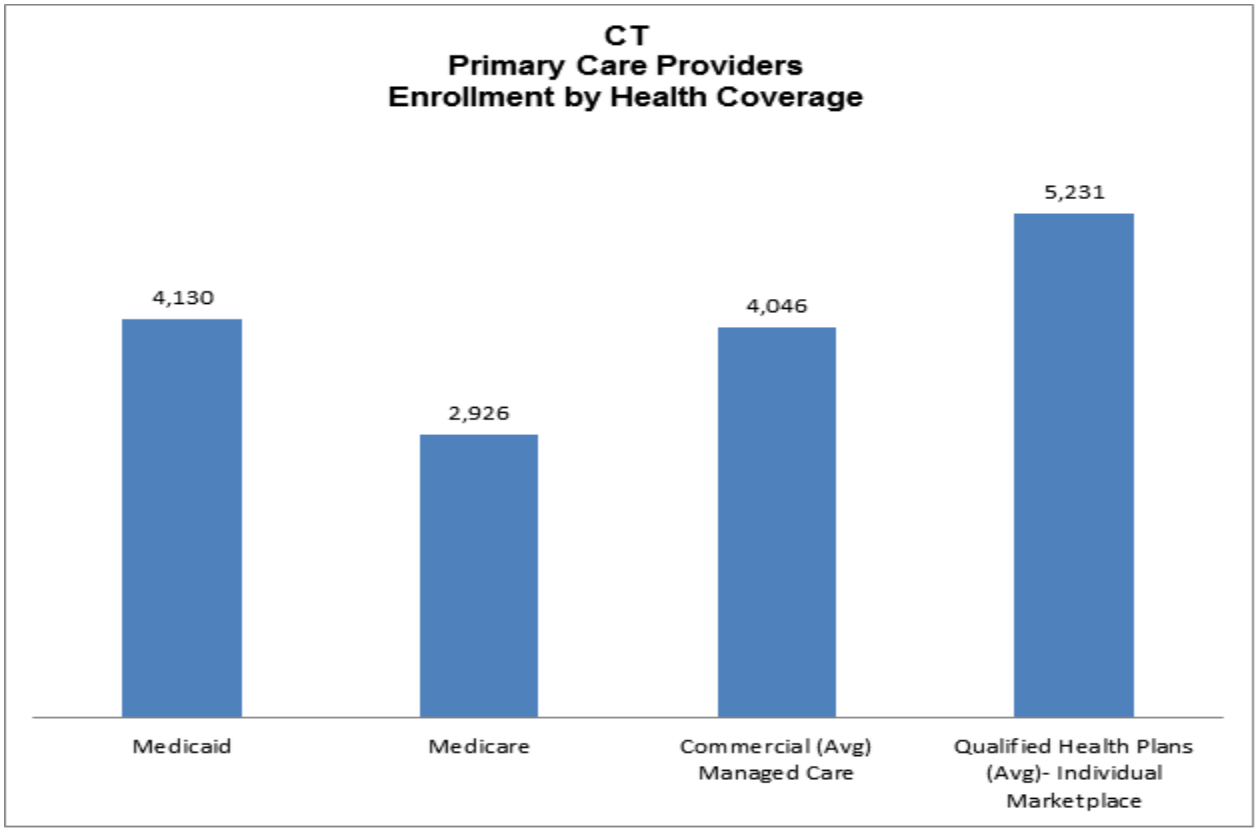
Overall, as the previous figures and tables show, there was adequate availability of providers for CMAP members throughout Connecticut in calendar year 2014. As shown, Windham and Litchfield counties have the higher member per provider ratio levels expected, due to the lower incidence of members within those areas. According to a report entitled, "State Standards for Access to Care in Medicaid Managed Care" by the Department of Health and Human Services (2014), for twenty states surveyed, the standard required minimum number of primary care providers ranged from one provider for every 100 members to one provider for every 2,500 (https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf). The CMAP program exceeds these standards, with a statewide average of one provider to fifty members. CMAP prioritizes enrollment of a sufficient number of health care providers to ensure member access.

Provider Network Comparative Analysis with Other Plans

DSS compared the numbers of the Connecticut primary care providers (PCPs) enrolled in CMAP to the CT PCPs enrolled in Medicare as well as those enrolled in CT commercial Health Maintenance Organizations (HMOs) and in CT commercial indemnity plans. Comparison of the CMAP enrolled primary care providers to the other CT provider networks shows a robust network of primary care providers available to CMAP members. Based on the available data, Connecticut can identify provider specialties within those enrolled as CMAP PCPs, as well as the total number of Medicare PCPs, but does not have information on the number of Connecticut PCPs reported by the commercial health plans. Commercial health plans defined PCP, as physicians practicing general internal medicine, general practice, family practice, and general pediatrics.

Further, DSS did not compare the number of CMAP enrolled primary care providers to the number of PCPs reported by the state's health insurance exchange, Access Health CT. The state could not determine which provider types were included in the number of PCPs that was provided by Access Health CT, and was able unable to determine if that number represented an unduplicated count of providers, because some may practice in multiple locations.

Fig. 22. Number of Primary Care Providers by Health Coverage CY 2014



Reference:

- **Medicaid** data was obtained from the CT Department of Socials Services Business Objects Data Warehouse. The data reflects all providers captured in the claims universe for the calendar year 2014 dates of service.

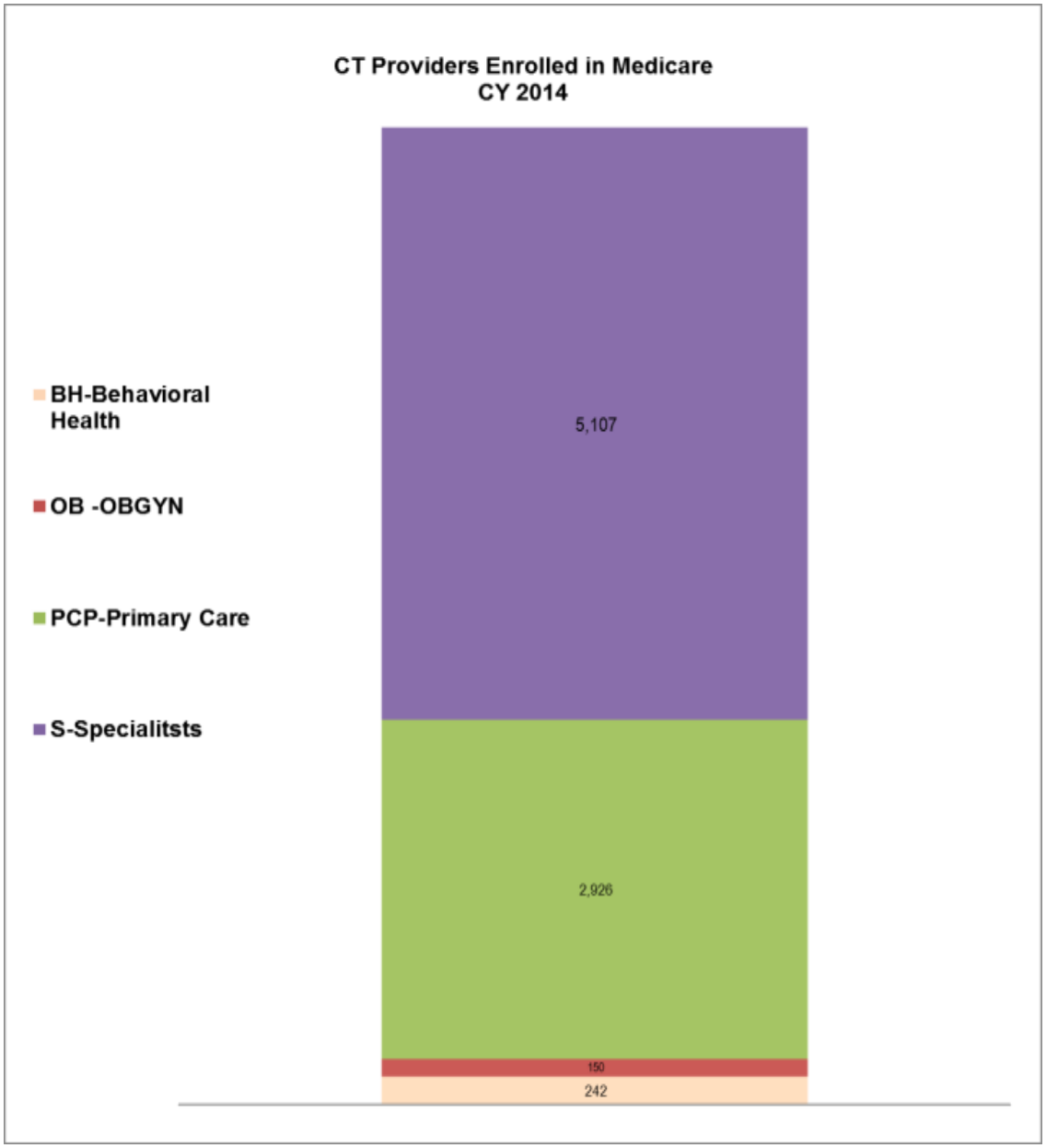
- **Medicare** data was obtained from the Centers for Medicare & Medicaid Services (CMS)public data set, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File: Medicare Physician and Other Supplier Data CY 2014. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html

- **Qualified Health Plans-Individual Marketplace** data was obtained from the October 2014 presentation to the AHCT BOD regarding network adequacy; http://www.ct.gov/hix/lib/hix/PM_NtwkAcessOverview_20141018.pdf

- **Commercial Health Maintenance Organizations** data was obtained from the Consumer Report Card on Health Insurance Carriers in Connecticut, published in October 2014 by the Connecticut Department of Insurance. http://www.ct.gov/cid/cwp/view.asp?q=390172#ManageCare

- **CT Providers enrolled in Medicare** data sets were extracted from CMS's National Claims History (NCH) Standard Analytic Files (SAFs) as the primary data source.

