STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

ACCESS MONITORIN REVIEW PLAN
FOR
CONNECTICUT'S MEDICAID PRORAM

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.

Triennial Update September 30, 2019

Table of Contents

I. OVERVIEW OF ACCESS MONITORING REVIEW PLAN (AMRP) TRIENNIAL UPDATE

The Connecticut Department of Social Services (Department or DSS), Connecticut's single state Medicaid agency, prepared this update to the Access Monitoring Review Plan (Plan or AMRP) in order to (1) continue to ensure that individuals have sufficient access to Medicaid services and (2) to ensure compliance with the U.S. Centers for Medicare and Medicaid Services (CMS) access regulations codified under 42 C.F.R. §§ 447.203(b), that specifically requires an update to the AMRP every three years. The first AMRP was completed and published September 30, 2016 and this AMRP is the triennial update. Where appropriate, this publication will provide updated data, such as changes to contracted vendors, provider enrollment data, member statistics and utilization data and all other static information will remain the same. DSS welcomes feedback from CMS, providers, members, and other stakeholders in support of continuing to improve access to services, as well as monitoring and ensuring continued access to Medicaid services.

Overview of CMAP

The Connecticut Medical Assistance Program (CMAP), which includes Connecticut's Medicaid program and Children's Health Insurance Program (CHIP) serves approximately 960,000 people (CY 2018 estimate), 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 to medically necessary services, 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.

II. CONNECTICUT OVERVIEW[(a)]

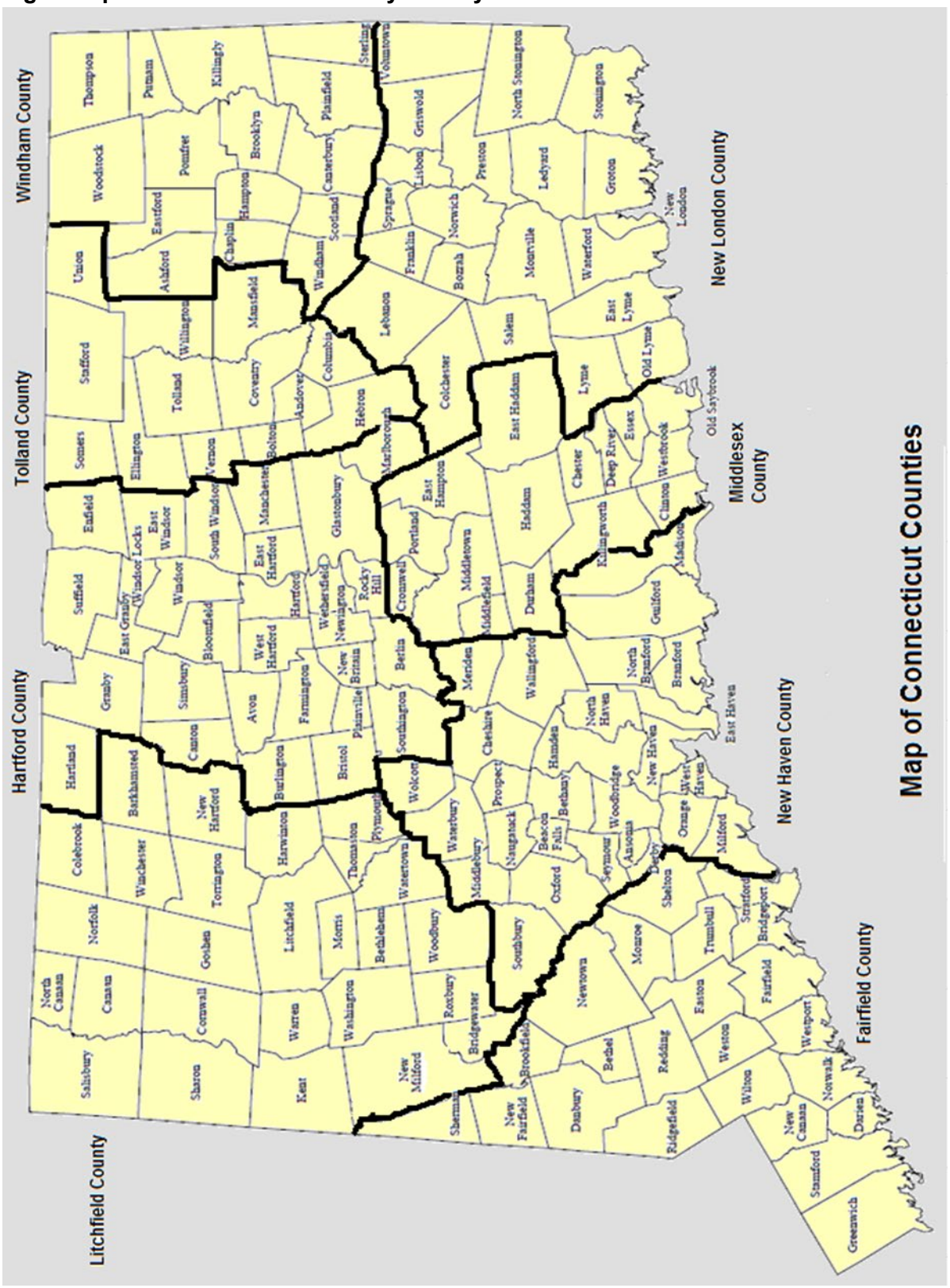
Connecticut is the third smallest state in land area at 5,543 sq. mi (14,357 km^2). It was the 29th most populous state, according to calendar year (CY) 2014 data, and, with a density of 739/sq mi (285/km^2), the fourth most densely populated of the 50 states. According to 2014 data, Connecticut's geodetic 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						

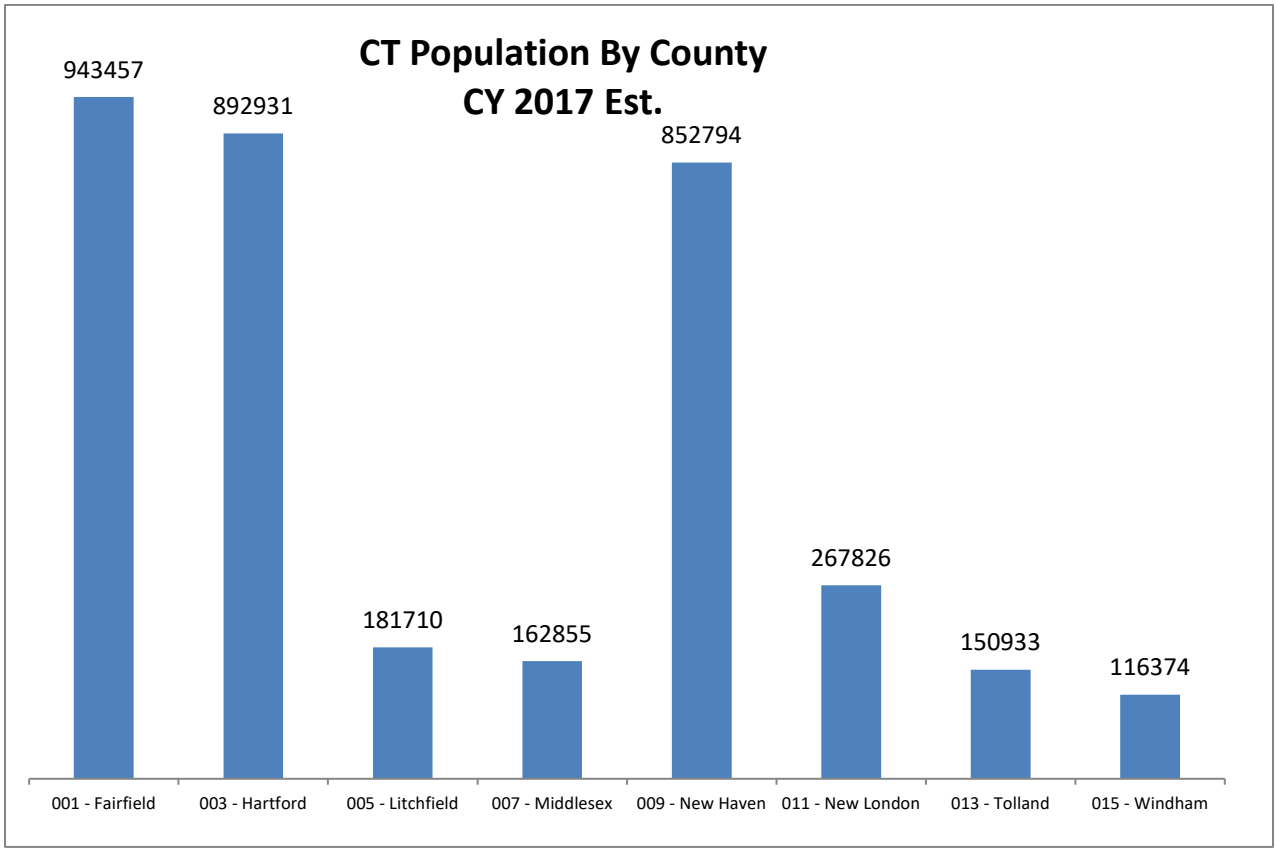
Department of Economic and Community Development, 2016.
http://www.ct.gov/ecd/cwp/view.asp?a=1106&q=250994

Fig. 1 Map of Connecticut Towns by County



In 2017, there were an estimated 3,568,880 people residing in Connecticut; similar to the data reported in 2014, the greatest number of people, over 943,000, resides in Fairfield County, and the least number, just over 116,374, resides in Windham County. [(1)]

Figure 2. CT Population by County (CY 2017 Estimates)