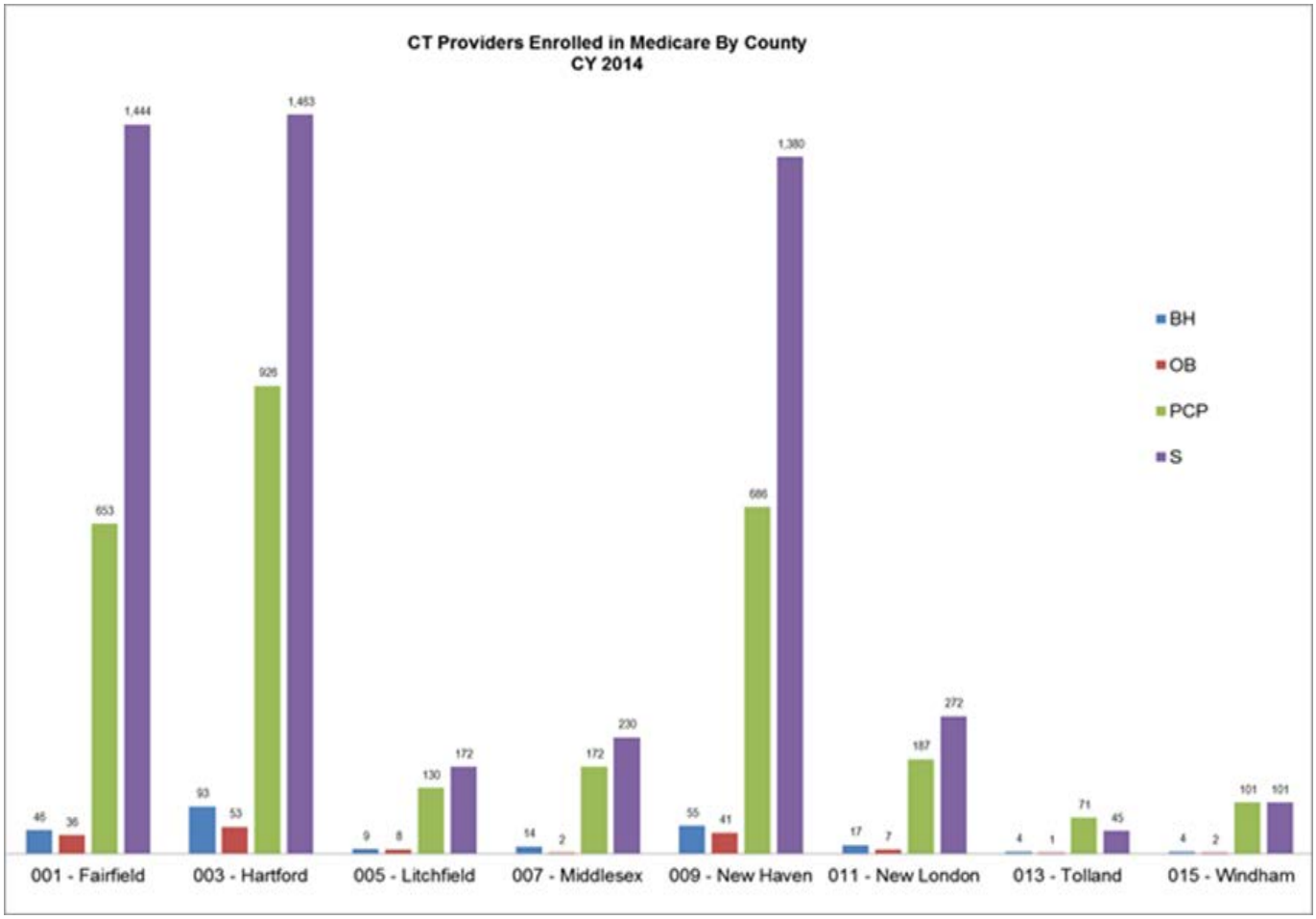
Fig. 23 CT Providers Enrolled in Medicare



The following providers' specialties/types were included in the CT Medicare data set: BH=Behavioral Health; S=Specialist; PCP= Primary Care Provider; OB=OBGYN. Provider specialties not included in the Medicaid Access Monitoring Review Plan or not covered under CT State Plan were not included in the CT Medicare data set.

Connecticut data set of providers enrolled in Medicare includes providers identified as individuals accepting Medicare fees. The provider's zip code was used to designate Medicare providers by Connecticut County.

Figure 24. CT Providers Enrolled in Medicare by County CY 2014



Reference: Medicare data was obtained from Medicare claim data provided by the Centers for Medicare and Medicaid's (CMS) Medicare's National Claims History (NCH) Standard Analytical Files (SAF); Medicare data include claims with dates of service in calendar year 2014 and accreted to the NCH as of 6/30/2014 and contain 100%of Medicare final action claims for members who are enrolled in the Medicare FFS program.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier2014.html

Table 23: Providers' specialties/types included in the CT Medicare data set

Table of Medicare Provider Specialties included in the AWRP Data Set	
PCP	**Behavioral Health**
Family Practice	Clinical Psychologist
General Practice	Geriatric Psychiatry
Geriatric Medicine	Licensed Clinical Social Worker
Internal Medicine	Psychiatry
Nurse Practitioner	Psychologist (billing independently)
Pediatric Medicine	
Physician Assistant	**OB/GYN**
Preventive Medicine	Certified Nurse Midwife
	Obstetrics/Gynecology
Specialists	
Allergy/Immunology	Neurology
Anesthesiology	Neurosurgery
Cardiac Surgery	Nuclear Medicine
Cardiology	Ophthalmology
Colorectal Surgery (formerly proctology)	Oral Surgery (dentists only)
Critical Care (Intensivists)	Orthopedic Surgery
CRNA	Osteopathic Manipulative Medicine
Dermatology	Otolaryngology
Diagnostic Radiology	Pain Management
Emergency Medicine	Pathology
Endocrinology	Physical Medicine and Rehabilitation
Gastroenterology	Plastic and Reconstructive Surgery
General Surgery	Pulmonary Disease
Hematology	Rheumatology
Infectious Disease	Sleep Medicine
Maxillofacial Surgery	Sports Medicine
Multispecialty Clinic/Group Practice	Thoracic Surgery
Nephrology	Urology

Rate Comparison: Analysis of CMAP Reimbursement Compared to Medicare and Other States' Medicaid Programs

CMAP utilizes a range of payment methodologies for covered services. For many services, the program uses Medicare rates as the basis for calculating CMAP reimbursement. The current physician fee schedule, which reimburses for services rendered by actively enrolled physicians, advanced practice registered nurses (APRNs), certified nurse midwives (CNMs), and physician assistants (PAs), contains various rate types that, in combination with other specific criteria, reimburse a set of services at a percentage of the Medicare fee schedule. The majority of adult general medicine and surgical fees are set at approximately 57.5% of the 2007 Medicare physician fee schedule (participating, non-facility). Exceptions to the 57.5% of 2007 Medicare include:

(1) dialysis services, which are reimbursed at approximately 92-94% of Medicare;
(2) physician administered drugs, biologics, vaccines and toxoids, which are reimbursed at 100% of the April 2013 Medicare Drug Pricing File;
(3) fees for obstetric services, which are reimbursed at approximately 145% of the 2007 Medicare fee schedule; and,
(4) pediatric fees, which are set at approximately 85% of 2007 Medicare. Pediatric well-child visits are set at a fixed uniform fee. Payment at the obstetric and pediatric rates is based on the billing provider type and specialty, as well as member age for pediatric services and member gender for obstetric services.

The following provider types are reimbursed at 90% of the physician fee schedule within their scope of practice: APRNs, CNMs, and PAs.

The above fees are not typically updated to reflect changes to the Medicare fee schedule. Instead, updates are dependent on a number of factors, including the funding appropriated by the Connecticut General Assembly to Medicaid as part of the state budget.

Over the years, CMAP has continued to develop and seek support for various initiatives designed to improve and support access to care for covered services, such as:

- implementation of the ACA Increased Payments for primary care services at 100% of specified Medicare reimbursement levels for specified years (in accordance Section 1202 of the Affordable Care Act), which has subsequently been extended by CMAP for a smaller subset of codes focusing on community-based primary care services and renamed "HUSKY Health Increased Payments for Primary Care Services";

- the Person Centered Medical Homes (PCMH) program, which was implemented January 1, 2012 and provides enhanced fee-for-service payments to primary care practices that have received recognition from the National Committee for Quality Assurance (NCQA), as well as performance and year-over-year improvement payments;

- implementation of strategies designed to improve access to community-based services for individuals with behavioral health conditions, including expansion of coverage for services provided by licensed behavioral health clinicians in independent practice to individuals of all ages (previously covered only for individuals under age 21) and implementation of a Behavioral Health Home program pursuant to section 1945 of the Social Security Act for specified individuals with severe and persistent mental illness;

- implementation of strategies designed to improve access to community-based services, including for individuals those who are transitioning from institutional environments to the community, such as the Money Follows the Person Project and the Community First Choice program under section 1915(k) of the Social Security Act;

- implementation of additional methods of providing home health medication administration services including: coverage for electronic medication administration devices ("med boxes"); coverage for nurse delegation of medication administration to certified home health aides; and coverage for home health aide prompting of medication administration; and,

- implementation of a telemedicine program (e-consults) in Federally Qualified Health Centers to promote access to specialists' services.

The following is a comparative rate analysis of the five most heavily utilized procedure codes for primary care services, medical clinics, obstetrical services, behavioral health, physician specialist, and dental primary care services. This analysis compares CMAP fee-for-service rates, to equivalent reimbursement amounts paid through Medicare and amounts paid by neighboring Medicaid programs in New York and Massachusetts. These programs were chosen because they are neighboring states with similar coverage and population needs compared to other surrounding states, especially in the New England area. Due to reimbursement methods for specific providers, this analysis does not contain provider types for which an accurate rate comparison could not be conducted (e.g., home health providers, hospitals). The reimbursement analysis was only performed when reimbursement component parts were similar in service performed, performing practitioner, rate structure, and location of service.

A comparison to rates reimbursed under commercial insurance plans was not conducted due to DSS' inability to obtain commercial rate information, primarily because commercial plans consider such information proprietary. Connecticut reached out several times to key agencies, including the Connecticut State Comptroller's Office, which is responsible for administering health benefits for State of Connecticut employees, and the Connecticut Department of Insurance, to obtain commercial rate information. However, attempts at acquiring this information were unsuccessful. If, in the future, the State is able to obtain information pertaining to commercial rates, even as an aggregate percentage, the analysis will be updated.

The analysis focused on fee-for-service procedure codes, and services that are primary care in nature. Routine services like vaccine administration, and laboratory testing were excluded from the analysis due to significant differences in how these services are reimbursed under CMAP compared to Medicare and neighboring states' Medicaid programs.

The State queried the Medicaid Management Information System (MMIS) to identify the five most utilized procedure codes. Query conditions focused on calendar year 2014, units of service with a threshold over 1,000, and in-state paid claims only. Each rate analysis section contains a methodology description, equivalent rate comparison, and procedure code information. Connecticut reimbursement rates used in the analysis are from the Connecticut 2014 fee schedule Affordable Care Act (ACA) Section 1202 Increased Payments for Services Furnished by Certain Primary Care Physicians, and other corresponding fee schedules. For example, dental reimbursement rates are located on the dental fee schedule, and services performed in the medical clinic correspond to the medical clinic fee schedule.

In most cases, the Connecticut Medicaid/Medicare rate analysis uses the 2014 Medicare rate type 'Non-facility, participating provider' (NON FAC PAR) for comparison. Medicare defines this rate type as an "allowance for participating physician or non-physician practitioner when services are performed in a non-facility setting". Medicare and neighboring states may not pay for all services covered by CMAP. Therefore, a direct comparison was not always possible. In order to maintain an accurate picture of access as directly related to utilization of the services under CMAP, alternate services for the services not covered under Medicare and the neighboring Medicaid programs were not chosen. The rate column will feature 'NA' (Not Applicable), when a direct rate analysis could not be conducted.

To establish a direct comparison between Connecticut and Massachusetts Medicaid, the demonstration features reimbursement for services covered under MassHealth ACA Section 1202, General Provision Code of Massachusetts Regulations (CMR) 317 (Medicine), Massachusetts surgical fee schedule, and the mental health clinic fee schedule. Each rate demonstration will feature the appropriate fee schedule.

New York's rate comparison features locality specific fees from New York's Primary Care Rate Increase (PCRI) fee schedule under ACA Section 1202. Since Connecticut rates do not have geographic adjustors, New York's various locality specific rates were averaged to compute a single rate for comparison purposes. The analysis also featured New York's NYS Medicaid Medicine Services Fee Schedule for clinic services and the NY Psychologist Fee Schedule for behavioral health services. Each rate demonstration section features the appropriate fee schedule.

Results show that, of the services featured in this analysis (primary care services, medical clinics, obstetrical services, behavioral health, physician specialist, and dental primary care services), Connecticut pays ***equal to or higher*** than ***50%*** of the services covered by Medicare; ***equal to or higher*** than ***79%*** of the services covered by New York; and ***equal to or higher*** than ***76%*** of the services covered by Massachusetts. Additionally, Connecticut reimburses for ***36% more*** services than under the Medicare program, since Medicare does not cover dental care and pediatric well-child visits. Connecticut also covers ***3% more*** services (dental) than Massachusetts and ***3% more*** services (psychotherapy) than New York.