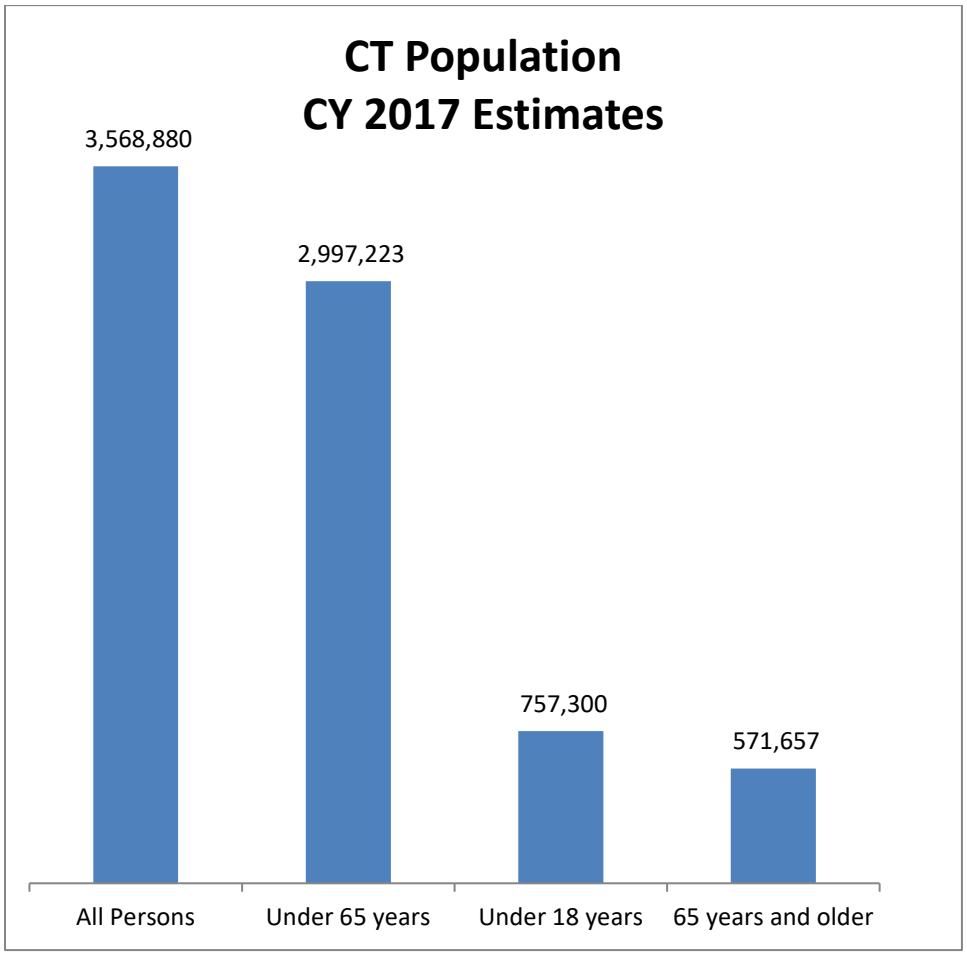
Connecticut Population Density by County [(2)] is shown in Table 2, below.

Table 2. CT Population Density by County (CY 2017 Estimates)

CY 2017 Population Density per Square mile	CT County
1,510	Fairfield
1,411	New Haven
1,215	Hartford
441	Middlesex
403	New London
368	Tolland
227	Windham
197	Litchfield

In 2017, children under the age of 18 accounted for 21.2% of Connecticut's population, while individuals ages 18-64 accounted for 62.8% and those age 65 and over accounted for 16.0%. Refer to Figure 3 for the breakdown.

Figure 3. CT 2017 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 the 2017 Data Release American Community Survey (ACS) U.S Census Bureau https://factfinder.census.gov**

(2)**Connecticut Density by County** (Table 2) Data is based on the 2017 Population Estimates included in the Annual Estimates of the Residential Population: April 1, 2010 to July 1, 2018 Data Release American Community Survey (ACS) U.S Census Bureau
https://factfinder.census.gov

Overview of CT Health Status

By most measures, based on reported and surveyed data, Connecticut residents remain healthier on average than the nation as a whole in areas such as the percentage of adult smokers, the percentage of annual dental visits, cancer deaths, adults diagnosed with cardiovascular disease and the percentage of adults who are overweight or obese. Based on 2010-2015 data reported by the Kaiser Family Foundation, life expectancy among residents of Connecticut was the 5th highest among the 50 states reported at 80.9 years. Hawaii, California, Minnesota and New York were the four states ranking higher than CT among life expectancy at birth.

In 2017 when CT residents were surveyed, approximately 14.5% reported they had "fair or poor health," a statistic that was comparable to what was reported for 2014 (14.3%) during the first iteration of the AMRP. The nationwide average for this statistic increased from 17.8% to 18.4% showing that CT residents self-reported depiction of health remained relatively stable. Of particular note, however, the percentage of individuals diagnosed with asthma, although significantly lower than previous reported rates, still remained higher than the national average at 10.7% (CT) versus 9.1% (U.S.) (2014 data 14.1% CT; 13.5% U.S.); and the percentage of individuals diagnosed with diabetes slightly increased both nationally and in CT versus data reported in 2014 (U.S. 10.5% vs. 10.8% and CT 9.2% vs. 9.8%).