Primary Care Services Provided by Medical Clinics

Medical clinics provide medical or medically-related services for the diagnosis, treatment and care of persons with chronic or acute conditions. Services are typically preventive, diagnostic, or therapeutic. Services are provided to outpatients and furnished by or under the direction of a physician within a medical clinic setting and reimbursed under the Medical Clinic Fee Schedule. A majority of the medical clinics currently enrolled under the CMAP program are school based health centers (SBHC) that provide services during school hours, only to students enrolled with the SBHC, , and are operational during the designated school year. The services typically provided in the SBHC setting are vaccinations, evaluation and management services and routine behavioral health services.

For a direct rate comparison, Massachusetts reimbursement for services performed in the clinic setting is covered under MassHealth General Provision CMR 317. New York fees are provided in the clinic setting and are reimbursed under the NYS Medicaid Medicine Services Fee Schedule. Instead of using Medicare's facility rate type, the NON FAC PAR rate type is included in the demonstration. As noted above, because Connecticut medical clinic providers are

primarily SBHCs – and medical clinics are not acknowledged as a provider type reimbursed under Medicare – the NON FAC PAR rate was used as an equivalent for comparison purposes.

Results show that 82% of the most utilized primary care services delivered at medical clinics during CY 2014 were evaluation and management services (office visits) provided to established patients; the remaining 18% of evaluation and management services were provided to new patients. Connecticut's reimbursement for services provided at medical clinics average:

- 71% of Medicare
- 105% of Massachusetts
- 141% of New York

Table 24: Primary Care Services Provided by Medical Clinics

Code	Service	Share of Utilization	CT Clinic Rate	Medicare		Neighboring State Medicaid Fees			
				NON FAC Rate	% of Medicare	New York Rate	% of NY	Mass. Rate	% of MA
99213	Established patient office visit, 15min	46%	$52.15	$78.65	***66%***	$37.41	***139%***	$52.37	***100%***
99203	New patient office visit, 30min	18%	$80.65	$116.60	***69%***	$56.93	***142%***	$77.94	***103%***
99212	Established patient office visit, 10min	13%	$32.58	$47.36	***69%***	$23.48	***139%***	$31.87	***102%***
99211	Established patient office visit, 5min	12%	$18.14	$21.84	***83%***	$12.56	***144%***	$15.41	***118%***
99214	Established patient office visit 25min	11%	$78.94	$115.81	***68%***	$56.18	***141%***	$77.46	***102%***
		100%		***Average***	***71%***		***141%***		***105%***

This comparison shows that reimbursement under CMAP in the medical clinic setting is almost three-quarters the reimbursement for the same type of services under the Medicare program. Note as outlined above, since Medicare does not recognize "clinic" as a provider type, the Non-facility, office based participating provider Medicare rate was used for the comparison. The reimbursement under CMAP was more than the reimbursement provided by neighboring state Medicaid programs for medical clinic services.

Physician, APRN, PA – Primary Care Services Provided in the Office Setting

Under Connecticut Medicaid, primary care practitioners provide medical or medically related services for diagnosis, treatment and care of persons with chronic or acute conditions. Services are typically preventive, diagnostic, therapeutic, rehabilitative, or palliative.

Connecticut pays two rate types for primary care services – a standard rate (DEF or MPH) and for select services, a pediatric rate (PED). The analysis compares Connecticut's adult rate type to Massachusetts fees for primary care services covered under MassHealth ACA Section 1202. New York fees for PCRI services are locality specific under ACA Section 1202. New York's various locality specific rates were averaged to create a single rate to compare to Connecticut's adult rate.

For the purposes of this analysis, primary care services were analyzed based on paid claims submitted by the following provider types: physicians, advanced practice registered nurses, and physician assistants. Results show that 100% of the most utilized services under primary care were established patient evaluation and management office visits. Three out of the five procedure codes billed were for services rendered to members under the age of 11 (based on the specific procedure code descriptions), billing for these procedure codes accounted for 17% of the overall utilization of primary care service. The other 83% of overall utilization was for evaluation and management service procedure codes that do not differentiate the age of the patient. Since majority of the enrolled primary care providers in Connecticut have attested to qualify for the ACA Enhanced Primary Care Rates as prescribed under Section 1202 of the Affordable Care Act, and continuation of the policy after Section 1202 of the ACA expired on December 31, 2014, the following rate comparison will focus on a comparison between CT's ACA Enhanced Rate, Medicare, MassHealth and New York's ACA Enhanced Rates making the pediatric rate obsolete for the services commonly utilized under primary care. When compared to New York and Massachusetts Medicaid, CMAP's ACA Enhanced reimbursement for primary care services average:

- 104% of Massachusetts
- 99% of New York

Medicare does not cover three out of the five procedures that are specific to children. Of the two services Medicare does cover, Connecticut's adult ACA rate reimburses at 101% of the 2014 Medicare rate.

Table 25: Physician, APRN, PA - Primary Care Services										
Code	**Service**	**Share of Utilization**	**2014 CT ACA Rate**	**CT PED Rate**	**Medicare**		**Neighboring State Medicaid Fees**			
					NON FAC Rate	**% of Medicare**	**New York**	**% of NY**	**Mass.**	**% of MA**
99213	Est. patient office visit, 15min	52%	$79.19	$55.41	$78.65	***101%***	$80.08	***99%***	$76.38	***104%***
99214	Est. patient office visit 25 min	31%	$116.60	$83.87	$115.81	***101%***	$117.92	***99%***	$112.57	***104%***
99391	Est. patient preventive exam infant < 1 year	6%	$108.14	$93.60	NA		$109.33	***99%***	$104.43	***104%***
99392	Est. patient preventive exam, age 1-4	6%	$115.39	$93.60	NA		$116.71	***99%***	$111.40	***104%***
99393	Est. patient preventive exam, age 5-11	5%	$114.99	$93.60	NA		$116.30	***99%***	$111.01	***104%***
		100%					***Average***	***99%***		***104%***

Dental Primary Care

Primary care dental services are diagnostic, preventive, or restorative procedures performed by a licensed dentist in a private or group practice. Connecticut's dental fee schedule reimburses for services rendered to adult members at 52% of the rate reimbursed for services rendered to the pediatric population. On the CT Dental Fee Schedule, the pediatric population is defined as members under the age of 21.

Since Medicare does not pay for dental services, the rate analysis features New York and Massachusetts Medicaid only. Like Connecticut, Massachusetts reimburses separately for adults and children (Allowed Fee for adults and Early and Periodic Screening, Diagnostic and Treatment EPSDT for children under age 21). The rate analysis between Connecticut and Massachusetts compares adult-to-adult and child-to-child rate types. New York pays a single dental service fee that is applicable to both children and adults. For direct rate analysis purposes, Connecticut's rate for children was compared to New York's single rate.

Results show that Connecticut covers more dental services than Massachusetts. While both New York and Connecticut pay for topical application of fluoride (D1208), Connecticut pays 207% more for this service.
Connecticut's reimbursement for primary care dental services average:

- 154% of New York
- 105% of Massachusetts EPSDT (child) rate type

- 77% of Massachusetts Allowed Fee (adult) rate type

Table 26: Dental Primary Care

Code	Service	Share of Utilization	CT Child Rate	CT Adult Rate	Neighboring State Medicaid Fees					
					New York	% of NY	Mass. Allowed Fee	% of Allowed Fee	Mass. EPSDT	% of EPSDT
D0120	Periodic oral evaluation est patient	25%	$35	$18.20	$25	***140%***	$20	***91%***	$29	***121%***
D1120	Prophylaxis-child	23%	$46	$23.92	$43	***107%***	$36	***66%***	$51	***90%***
D1208	Topical application of fluoride	22%	$29	$15.08	$14	***207%***	NA		NA	
D1351	Sealant-per tooth	18%	$40	$20.80	$35	***114%***	$28	***74%***	$41	***98%***
D0274	Bitewings - four radiographic images	11%	$48	$24.96	$24	***200%***	$33	***76%***	$43	***112%***
		100%		***Average***		***154%***		***77%***		***105%***

Physician Specialist Services

Physician specialist's services include services rendered by physicians, physician groups, advanced practice registered nurses, advanced practice registered nurse groups, and physician assistants. CMAP reimbursement rates for physician specialist services are listed on the Physician Surgical Fee Schedule located on the CT Medical Assistance Program Website. Massachusetts fees for specialist services are covered under MassHealth General Provision 101 CMR 317 fee schedule. New York services for specialists are reimbursed under the NYS Medicaid Medicine Services Fee Schedule.

Calendar year 2014 results show that new patient evaluation and management (E&M) office visits accounted for approximately 18% of the services provided; while 69% of utilization was for an established patient E&M office visit. Thirteen percent of the total utilization was provided to members for services subsequent to hospital care for a procedure or hospital admission. Connecticut's reimbursement for specialist services average:

- 55% of Medicare
- 82% of Massachusetts
- 123% of New York

Table 27: Physician Specialists									
Code	**Service**	**Share of Utili-zation**	**CT DEF Rate**	**Medicare**		**Neighboring State Medicaid Fees**			
				NON FAC Rate	**% of Medicare**	**New York**	**% of NY**	**Mass.**	**% of MA**
99213	Est. patient office visit 15 min	38%	$42.93	$78.65	***55%***	$37.41	***115%***	$52.37	***82%***
99214	Est. patient office visit 25 min	31%	$64.99	$115.81	***56%***	$56.18	***116%***	$77.46	***84%***
99232	Subsequen t hospital inpatient care, 25 min	13%	$39.25	$76.51	***51%***	$26.01	***151%***	$51.02	***77%***
99203	New patient visit, 30 min	10%	$66.40	$116.60	***57%***	$56.93	***117%***	$77.94	***85%***
99204	New patient visit, 45 min	8%	$100.17	$178.42	***56%***	$86.41	***116%***	$118.82	***84%***
		100%		***Average***	***55%***		***123%***		***82%***

Behavioral Health Services – Office Setting

Behavioral health services (including substance abuse services) are reimbursed in a variety of settings under CMAP including independent office, outpatient hospital, free standing behavioral health clinic, and methadone maintenance facility. Since the difference in coverage and reimbursement methodologies under Medicare and neighboring Medicaid agencies is too vast for a meaningful comparison, the analysis will focus on behavioral health services performed in the independent practice office setting only.

Behavioral health services performed in the office setting may receive reimbursement for services from the Physician Office & Outpatient Service Fee Schedule. This fee schedule features a default rate (DEF) as the primary reimbursement payment. Connecticut pays different reimbursement amounts based on the education level of the practitioner providing the service. For example, psychiatrists are reimbursed at 100% of the CMAP physician fee schedule, psychiatric APRNs are reimbursed at 90% of the CMAP physician rate. Psychologists are reimbursed approximately 85% of the CMAP physician rate, while licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed alcohol and drug counselors are reimbursed at approximately 70% of the CMAP physician rate.

For analysis purposes, the full reimbursement rate (DEF) will be compared to the full reimbursement rate for the same service provided by Massachusetts and New York. Medicare is left out of this comparison since there is no equitable rate comparison to Connecticut's reimbursement amounts.

Massachusetts fees for behavioral health services are covered under the MassHealth General Provision 101 CMR 317 fee schedule. New York reimbursement rates are featured on the Clinical Psychology Procedure Codes & Fee Schedule.

Results show Connecticut pays for more behavioral health services than New York for reimbursement under the highest reimbursement amount. Connecticut also covers a higher reimbursement amount than Massachusetts.

- 139% of Massachusetts
- 144% of New York

Table 28: Behavioral Health Services - Office Setting

Code	Service	Share of Utilization	CT Rate	Neighboring State Medicaid Fees			
				New York	% of NY	Mass.	% of MA
90837	Psychotherapy, 60min	43%	$135.19	$72.35	***187%***	$90.29	***150%***
90834	Psychotherapy, 45min	27%	$90.17	$46.46	***194%***	$61.81	***146%***
90853	Group psychotherapy	12%	$34.13	$18.67	***183%***	$23.76	***144%***
90847	Family psychotherapy	12%	$109.60	NA	***0%***	$77.28	***142%***
90791	Psychiatric diagnostic evaluation	6%	$147.50	$93.26	***158%***	$117.42	***126%***
		100%	***Average***		***144%***		***139%***

Physician, Mid-Wives, PA - OB Services

The most common reimbursement methodology for obstetrical (OB) services used by Connecticut is a global fee for all the OB services provided to a member. The global fee is paid through the physician surgical fee schedule. The global fee includes reimbursement for all routine prenatal visits, professional delivery services, and the postpartum care bundled into one rate. In the event that a provider does not render all of the components to be eligible for the global payment, the provider is expected to bill for the portion of the care that was provided, (i.e. vaginal delivery CPT code - 59409, cesarean delivery CPT code - 59514) and the applicable rate will be reimbursed based on the physician surgical fee schedule. Additionally some services are eligible for reimbursement in addition to the global payment, such as fetal non-

stress testing (59025). For purposes of this rate analysis, all of the OB fees were derived from the physician surgical fee schedule.

New York's obstetrical fees are listed on the New York State MOMS Fee Schedule, except for the global caesarian service (59510), which is featured on New York's surgical fee schedule. Like Connecticut, Massachusetts lists most of the OB services in a surgical fee schedule.

Connecticut pays higher rates of reimbursement for OB services compared to Medicare and neighboring states. Connecticut's reimbursement for OB services average:

- 122% of Medicare
- 133% of Massachusetts
- 140% of New York

Table 29: Physician, Mid-Wives, PA - OB Services

Code	Service	Share of Utilization	CT Rate	Medicare		Neighboring State Medicaid Fees			
				NON FAC Rate	% of Medicare	NY	% of NY	Mass.	% of MA
59025	Fetal non-stress test	65%	$66.24	$54.06	***123%***	$70.00	***95%***	$48.01	***138%***
59400	Obstetrical pre- & postpartum care & vaginal delivery	14%	$2612.33	$2334.25	***112%***	$1462.64	***179%***	$2045.18	***128%***
59510	Cesarean delivery with pre & post-delivery care	7%	$2950.61	$2593.23	***114%***	$1948.09	***151%***	$2309.68	***128%***
59514	Cesarean delivery	7%	$1375.77	$1025.14	***134%***	$974.28	***141%***	$1006.12	***137%***
59409	Vaginal delivery	7%	$1164.31	$908.98	***128%***	$883.00	***132%***	$851.74	***137%***
		100%		**Average**	***122%***		***140%***		***133%***

Access Analysis by Category: Utilization Trends CYs 2013 - 2015

In order to fulfill the scope of Access Monitoring Review Plan, Connecticut Medicaid established baseline utilization targets for three general categories, *Medical Primary Care, Dental Primary Care and Behavioral Health Care services,* to identify any variance among members by geographical areas. Additionally, DSS analyzed pre-and post-natal services and home health services utilization for CT members. The utilization patterns were examined for CMAP members of age group 21 years and above (Adult) vs. age 0 to 20 (Child) in each of the eight counties for calendar years (CYs) – 2013, 2014 and 2015. The rate of access to service is the percent of members who had at least one visit during a year to the total number of unduplicated members in the same age category residing in each county. Additionally, utilization of service patterns was examined by benefit plan (HUSKY A, C & D). Members who received services from out-of-state providers and those with unknown residences at the time of service were excluded from the analysis. However, the statewide averages reflect all of the members enrolled in each year. Members are the unduplicated HUSKY A, C and D members enrolled in CMAP during each calendar year. All trends are based on administrative eligibility and claims data.

Primary Care Services

Medical Primary Care

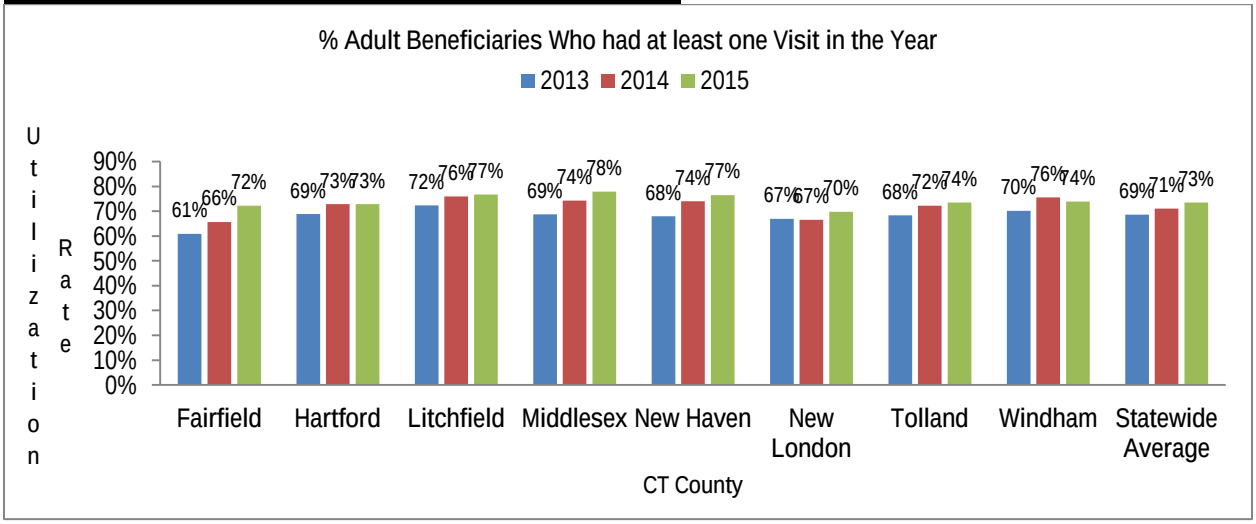
Utilization was assessed for adults and children by county for medical primary care services identified by specific procedure codes and provided by the following categories of providers: Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs and Hospital Outpatient Clinics.

Table 30: Distribution of Adult Utilization of Medical Primary Care Services by County: Provided by Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs and Hospital Outpatient Clinics, for CY2013 - CY2015

Beneficiary (Adult) County	2013		2014		2015	
	Total Number of Adults	% Who had at least one visit in CY	Total Number of Adults	% Who had at least one visit in CY	Total Number of Adults	% Who had at least one visit in CY
Fairfield	90,976	60.8%	111,508	65.7%	126,411	72.2%
Hartford	129,246	68.8%	147,416	72.9%	162,083	72.8%
Litchfield	18,924	72.4%	22,773	75.9%	25,134	76.7%
Middlesex	15,267	68.7%	18,101	74.3%	20,076	77.9%
New Haven	126,987	68.0%	146,255	74.0%	160,963	76.5%
New London	35,513	67.0%	40,297	66.6%	44,124	69.8%
Tolland	10,393	68.4%	12,579	72.3%	14,195	73.6%
Windham	17,971	70.1%	20,132	75.6%	21,942	73.9%
Statewide	430,919	68.6%	517,214	70.6%	573,682	73.5%

Source: CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Fig. 25: Rate of Adult Utilization of Medical Primary Care Services by County, Provided by Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs and Hospital Outpatient Clinics, for CY2013 - CY2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with date of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

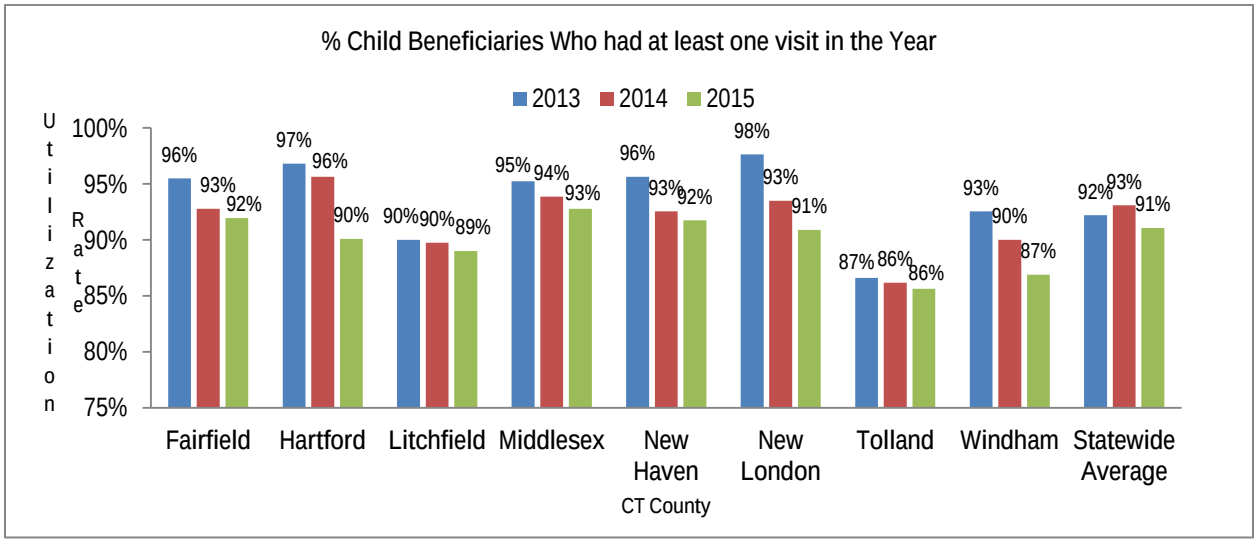
For adult beneficiaries (age 21 and above), the statewide rate of access (the percentage of adult beneficiaries who made at least one visit to a medical primary care provider in a year) increased consistently at an annual average of 2% from CY 2013 to CY 2015 (see Table 30 and Figure 25 above). For all counties, except Windham County which showed a slight decrease between CY 2014 and 2015, showed an increase in utilization over the 3 year time period analyzed. This trend, which on average was a 2% increase over time, showed that Connecticut adult members were able to access medical primary care services over the 3 years. It should be noted that the some of the larger percent increases in utilization between calendar years occurred between CY 2013 and 2014. CMAP implemented the ACA Enhanced Primary Care Rates as prescribed under Section 1202 of the Affordable Care Act, for years 2013 through 2014 and implemented a policy for the continuation of an enhanced payment for community based primary care services after Section 1202 of the ACA expired on December 31, 2014. Implementation and continuation of this policy may have resulted in a positive impact on the adult beneficiaries' access to primary care services under CMAP.