In the area of individuals reporting dependence or abuse of alcohol, illicit drugs, and episodes of major depression, Connecticut as well as states throughout the nation needs to focus more efforts. In all three areas, with the exception of the 18+ population reporting episodes of major depression, percentages reported for CT residents remained higher than the percentages reported nationally (see Table 3). In the areas of illicit drug use and major depression for both age categories (ages 18+ and ages 12-17 years) reported for CT, the percentages reported for 2017 increased as compared to percentages reported for 2014. Access to mental health and substance use disorder screening and treatment remains an important topic both nationally and in CT.

The following table (Table 3) outlines important indicators of Connecticut residents' health outcomes:

Table 3: Comparison of Health Outcomes – 2014 vs 2017 Data

Comparison of Health Outcomes	U.S.			CT	
Percentage of adults who:	2014	**2017**		2014	**2017**
Smoke	17.4%	**16.4%**		15.4%	**12.7%**
Are overweight or obese	64.1%	**65.4%**		60.4%	**63.2%**
Participate in any physical activities or exercise	76.3%	**73.4%**		79.4%	**76.0%**
Birth outcomes					
Pre-term	9.6%	**9.9%**		9.2%	**9.5%**
Low birth weight	8.0%	**8.3%**		7.6%	**8.1%**
2016 Infant mortality rate (per 1,000)	6	**5.9**		4.8	**4.8**
Percentage of individuals reporting:					
Annual dental visits	64.4%	**65.7%**		74.9%	**77.8%**
Adults 65+ who have had all teeth extracted	14.9%	**14.5%**		10.9%	**9.6%**
Cancer rates per 100,000					
Age adjusted invasive cancer rate	440.3	**437.7**		477.1	**468.6**
Cancer deaths	166.4	**152.5**		152	**139.5**
Asthma and Diabetes					
Asthma	13.5%	**9.1%**		14.1%	**10.7%**
Diabetes	10.5%	**10.8%**		9.2%	**9.8%**
2013 Deaths due to diabetes per 100,000	21.2	**21.5**		14.8	**14.5**
Cardiovascular Disease					
Adults with cardiovascular disease	6.7%	**6.4%**		5.9%	**5.9%**
Deaths due to heart disease per 100,000	167	**165**		145.6	**141.6**
Individuals Reporting Dependence or Abuse of:					
Alcohol					
Ages 12-17	2.8%	**1.9%**		2.7%	**2.5%**
Age 18+	6.9%	**5.7%**		7.7%	**6.3%**
Illicit Drugs					
Ages 12-17	3.5%	**3.1%**		3.3%	**3.6%**
Age 18+	2.6%	**2.7%**		2.8%	**3.4%**
Opioid Deaths rate per 100,000	9	**9**		15.2	**15.2**
Episodes of major depression					
Ages 12-17	11.0%	**12.9%**		9.7%	**13.1%**
Age 18+	6.6%	**6.8%**		6.0%	**6.8%**
2016-2017 Rate of adults reporting having mental illness	18.3%	**18.2%**		16.4%	**17.8%**
Incomes & Poverty Rates					
Median Income	$53,657	**$60,336**		$70,161	**$74,168**
Poverty Rate	14.8%	**12.3%**		13.4%	**9.6%**

CT Health Insurance Coverage [3]

In CY 2017, Connecticut continued with 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 2017 estimates provided by the US Census Bureau - American Community Survey, 95.4% 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 92.6%. According to this survey, approximately 17.3% of Connecticut's population was enrolled in Medicaid, which was in line with the national average of 17.5%. The percentage of children covered by Medicaid in Connecticut was slightly higher reported at 38.8% than the national average of 34.2% based on CY 2017 data (see Figure 5). Previously, Connecticut noted that the state saw a significantly improved 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 2017 Health Insurance Coverage – CT versus US