Table 31: Distribution of Child Utilization of Medical Primary Care Services by County, provided by Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs, and Hospital Outpatient Clinics for CY 2013 to 2015

Member (Children) County	2013		2014		2015	
	Total Number of Children	% Who had at least one visit in CY	Total Number of Children	% Who had at least one visit in CY	Total Number of Children	% Who had at least one visit in CY
Fairfield	78,882	95.5%	87,906	92.8%	93,725	92.0%
Hartford	92,411	96.8%	99,955	95.6%	104,401	90.1%
Litchfield	13,323	90.0%	14,524	89.7%	15,065	89.0%
Middlesex	9,635	95.2%	10,497	93.9%	10,903	92.8%
New Haven	94,969	95.6%	102,872	92.6%	107,494	91.7%
New London	25,038	97.6%	27,193	93.5%	28,207	90.9%
Tolland	7,751	86.6%	8,535	86.2%	8,817	85.6%
Windham	13,124	92.5%	14,107	90.0%	14,639	86.9%
Statewide	347,164	92.2%	366,009	93.1%	383,310	91.0%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Fig. 26: Rate of Child Utilization of Medical Primary Care Services provided by Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs, and Hospital Outpatient Clinics, by County for CY 2013 to 2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

The statewide average rate of access to medical primary care for CMAP members age 0 to 20 increased from 92% in CY 2013 to 93% in CY 2014, but dropped to 91% in CY 2015 (Table 31 and Figure 26 above). As seen in the table and figure, each individual county showed a decline in utilization from year to year between 2013 and 2015 (with the exception of CYs 2013 and 2014 for Tolland County). Additionally, Tolland County is the only county that showed utilization rates consistently below 90% as compared to all other counties. Given that Tolland County has the lowest percent of CMAP members under the age of 21 years; it was not surprising to note

lower rates of utilization. Both adult and child utilization rates for medical primary care services in this analysis were either in-line with or slightly above the national Medicaid 50th percentile HEDIS measure rate for Adult's Access to Preventive/Ambulatory Health Services (in-line with the CY 2014 national HEDIS data) and Children and Adolescents' Access to Primary Care Practitioners respectively (slightly higher than the CY 2014 HEDIS National data). HEDIS data for CY 2015 was not available at the time of this analysis.

A specific reason(s) for the decline in utilization between calendar years among child beneficiaries across counties could not be identified within this analysis. It should be noted, however, that the services included in the definition of primary care include not only well-child visits (*i.e.*, preventive medicine visits), but also includes office visits for sick or injury-related diagnoses (*i.e.*, sick visits). A decline in the number of visits to a primary care provider cannot be viewed as a negative impact on access to care as without additional detailed information as to the types and reasons for visits (preventive versus sick visits). A decline in utilization based on a decline in the number of sick and injury related visits would be considered a positive impact on the overall care of CMAP child beneficiaries. The CMAP has a long-standing policy of enhanced reimbursement for select services (including primary care evaluation and management services) rendered to children (pediatric population under the age of 21). This reimbursement was in place prior and then superseded by the enhanced reimbursement provided under Section 1202 of the ACA and the modified continuation of the policy enacted by Section 1202 renamed as the HUSKY Health Primary Care Increased Payment Policy.

Table 32: Distribution of Utilization of Medical Primary Care Services by Benefit Plan, as provided by Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs, and Hospital Outpatient Clinics for CY 2013 to 2015

Benefit Plan (All Recipients)	CY 2013		CY 2014		CY 2015	
	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY
HUSKY A	516,784	84.8%	552,244	85.3%	578,963	80.8%
HUSKY C	118,105	40.6%	115,606	39.6%	112,387	38.8%
HUSKY D	143,195	69.8%	215,373	69.0%	265,643	64.6%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

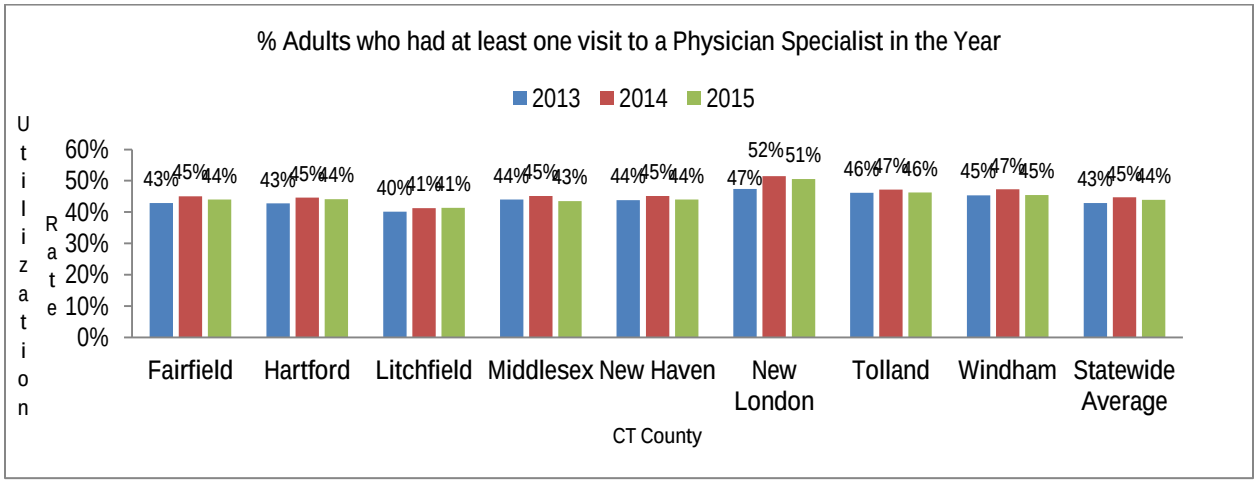
Physician Specialist Services

Table 33: Distribution of Adult Utilization of Physician Specialist Services - CY2013 - CY2015

Member (Adult) County	2013		2014		2015	
	Total Number of Adults	% Who had at least one visit in the CY	Total Number of Adult	% Who had at least one visit in the CY	Total Number of Adults	% Who had at least one visit in the CY
Fairfield	90,976	42.9%	111,508	45.1%	126,411	44.1%
Hartford	129,246	42.8%	147,416	44.6%	162,083	44.2%
Litchfield	18,924	40.2%	22,773	41.2%	25,134	41.4%
Middlesex	15,267	44.0%	18,101	45.1%	20,076	43.5%
New Haven	126,987	43.8%	146,255	45.1%	160,963	44.0%
New London	35,513	47.4%	40,297	51.5%	44,124	50.6%
Tolland	10,393	46.2%	12,579	47.2%	14,195	46.2%
Windham	17,971	45.4%	20,132	47.3%	21,942	45.5%
Statewide	430,919	44.4%	517,214	44.9%	573,682	44.1%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Figure 27: Rate of Adult Utilization of Physician Specialist Services – CY 2013-2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Utilization of specialist services was queried based on a provider type and specialty not identified as a primary care, behavioral health, obstetric or home health provider, since these providers are analyzed under their respective category of care as specified in the final rule. The percentage of adult beneficiaries who received service from one of the selected specialist providers at least once during a calendar year remained consistently between 40% and 52% across all eight counties. New London County appears to have had the highest percentages (49% to 52%) of adult beneficiaries who had at least one visit with a specialist in the three year period, Tables 33 and Figure 27 above. Given the wide range of specialist services captured by this analysis, the relatively stable utilization rates, the lack of unresolved access to care

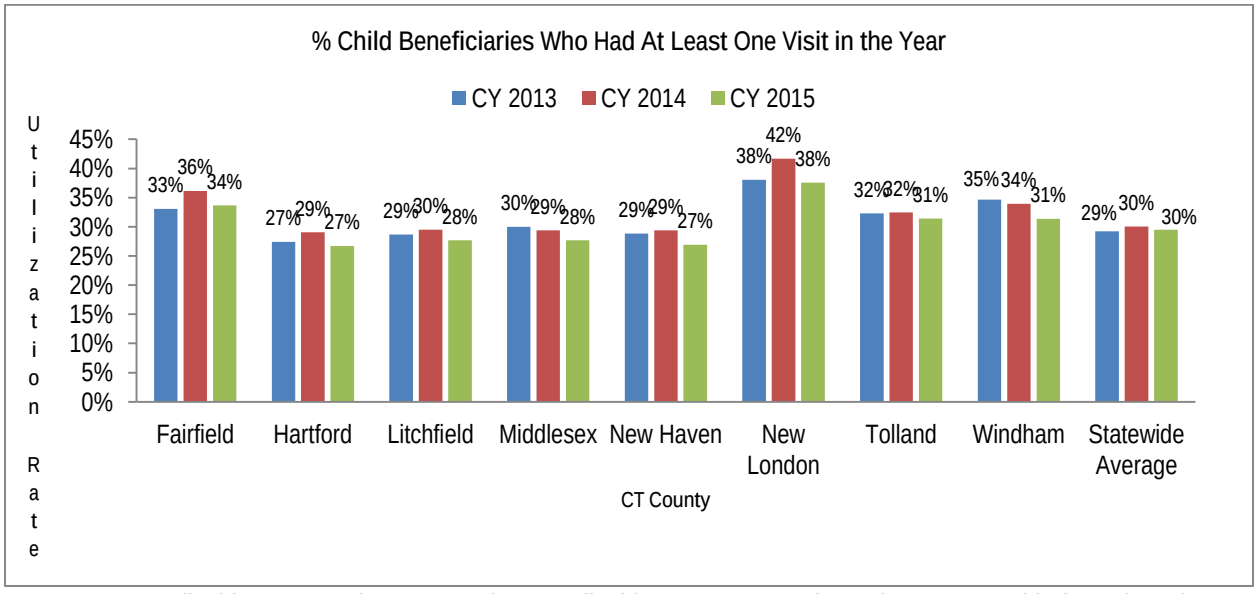
inquiries, the lack of established standards to use for comparative purposes, DSS cannot determine that based on this baseline data that there is a lack of access to specialist care.

Table 34: Distribution of Child Utilization of Physician Specialist Services - CY2013 - CY2015

Member (Children) County	2013		2014		2015	
	Total Number of Children	% Who had at least one visit in the CY	Total Number of Children	% Who had at least one visit in the CY	Total Number of Children	% Who had at least one visit in the CY
Fairfield	78,882	33.0%	87,906	36.1%	93,725	33.7%
Hartford	92,411	27.4%	99,955	29.1%	104,401	26.7%
Litchfield	13,323	28.7%	14,524	29.5%	15,065	27.7%
Middlesex	9,635	30.0%	10,497	29.4%	10,903	27.7%
New Haven	94,969	28.8%	102,872	29.4%	107,494	26.9%
New London	25,038	38.1%	27,193	41.7%	28,207	37.6%
Tolland	7,751	32.3%	8,535	32.5%	8,817	31.4%
Windham	13,124	34.7%	14,107	34.0%	14,639	31.4%
Statewide	347,164	29.2%	366009	30.0.0%	383310	29.5%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Figure 28: Rate of Child Utilization of Physician Specialist Services - CY2013 - CY2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

The state-wide average percent of CMAP child beneficiaries who received services from an enrolled specialist at least once during calendar years 2013-2015 ranged between 29% and 30%, with New London representing the county with the highest individual county utilization. (See Table 34 and Figure 28). Given the number of children covered under HUSKY C, which

was the eligibility program most likely requiring the intervention of a medical specialist, was approximately 1% based on CY 2014 data, and the lack of established standards and tracking of children's access to specialists care (as compared to primary care services) the data represented above cannot be viewed in the context of determination of an access to care issue and can serve as a baseline for a utilization pattern of care for child beneficiaries.