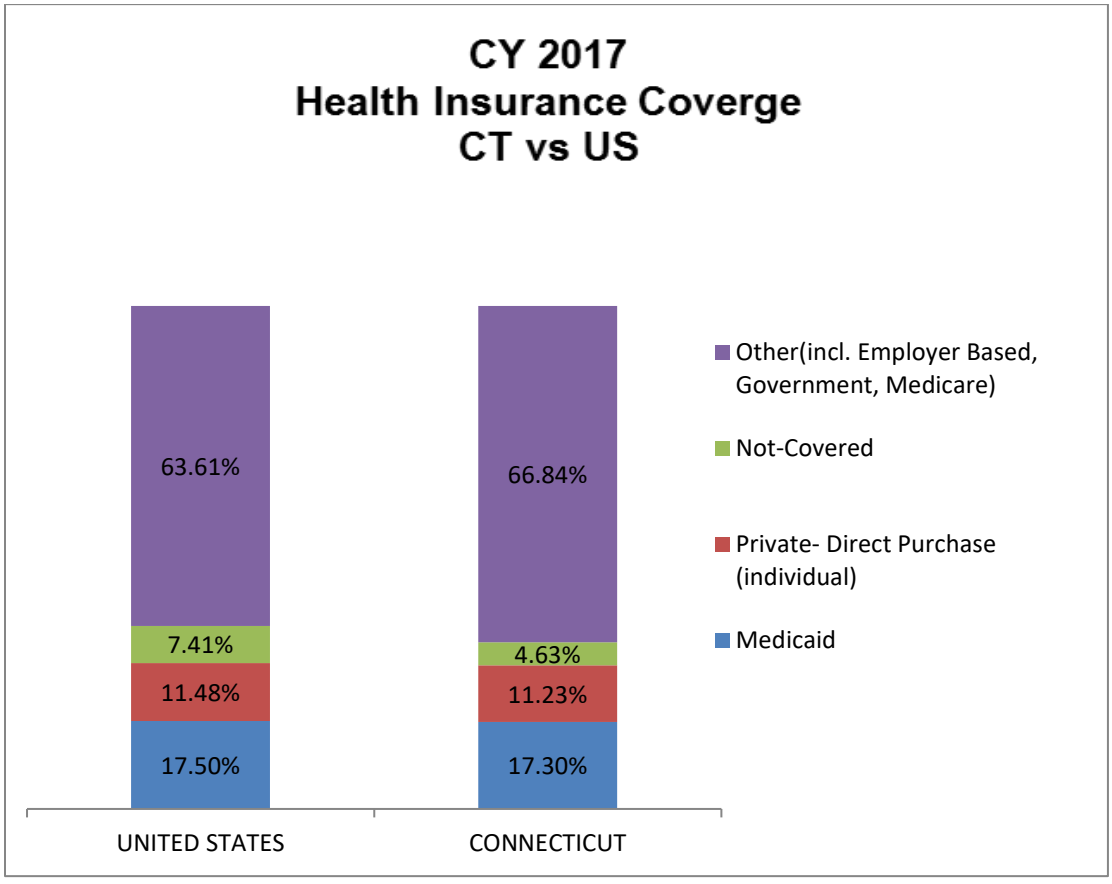
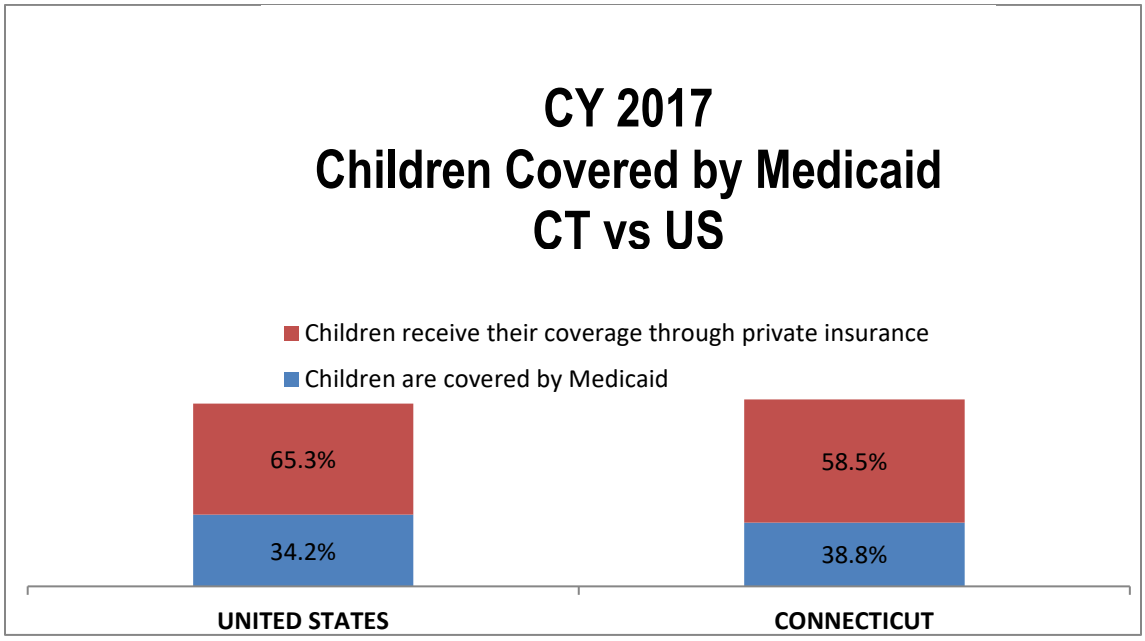


Figure 5: CY 2017 Children Covered by Medicaid – CT vs US



**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 may not equal 100%.*

Reference:

[3] **Health Insurance Coverage** data was obtained from the Health Insurance Historical Tables HIC CPS and HIC ACSpublished by the U.S. Census Bureau; https://www.census.gov

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 updated AMRP will continue to 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 does not utilize managed care arrangements for services, with the exception of transportation, under which companies receive capitated payments for serving members. Instead, Connecticut continues to utilize a self-insured, managed fee-for-service approach. In order to achieve better health care experience outcomes, and engagement with CMAP providers, the Department continues to contract with ASOs for the following service types:

- Medical (Community Health Network of Connecticut or CHNCT)
- Behavioral Health (Beacon Health Options),
- Dental (BeneCare)

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.

Effective January 1, 2018, the Department entered into a risk contract ("broker contract") with Veyo, a Total Transit company to provide beneficiaries with access to Non-Emergency Medical Transportation under CMAP. Through this brokerage program, Veyo is reimbursed based on a per member/per month basis, with the intent to provide the broker with the flexibility and capacity to engage a range of transportation options throughout the state in order to best serve Medicaid beneficiaries.

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 (DXC Technology). 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) manages the administration of medical services and goods for the CT Medicaid and CHIP programs known as the HUSKY Health Program. CHNCT served as a CMAP Managed Care Organization for 16 years. Effective January 1, 2012, CHNCT was selected to serve as the CMAP medical Administrative Services Organization (ASO) under CT's self-insured, managed fee for service model. Core operations include:

- operating a member and provider services Call Center;
- member assistance with benefit information, PCP selection, identification of appropriate specialists & other providers, appointment coordination and scheduling, and outreach;
- administering the member appeals and provider re-evaluation process;
- support to provider practices to become and maintain Person-Centered Medical Home (PCMH) recognition;
- retaining and expanding the provider network; and
- utilization management: authorizing requests for medically necessary services.

CHNCT also provides an Intensive Care Management (ICM) Program. The primary goal of this program is to identify and coordinate care for members with complex needs and address barriers that place them at higher risk for poor health outcomes utilizing a culturally aware and person-centered approach. 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. One of many ways members are identified for ICM is through a predictive modeling tool that stratifies

members by risk category. Trained ICM nurses in collaboration with providers and other partners, work with members to optimize their health outcomes with education, care coordination, provider coordination, self-management of chronic conditions and medication management, as well as reduce emergency room visits and missed appointments. ICM teams are nurse-led, geographically grouped, and include Community Health Workers to address 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 care 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 and/or medical conditions.

Non-emergency Medical Transportation ASO

Effective January 1, 2018, the Department contracted with Veyo, a Total Transit Company 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

DXC Technology acquired Hewlett Packard Enterprises (HPE) and is the MMIS fiscal agent for CMAP. The services provided have not changed and include 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. DXC Technology also provides operational support of these functions, for example: provider call center; member call center; provider relations representatives; and provider communications, including operation of the www.ctdssmap.com web site, and provider bulletins and newsletters. In addition, DXC Technology supports the CMAP Electronic Health Record (EHR) Incentive program via the CT Medical Assistance Provider Incentive Repository (MAPIR) attestation system and provider representative support. DXC Technology also operates the data warehouse via a separate contract administered by Information Technology Services.

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) 2016 through 2018, 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 multiple managed care organizations. It also provides a uniform fee schedule and has the capacity to promptly reimburse providers through a single fiscal intermediary – DXC Technology (formerly 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 2016, CY 2017 and CY 2018 provides data on 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. This data also enables 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 2016, 2017 and 2018. Utilization trends were calculated based on data extracted for each category, comparing the utilization between CY 2016, CY 2017 and CY 2018 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 2017. Data for CY 2018 was not available at the time of this update. 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.

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 2016, 2017 and 2018. 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 qualify for full benefit under both Medicare and Medicaid ("full duals"), full duals were included in the member data. However, the analysis, excludes 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 2016, CY 2017, and/or CY 2018, with a claims run-out period set to paid claims through May 1, 2019. 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 2,500 providers as of July 2019 (the previous number of OPR reported in 2016 was 3000); 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 ordering a service, prescribing and/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:

- Physician (broken out into primary care, specialists, and obstetrics);
- Advanced Practice Registered Nurses;
- Physician Assistants;
- Certified Nurse Midwives;
- Freestanding Medical Clinics;
- School Based Health Centers (not operated by an FQHC or Outpatient Hospital);
- Freestanding Behavioral Health Clinics;
- Medical FQHCs;
- Behavioral Health FQHCs;
- Dental FQHCs;
- Outpatient Hospital Clinics;
- Dental Primary Care (general dentists and pediatric dentists);
- 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
- Home Health Agencies.

Utilization: The utilization data included paid claims data for dates of service in calendar years 2016, 2017 and 2018 with a claims run-out period through May 1, 2019. 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 (BH) 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 and/or provider specialties.

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 2016, CY 2017 and CY 2018. 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 2016, CY 2017 and CY 2018 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 year 2017 to determine how the state measured against national standards (50th percentile).