Table 35: Distribution of Member Utilization of Physician Specialist Services by Benefit Plan

Benefit Plan (All Recipients)	CY 2013		CY 2014		CY 2015	
	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY
HUSKY A	516,784	36.4%	552,244	37.4%	605,778	39.1%
HUSKY C	118,105	30.6%	115,606	30.0%	112,408	33.2%
HUSKY D	143,195	52.3%	215,373	50.2%	279,799	51.3%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016

Dental Primary Care

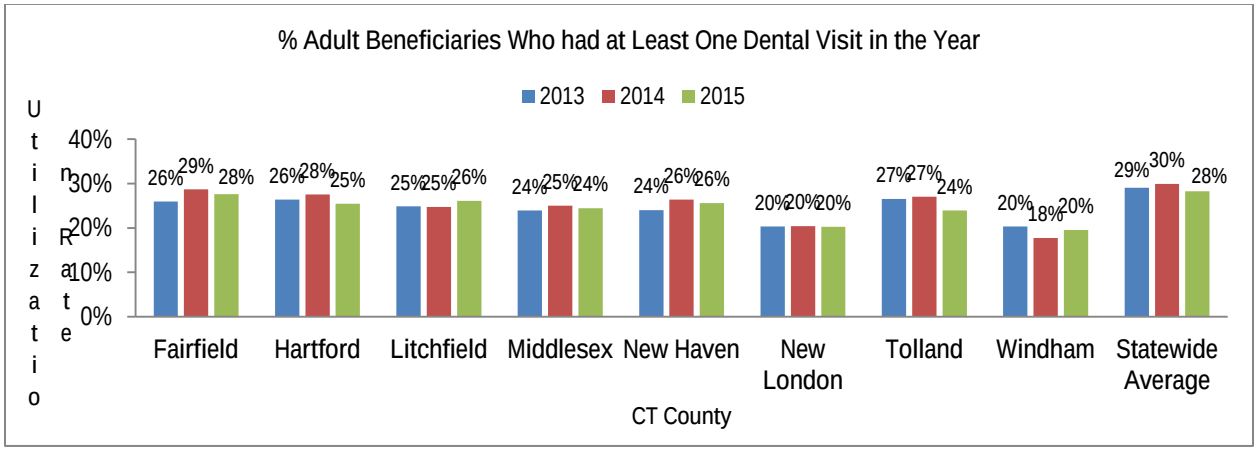
Table 36: Distribution of Adult Utilization of Dental Primary Care Services by County, provided by Independent Dentists, Dental FQHCs, and Hospital Outpatient Dental Clinics for CYs 2013 to 2015

Member (Adult) County	2013		2014		2015	
	Total Number of Adults	% Who had at least one visit in the CY	Total Number of Adults	% Who had at least one visit in the CY	Total Number of Adults	% Who had at least one visit in the CY
Fairfield	90,976	26.0%	111,582	28.7%	126,400	27.6%
Hartford	129,246	26.4%	147,357	27.6%	162,003	25.5%
Litchfield	18,924	24.9%	22,782	24.7%	25,126	26.1%
Middlesex	15,267	23.9%	18,093	25.0%	20,080	24.5%
New Haven	126,987	24.0%	146,287	26.4%	160,953	25.6%
New London	35,513	20.3%	40,276	20.4%	44,130	20.2%
Tolland	10,393	26.5%	12,577	27.1%	14,186	24.0%
Windham	17,971	20.3%	20,118	17.7%	21,932	19.5%
Statewide	430,919	29.1%	517,214	30.0%	573,682	28.3%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Statewide, 28% to 30% of adult CMAP members (age 21 and above) had at least one dental primary care encounter every year for the three CYs. Table 36 above and Figure 29 below showed that the rate of adult access to dental primary care services was between 20% -29% among all of the counties over the three-year period. The national average for young adults (ages 19 to 21) who had at least one dental visit during the year in 2014 was 32% (NCQA: State of Health Care Quality, 2015). It should be noted that while Table 36 and Figure 29 show that Windham and New London Counties have significantly lower rates of utilization as compared to the other counties, these counties do not have a large number of licensed dentists practicing in the counties in general (not unique to Medicaid) and beneficiaries in these counties have access to at least 2 dentists within a 20 mile radius as established under the dental ASO contract standard.

Figure 29: Rate of Adult Utilization of Dental Primary Care Services - CY 2013 to CY 2015



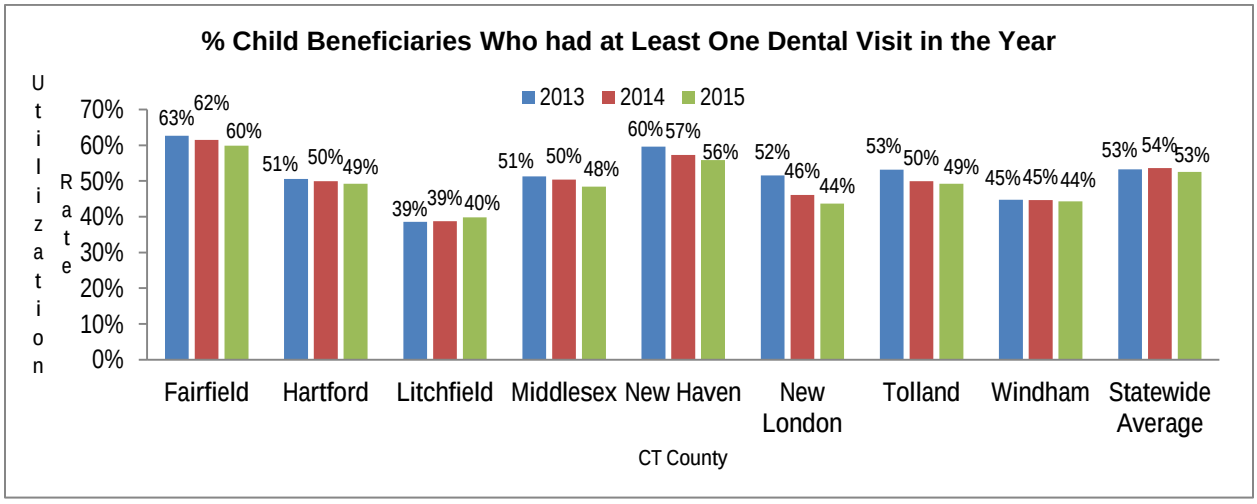
Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Table 37: Distribution of Child Utilization of Dental Primary Care Services by County, provided by Independent Dentists, Dental FQHCs, and Hospital Outpatient Dental Clinics for CYs 2013 to 2015

Member (Children) County	2013		2014		2015	
	Total Number of Children	% Who had at least one visit in the CY	Total Number of Children	% Who had at least one visit in the CY	Total Number of Children	% Who had at least one visit in the CY
Fairfield	78,882	62.7%	87,906	61.5%	93,725	59.9%
Hartford	92,411	50.6%	99,955	50.0%	104,401	49.2%
Litchfield	13,323	38.6%	14,524	38.7%	15,065	39.8%
Middlesex	9,635	51.3%	10,497	50.4%	10,903	48.4%
New Haven	94,969	59.6%	102,872	57.3%	107,494	55.9%
New London	25,038	51.5%	27,193	46.1%	28,207	43.7%
Tolland	7,751	53.2%	8,535	50.0%	8,817	49.2%
Windham	13,124	44.8%	14,107	44.6%	14,639	44.3%
Statewide	347164	53.3%	366,009	53.6%	383,310	52.6%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Figure 30: Rate of Child Utilization of Dental Primary Care Services – CY 2013 to CY 2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

From Table 37 and Figure 30 above, the statewide average percentage of CMAP child members (age 0 to 20) who had at least one dental primary care visit during the year was 53% in CY 2013, 54% in 2014 and 53% in CY 2015. Fairfield County was consistently the highest in member use of this service (see Figure 30 above). Although there were decreased in the utilization rates over the three years analyzed, the percentage of CMAP child members who had at least one dental primary care visit remained above the NCQA national Medicaid average of 35.6% for CY 2014 and within the National Medicaid 50th Percentile of 52.7% for CY 2013 (CT CY 2013 Medicaid HEDIS Measures).

Table 38: Distribution of Member Utilization of Dental Primary Care Services

Benefit Plan (All Recipients)	CY 2013		CY 2014		CY 2015	
	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY
HUSKY A	516,784	55.7%	552,244	55.8%	605,778	52.7%
HUSKY C	118,105	41.8%	115,606	42.1%	112,408	42.3%
HUSKY D	143,195	37.6%	215,373	36.8%	279,799	31.8%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

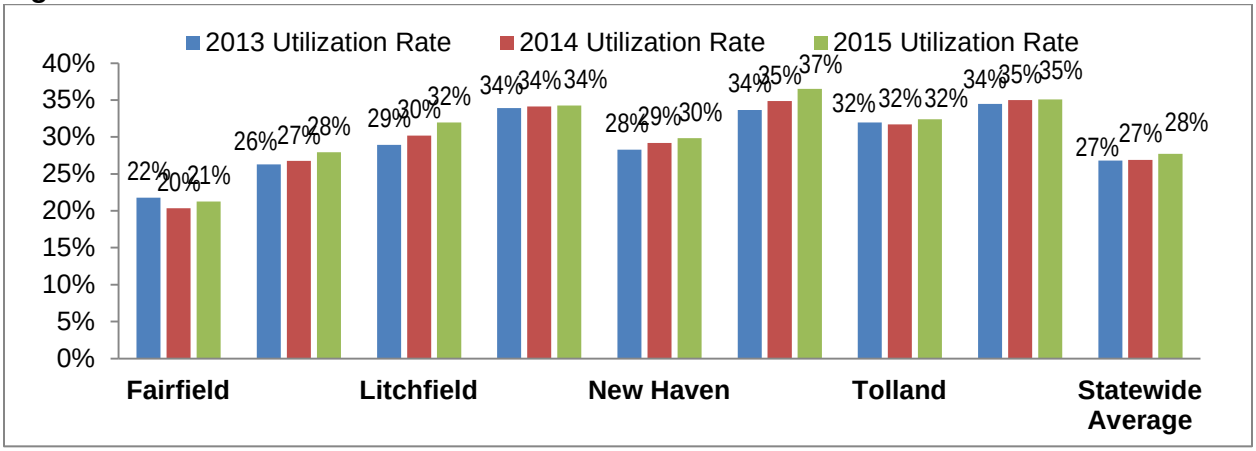
Behavioral Health Services

Table 39: Distribution of Adult Utilization of Behavioral Health Services - CY2013 - CY2015

Member (Adult) County	2013		2014		2015	
	Total Number of Adults	% Who had at least one visit in the CY	Total Number of Adults	% Who had at least one visit in the CY	Total Number of Adults	% Who had at least one visit in the CY
Fairfield	90,976	21.2%	111,508	20.4%	126,411	21.3%
Hartford	129,246	25.6%	147,416	26.7%	162,083	27.9%
Litchfield	18,924	28.3%	22,773	30.2%	25,134	32.0%
Middlesex	15,267	33.2%	18,101	34.1%	20,076	34.3%
New Haven	126,987	27.5%	146,255	29.2%	160,963	29.8%
New London	35,513	32.9%	40,297	34.8%	44,124	36.5%
Tolland	10,393	31.3%	12,579	31.7%	14,195	32.4%
Windham	17,971	33.5%	20,132	35.0%	21,942	35.1%
Statewide	445,277	26.8%	519061	26.9%	574,928	27.7%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Figure 31: Rate of Adult Utilization of Behavioral Health Services - CY2013 - CY2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