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 medical and dental mystery shopper survey is an annual anonymous telephone survey that is conducted by an external vendor contracted by CMAP medical and dental ASOs to assess HUSKY member's access to care. The mystery shopper process involves researchers calling provider offices of various types and specialties posing as a HUSKY Health Program member attempting to make an appointment for themselves or on behalf of their child. The survey aims to evaluate the following:

- Appointment availability at the site desired
- Appointment availability as a result of self-identifying as a HUSKY Health Program member
- Reasons for lack of appointment availability
- Provider Network validation of open-panel practices
- When an appointment is offered, the survey researcher records the result 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 by provider specialty and practice type.

Access to care measured by complaints / inquiries

Another method to evaluate member access to care is to capture the nature and volume of complaints and inquiries members have regarding their health care services. HUSKY Health members are provided information on the various ways to make inquiries or share their concerns via member handbooks, the HUSKY Health website, social media, welcome materials and phone or email communication with member services of each applicable ASO. Most member complaints are lodged in the form of a direct phone call made to the respective ASO or vendor's Call Center. On a quarterly basis, each ASO generates and submits to DSS a Call Center report and a Complaint report. The Call Center report trends the volume and nature of calls received. The ASO Complaint reports include similar metrics but differ slightly in that behavioral health includes the number of days until resolution, while dental and medical complaint reports report the turnaround time to resolve each complaint. All three ASO reports contain similar subcategories of complaint reasons. The medical ASO is contractually required

to meet an established performance standard timeframe for complaint resolution or risk a financial penalty.

Access to care measured by the Consumer Assessment Health Plan Survey (CAHPS)
Results received from an annual adult and child Medicaid and CHIP CAHPS member satisfaction survey inform efforts to recruit specific provider specialties as expressed by members as a need. Beginning in 2018, the following supplemental custom question was added to the CAHPS survey:
If you had difficulty seeing a specialist, which specialists were a problem for you? (Check all that apply)

- OB/Gynecology
- Cardiology
- Neurology
- Dermatology
- Orthopedics
- Ophthalmology
- Gastrointestinal
- Ear, Nose and Throat
- Behavioral Health
- Other
- I did not have any difficulty seeing a specialist
- I did not see a specialist

Stakeholder Engagement

For the first iteration of the AMRP, DSS presented, on March 11, 2016, 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 continues to engage with MAPOC and other stakeholders to ensure that it receives robust feedback from a variety of perspectives.

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).

In response to some of the comments received on the first iteration of the AMRP, this update includes an updated narrative from the dental ASO and was specific include the provider type and specialty created for SBHCs that are not operated by FQHC or outpatient hospitals. This update did not include changes to the method used to extract the provider data (as recommended by Benecare) because the goal was to keep as consistent as possible the data extract to be able to make comparisons as applicable. Additionally, mapping of the SBHCs would (1) skew the data previously reported for outpatient hospitals and FQHCs, since the sites operated by these entities are SBHCs, but for purposes of regulations, payments and overall CMAP rules these sites are viewed as an FQHC or outpatient hospital as applicable. While there is a separate provider specialty for SBHCs that are not operated by FQHCs or outpatient hospitals, isolation of this data would not be representative and would not provide the overall view of SBHC landscape suggested by the comment. Data associated with SBHCs was included in the first iteration and is also included in this update under one of the respective categories: FQHCs, outpatient hospitals, or medical clinics data.

DSS continues to engage with MAPOC and other stakeholders, including community members, advocates and the provider community to ensure that it receives robust feedback from a variety of perspectives regrading access to services covered under the CMAP.

DATA AND ANALYSIS

CMAP Members

CMAP coverage is available for residents meeting various eligibility criteria. These programs are referred to as HUSKY Health 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", while others will fall under the Children's Health Insurance Program (CHIP).

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 AMRP 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.

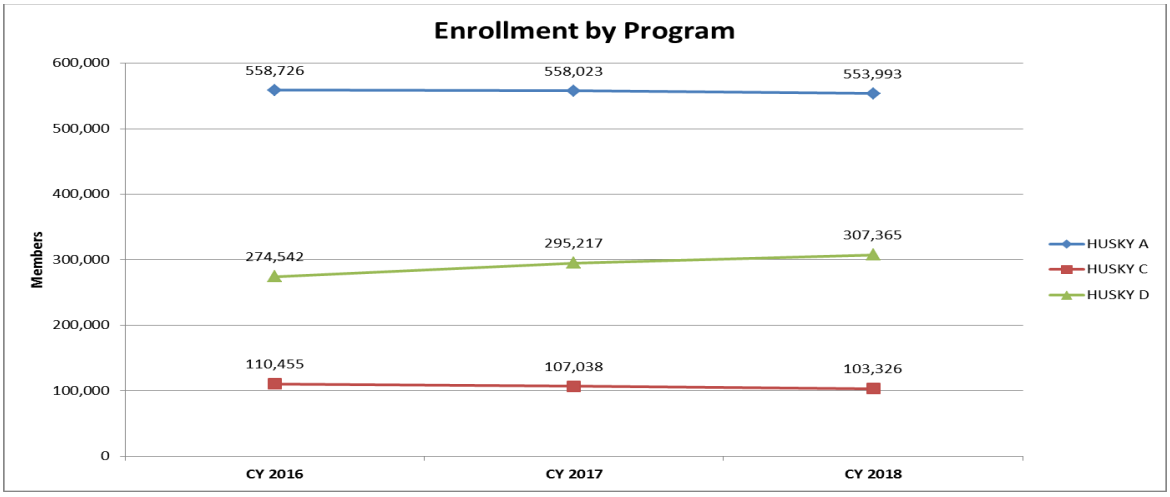
The unduplicated count of Medicaid members in Connecticut in CY 2017 is shown below in Table 4. The overall number of individuals enrolled under CMAP increased by approximately 8% (CY reported total 883,223) between the data reported for CY 2014 and CY 2017. Based on the reported enrollment data for 2017 the number of HUSKY C members decreased by approximately 8.0% while the number of individuals covered under HUSKY A and C grew, with the largest increase in HUSKY D of nearly 27%.