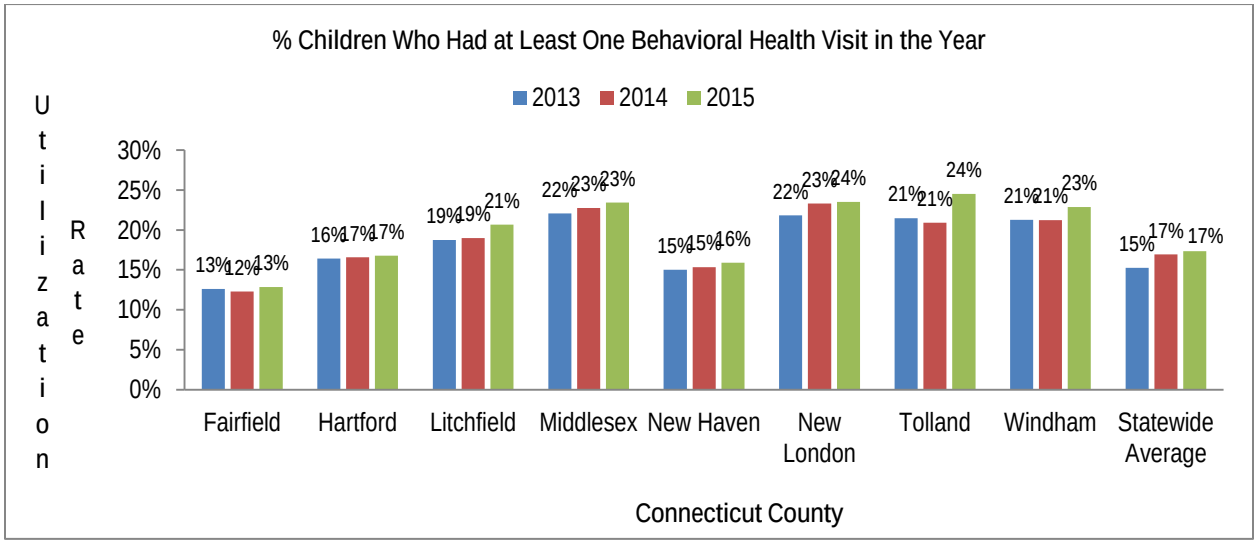
The statewide average utilization of behavioral health services by adult CMAP members was 26% in CY 2013, 27% in CY 2014 and 28% in CY 2015. Across all counties, 20% to 35% of this population visited a behavioral health provider at least once in each calendar year, (shown in Table 39 and Figure 31 above.) The highest utilization of behavioral health services among adult CMAP members over the three-year period was in New London, Windham and Middlesex Counties, while Fairfield County had the lowest utilization rates for this service over the three years.

Table 40: Distribution of Child Utilization of Behavioral Health Services – CY 2013 – CY2015

Member (Children) County	2013		2014		2015	
	Total Number of Children	% Who had at least one visit in the CY	Total Number of Children	% Who had at least one visit in the CY	Total Number of Children	% Who had at least one visit in the CY
Fairfield	78,882	12.6%	87,906	12.3%	93,759	12.8%
Hartford	92,411	16.4%	99,955	16.6%	104,394	16.8%
Litchfield	13,323	18.7%	14,524	19.0%	15,060	20.7%
Middlesex	9,635	22.1%	10,497	22.7%	10,909	23.4%
New Haven	94,969	15.0%	102,872	15.3%	107,460	15.9%
New London	25,038	21.8%	27,193	23.3%	28,228	23.5%
Tolland	7,751	21.5%	8,535	20.9%	8,826	24.5%
Windham	13,124	21.3%	14,107	21.2%	14,628	22.8%
Statewide	335,133	15.3%	365,589	16.9%	383,264	17.3%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Figure 32: Rate of Child Utilization of Behavioral Health Services – CY2013- CY2015



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

The statewide average utilization rate for Behavioral Health service for this population was between 16% and 17% for the three calendar years. Fairfield County had the lowest use of behavioral health services among the CMAP child members over the three calendar years – 13% in CY 2013 and 2015 and 12% in CY 2014 (see Table 40 and Figure 32 above), followed by New Haven County with 15%, 15% in CYs 2013 1nd 2014, and 16% in CY 2015 . New London, Tolland and Middlesex appear to have the highest utilization rates over the period of the three calendar years, with the rates increasing across all counties over the three years. Windham appeared to have an increase of 3% in the number of children using this service between CY 2014 and CY 2015.

Table 41: Distribution of Member Utilization of Behavioral Health Services by Eligibility Plan

Benefit Plan (All Recipients)	CY 2013		CY 2014		CY 2015	
	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY
HUSKY A	516,784	13.0%	552,244	13.1%	605,778	12.9%
HUSKY C	118,105	15.3%	115,606	15.8%	112,408	15.7%
HUSKY D	143,195	27.9%	215,373	23.7%	279,799	22.0%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Pre- and Post-natal Obstetric Services

The utilization patterns were examined for CMAP members of all age groups who received at least one visit during pre-and post-natal period of pregnancy across the eight counties for calendar years 2013 to 2015. The results of this analysis are in Table 42, 43 and 44. Table 42 below depicts the total number of CMAP paid only deliveries by county. Undocumented mothers and their deliveries were excluded. Utilization rate showed about 70% of women who gave birth to a child in calendar year 2014 received pre-and post-natal care and the trend held consistent over the past three years. Table 45 compares CT HEDIS Measures with the measures obtained for the National 50th percentile. As shown CT measures for CY 2013 and 2014 were comparable to the National measures for women who received prenatal and postpartum care.

Table 42: Number of CMAP Members Who received Pre- and Post-Partum Care

Member County	**2013 Number of CMAP Members Who Received Pre- and Post- Partum Care**	**2014 Number of CMAP Members Who Received Pre- and Post- Partum Care**	**2015 Number of CMAP Members Who Received Pre- and Post- Partum Care**
Fairfield	1766	1776	1703
Hartford	2659	2628	3034
Litchfield	479	458	474
Middlesex	298	313	295
New Haven	2488	2509	2555
New London	998	985	978
Tolland	247	258	269
Windham	477	485	476
Statewide Totals	**9,412**	**9,412**	**9,784**

Table 43: Number of CMAP Deliveries by County

Member County	2013 Number of CMAP Members Who had Live Deliveries	2014 Number of CMAP Members Who had Live Deliveries	2015 Number of CMAP Members Who had Live Deliveries
Fairfield	3498	3499	3648
Hartford	3064	3032	3623
Litchfield	511	498	522
Middlesex	377	375	369
New Haven	3936	3910	4046
New London	1052	1036	1037
Tolland	278	285	295
Windham	531	518	523
Statewide Totals	**13,247**	**13,153**	**14,063**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Table 44: Percent of Deliveries who received Pre- and Post-natal Care

Member County	2013 Percent of all Deliveries with Pre- and Post-Partum Care	2014 Percent of all Deliveries with Pre- and Post-Partum Care	2015 Percent of all Deliveries with Pre- and Post- Partum Care
Fairfield	50%	51%	47%
Hartford	87%	87%	84%
Litchfield	94%	92%	91%
Middlesex	79%	83%	80%
New Haven	63%	64%	63%
New London	95%	95%	94%
Tolland	89%	91%	91%
Windham	90%	94%	91%
Statewide Totals	71%	72%	70%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Table 45. CMAP HEDIS Measures Prenatal Care and Postpartum Care

		2013		2014	
HEDIS Measure*	**Short Description**	**CT**	**Nat'l 50th percentile**	**CT**	**Nat'l 50th percentile**
Prenatal	The % of deliveries that had one timely prenatal visit	80.3%	84.3%	85.6%	85.2%
Postpartum	The % of deliveries that had one timely post-partum visit	60.1%	62.8%	70.3%	62.8%

**2015 HEDIS National Data was not available at the time of this analysis*

Home Health Services

This analysis includes the utilization of home health services for CMAP members, Adult vs. Child, who received at least one home health service across the eight counties for the past three calendar years (CYs) 2013 to 2015. The results of this analysis are in Table 46 and 47. Utilization of home health services has declined over the past three years among the adult population compared to children across all counties.

Table 46: Number of CMAP Adult Members, who had at least one home health service during a calendar year

Member (Adult) County	2013 Utilization of Home Health Services	2014 Utilization of Home Health Services	2015 Utilization of Home Health Services
Fairfield	4,416	2,845	2,916
Hartford	5,416	3,456	3,611
Litchfield	863	516	553
Middlesex	520	401	462
New Haven	6,734	4,907	4,864
New London	1,307	985	1,039
Tolland	371	252	243
Windham	706	451	412
Statewide	20,333	13,813	14,100

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Table 47: Number of CMAP Child Members, who had at least one home health service during a calendar year

Member County	2013 Utilization of Home Health Services	2014 Utilization of Home Health Services	2015 Utilization of Home Health Services
Fairfield	755	724	758
Hartford	875	851	861
Litchfield	100	91	102
Middlesex	76	96	95
New Haven	772	825	822
New London	231	199	165
Tolland	60	47	63
Windham	95	92	103
Statewide	2,964	2,925	2,969

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

Table 48: Distribution of Member Utilization of Home Health Services by Benefit Plan

Benefit Plan (All Recipients)	CY 2013		CY 2014		CY 2015	
	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY	Number of Members in Benefit Plan	% Who had at least one visit in CY
HUSKY A	516,784	0.9%	552,244	0.9%	578,963	0.8%
HUSKY C	118,105	13.7%	115,606	7.4%	112,387	7.2%
HUSKY D	143,195	1.8%	215,373	1.7%	265,643	1.6%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2013 through December 31, 2015 of paid claims through May 2016.

VI. Conclusion on Access to Services in Connecticut's Medicaid Program

Monitoring and ensuring sufficient access to care has and continues to be one of DSS's top priorities for Connecticut's Medicaid program. In order to comply with 42 C.F.R. §§ 447.203(b) and 447.204, DSS obtained and analyzed data related to (1) member characteristics, (2) provider capacity, and (3) utilization. These data were analyzed in order to determine whether or not the CMAP program provides sufficient access to care. For the reasons described below, based on the data obtained and analyzed, DSS has concluded that CMAP provides sufficient access to services and complies with the federal access regulations.

Member Characteristics

As outlined in Table 15, of the total CMAP population enrolled during CY 2014, the majority of members were covered under HUSKY A (pregnant women, children and caretakers of children), with the second highest number of members were enrolled under HUSKY D (low income adults) and only 13% covered under HUSKY C (aged, blind and disabled). As previously discussed, enrollment under HUSKY A and D increased significantly starting in 2014, largely due to the Medicaid expansion implemented under Section 2001 of the ACA. As expected, the percentage of children is significantly higher under HUSKY A versus the other two eligibility groups. Note that this percentage was slightly lower than the U.S. average (Fig. 4). Slightly more women than men participate in HUSKY A and C, while with HUSKY D; the percentage of male participants was greater. Review of percentage members by county yielded the expected result that the three most populous counties (Fairfield, Hartford and New Haven) also have the highest percentage of Medicaid members. DSS offers the following observations based on data:

- increased enrollment under HUSKY A and D related to Medicaid eligibility expansion has required more practitioners to handle members' needs;
- policy and reimbursement interventions noted above have increased the number of providers available to serve these needs;
- the large number of children and women covered by HUSKY A indicate the need to continue carefully monitoring adequacy of participation of pediatric providers and providers for women's health needs; and,
- the need for providers in Fairfield, Hartford and New Haven counties is greater than surrounding areas, which reflects the higher population density in these counties.

While CMAP has higher income eligibility limits than most states, the vast majority of our members have relatively low incomes compared to the state's population as a whole. The income limit, combined with Connecticut's high cost of living (6th highest nationwide), makes attaining the optimal health status a challenge for many of our members. The inability to access affordable food, reliable transportation, safe housing and basic necessities presents barriers for our members to overcome before they can begin to consider health prevention and healthy lifestyle changes. DSS, together with our partners, has aggressively worked to help our members overcome these roadblocks to get quality healthcare in a timely manner. Specific examples include the following:

- Intensive Care Management (ICM) interventions that solicit information on social determinates (e.g. housing stability, food security, physical safety), facilitate

connections with community providers, and build such work into members' ICM care plans;
- transition supports and housing vouchers under the Connecticut Money Follows the Person Program;
- a highly successful state-funded supportive housing initiative;
- participation in the CMS Innovation Accelerator Program on Medicaid-Housing Partnerships, through which we will make recommendations to our state budget office concerning coverage of transition and tenancy-sustaining services under the Connecticut Medicaid State Plan; and
- State Balancing Inventive Program No Wrong Door efforts.

DSS uses a full complement of health measures and many processes and procedures (administered through each ASO) to monitor not only access to, but also quality of, the health care received.

Provider Capacity

As shown, CMAP has a robust provider network. The network includes 40 outpatient hospitals and 15 FQHCs (that include medical, behavioral health and dental specialties), both of which include several additional location sites throughout the state. Additionally, the network has enrolled over 17,000 non-institutional providers of services (physicians, physician assistants, certified nurse midwives, advanced practice registered nurses, general dentists, pediatric dentists, medical clinics, and others) who are able to provide primary care, specialist, and behavioral health, dental and obstetric care to CMAP members.

As is illustrated by Fig. 22, CMAP's state-wide primary care provider network contains almost twice the number of the primary care providers as are enrolled in Medicare, and is comparable to the incidence of PCPs in commercial plans. While comparison data for other categories of care (dental, physician specialists, obstetrics, and behavioral health) could not be readily obtained for use in this analysis, comparison of year-to-year network totals under the CMAP program showed that, for majority of the categories (medical primary care, dental primary care, behavioral health and obstetric providers), the total number of enrolled providers increased from CY 2013 to CY 2015.

Another important finding is that the majority of primary care dental services were performed by community dental providers, which is not the typical means through which Medicaid dental services are delivered throughout the rest of the U.S.

The only category that demonstrated a slight decrease in the number of enrolled providers between calendar years 2014 and 2015 was physician specialists. However the reduction was not significant and the change in the number of specialists in CY 2015 remained greater than the total for calendar year 2013 (see Table 14: Counts of CMAP Physician Specialists).

Analyzing the data on a county level revealed that Fairfield, Hartford and New Haven, which are the three most densely populated counties in Connecticut, had the highest incidence of enrolled outpatient hospital and FQHC service locations (see Fig. 11) and had some of the lowest member-to-provider ratios, which was expected given that these three counties were the most densely populated in the state and had the greatest number of CMAP members for CY 2014. Litchfield, Tolland and Windham counties had the highest member-to-provider ratios and the lowest number of CMAP enrolled providers consistently for all three years analyzed. These data

were consistent with data obtained for Connecticut providers enrolled in Medicare for CY 2014 and were in line with DSS's assumption that the least densely populated geographic areas in CT would have a more challenging time attracting providers across the board, not specific to any particular provider specialty or insurance coverage.

Utilization of Service

As outlined above, DSS assessed utilization of primary care, specialists, behavioral health, obstetric and home health services to determine if CMAP members had sufficient access to care. The following highlight our conclusions.

Medical Primary Care: Assessment of the use of medical primary care services between adults and children and across the counties showed the following:

- Between of 66% to 76% of the adult members had at least one primary care visit in CY 2014 (see Table 30 and Fig. 25). With the exception of Windham County (which showed a slight decrease for CY 2015), all of the counties' averages increased from CY 2013 to CY 2015, suggesting that adult access to primary care services has increased. Among children served by CMAP, the rate of access to Medical Primary Care Services ranged from 86% to 98% across the eight counties over the 3-year period, with a statewide average of 90%, 92% and 94% consecutively for the three years analyzed.
- DSS also examined the utilization of medical primary care services by eligibility plan and found that in CY 2013 and CY 2014 about 85% of HUSKY A, 40% of HUSKY C and, 70% and 69% respectively of HUSKY D members had at least one encounter with a medical primary care provider. When the utilization for HUSKY C was analyzed separately, it was noted that the utilization for primary care services showed a slight drop in CY 2015, but overall remained relatively stable at rates between 38% and 40% (Table 32). Of particular note, the increases in adult access to primary care and the stable high percentages of children's access to care could be directly related to the implementation of the ACA Section 1202 Increased Payments for Primary Care Services, which the state continued at the completion of the mandate, with modifications, by formalizing a state supported policy for community based increased primary care payments.

Given that 1) the numbers of members who had at least one visit to a Medical Primary Care provider within a year remained consistently within the range of 61% to 78% for adults and 86% to 98% for children, across the counties over the three calendar years; 2) the percentage of utilization among the HUSKY C population remained relatively stable; and 3) there were no unresolved complaints for access to care related issues during this period (ASO monitoring), DSS has concluded that this level of access to primary care was adequate and can therefore be used as baseline for future analyses.

Dental Primary Care: There is a lack of commercial, Medicare, or HEDIS standards to compare adult access to dental care against, therefore DSS focused on child dental access.

- The percentage of child members with at least one dental primary care visit during the year ranged from 39% to 63% in CY 2013, 39% to 62% in 2014 and from 40% to 60% in CY 2015 across Connecticut counties.

- Fairfield County was consistently the highest in member use of this service (see Table 37).
- Over the three years from CY 2013 to CY 2015, the percentage of CMAP child members who had at least one dental primary care visit as reported under the Connecticut Medicaid HEDIS Measures was approximately 73% for CY 2013 and CY 2014 which was significantly greater than the National Medicaid 50th percentile average of 53%. These results also remained above the NCQA national Medicaid average of 35.6% for CY 2014.

Physician Specialist Services: As shown in Table 33 and Fig. 27, the use of specialist services by CMAP adult members remained relatively stable from year to year without much variability among the counties. This result was also noted among the child members as displayed in Table 34 Results for the HUSKY C population showed a slight increase between CY 2014 and CY 2015 (30.0% vs. 33.2%, respectively). In the absence of any standards and measures against which to compare results, DSS analyzed the trend in utilization across the three of data to identify specific areas of concern based on age, county and eligibility group. The resultant data showed that specialist utilization either remained relatively stable from year to year, or slightly increased, between CY 2013 and CY 2015. Our conclusion is that, while DSS will continue to monitor this area, access to specialist care is adequate across the board for CMAP members.

Behavioral Health: As discussed previously, the number of enrolled behavioral health practitioners increased over the three year period analyzed. Consistent with this result, for all of Connecticut counties, utilization increased from CY 2013 to CY 2015 for both child and adult members. Fairfield, the most populous county in CT for CY 2014, had the lowest distribution of behavioral health utilization among both the child and adult populations for all years analyzed. HUSKY A and C utilization was stable over the three years, while HUSKY D utilization decreased from CY 2013 to CY 2015. Without sufficient data, measures and/or standards against which to compare, it is not possible to determine if these results are due to an access issue. Additionally, given that: routine behavioral health and substance use services typically require a diagnosed illness and given the lack of reported unresolved complaints from members regarding access to behavioral health services, it is not possible to determine if lower utilization in Fairfield County and the decrease in utilization among the HUSKY D population is indicative of an access deficiency. DSS has and will continue to facilitate access to behavioral health and substance use disorder services through:

1. reimbursement of validated screening tools in the primary care setting;
2. support with referrals to treatment resources;
3. strong partnerships with sister agencies (especially through the CT Behavioral Health Partnership, which is a collaboration among DSS, the Department of Children & Families and Department of Mental Health & Addiction Services); and
4. maintenance of a network of behavioral health Enhanced Care Clinics (ECCs). DSS and the behavioral health ASO will continue to monitor potential access to care issues and address and remedy any potential negative impacts across all counties and eligibility groups.

Obstetric Services: To support comparability with HEDIS measures, and to address challenges associated with identifying the specific number of prenatal visits that took place as part of the global delivery billing, DSS analyzed utilization of obstetric care by identifying the total number of deliveries per county and compared that number with the number of women in each county who had either the global delivery code billed (accounting for prenatal, delivery and post natal care), or prenatal or postnatal care billed during the calendar year. With the exception of

Fairfield and New Haven counties, the data showed that for CY 2014 the percentage of women who had a delivery during the calendar year that also received prenatal and postnatal care ranged between 83% and 95%. For CY 2015, the range dropped slightly to 80% - 94% for the same counties. The results for Fairfield and New Haven counties, however, lagged behind those of all other counties. The results showed that as few as 51% and 64% of Fairfield and New Haven residents, respectively, received prenatal and post natal care in CY 2014, despite these counties accounting for the most deliveries in all three of the years that were analyzed (see Tables 42, 43 and 44). When comparing the overall statewide average of prenatal and postnatal care received by members as reported under the HEDIS measures, CMAP has consistently for CY 2013 and 2014 remained comparable with the National Medicaid 50th percentile (Table 45).

DSS has an extremely strong interest in ensuring that pregnant women receive timely prenatal care, since timely and consistent access to this care has a direct impact on not only the health of the mother, but also on her (potentially CMAP eligible) baby. As shown above in the rate comparison, CMAP has an enhanced rate for obstetric care that is well above the Medicare rate, and is also higher than neighboring states' Medicaid programs. As mentioned previously, access to rates reimbursed by commercial payers could not be obtained for this analysis. DSS and its medical ASO will continue to monitor for "access to care" complaints and issues, especially in the Fairfield and New Haven areas, and address any concerns identified.

Home Health Services: Given that nursing and home health aide codes billed in units equal to the total time spent in the home, and that home health services can be required for short durations (i.e., short term care after a hospitalization) or for longer duration due to a member's diagnosis, DSS decided to determine, by county, the number of members who received a home health services over the three year time period. Between CY 2013 and CY 2014, the number of members who received a home health service decreased in all counties. In CY 2015, the number remained relatively stable as compared to the results for the previous year. As expected, the number of child members was far fewer than adult members receiving home health services. The HUSKY C population (aged, blind and disabled) accounted for the overwhelming majority of members who received home health services in all three years. Since the number of home health services did not substantially change between CY 2014 and CY 2015, DSS concluded that the decrease noted for the previous year was likely a result of a change to the prior authorization protocol for home health services. Under the ASO model, CMAP started reviewing home health requests more rigorously as than in prior years in order to substantiate the medical necessity of home health services. DSS will continue to monitor home health service utilization as required in the regulations, but at this time does not consider there is an access to care issue with home health service.

Monitoring Improvements

As a result of this and other analyses, DSS has noted several areas in which additional monitoring activities may be warranted. These activities include the following:

- Implementation of the full CAHPS survey. The Department will have these data for future analyses to assist in identifying any access to care issues.
- Implementation of a mystery shopper survey for behavioral health services. Currently, the behavioral health ASO performs a small survey for the enhanced care clinics but does not employ a full mystery shopper survey similar to the one used by the medical and dental ASOs. DSS will research the utility and possible benefits for developing a

mystery shopper survey protocol for use as a monitoring tool for behavioral health services.

- The final recommendation for monitoring improvements will allow DSS to fulfill a requirement of the access regulations by implementing a full access to care review with methods similar to the methodology described above. This will ensure that, prior to submitting a proposed Medicaid State Plan Amendment (SPA) to CMS that seeks to reduce a rate or restructure a payment methodology in a manner that may negatively impact access, DSS will be able to determine if there is sufficient access to care for the category for service that will be impacted and implement procedures to monitor the reduction/restructuring of service for the required time period.

Concluding Statement

DSS has determined that there is sufficient access to care for the Connecticut member population and that such access is comparable to the access available to the general population residing in the state and therefore complies with 42 C.F.R. §§ 447.203(b) and 447.204. CMAP provides a wide range of services to its members and strives to implement policies and procedures in a manner that will not only enhance access to care, but also strengthen the quality of services provided in a manner that is consistent with efficiency and economy. Consistent with longstanding obligations and these access regulations, DSS will continue to monitor access to care to assess for potentially negative impacts. DSS will also monitor impacts on access to care that are the result of proposed rate reductions and restructuring of reimbursement. If a significant access to care issue is identified, DSS will develop a corrective plan to address any potential deficiency.