Table 4: 2014 vs. 2017 Enrollment by Program

	CY 2014 Count	% of Total		CY 2017 Count	% of Total
HUSKY A	552,244	62.5%		558,023	58.1%
HUSKY C	115,606	13.1%		107,038	11.1%
HUSKY D	215,373	24.4%		295,217	30.7%
Total	**883,223**	**100.0%**		**960,278**	**100.0%**

HUSKY A enrollment remained relatively static between CYs 2016 and 2017 before declining slightly in CY 2018. HUSKY C enrollment (group for Aged, Blind and Disabled individuals) steadily declined over all three years analyzed. The largest change was noted for the enrollment under HUSKY D. HUSKY D enrollment grew significantly between CYs 2016, 2017 and 2018 as well when compared to previous reported enrollment numbers of CYs 2014, 2015 and 2016.

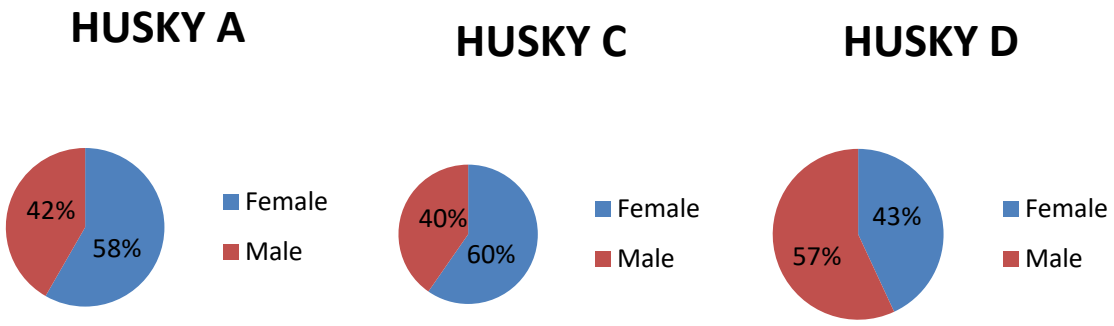
Fig. 6: Enrollment by Program CY 2016 through CY 2018



Gender

Overall, there continues to be slightly more female members (58%) in the HUSKY A, C and D plans combined as shown below. Additionally, of the three plans, HUSKY D continues to have a higher proportion of males based on 2017 enrollment, as shown in Fig. 7 below. These gender breakdowns are similar to statistics reported in 2014.

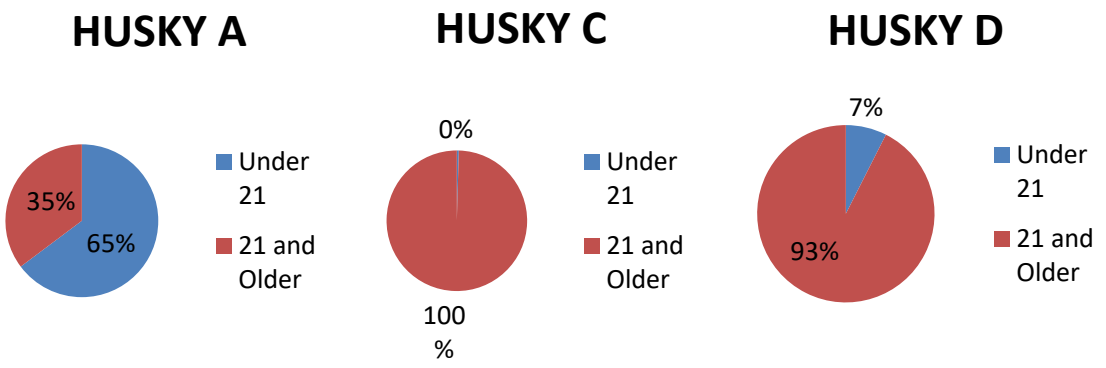
Fig. 7: Program by Gender



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 2017, 65% of HUSKY A members were children, compared to 7% of HUSKY D members and 0.8% of HUSKY C members (Fig. 8).

Fig. 8 Program by Age



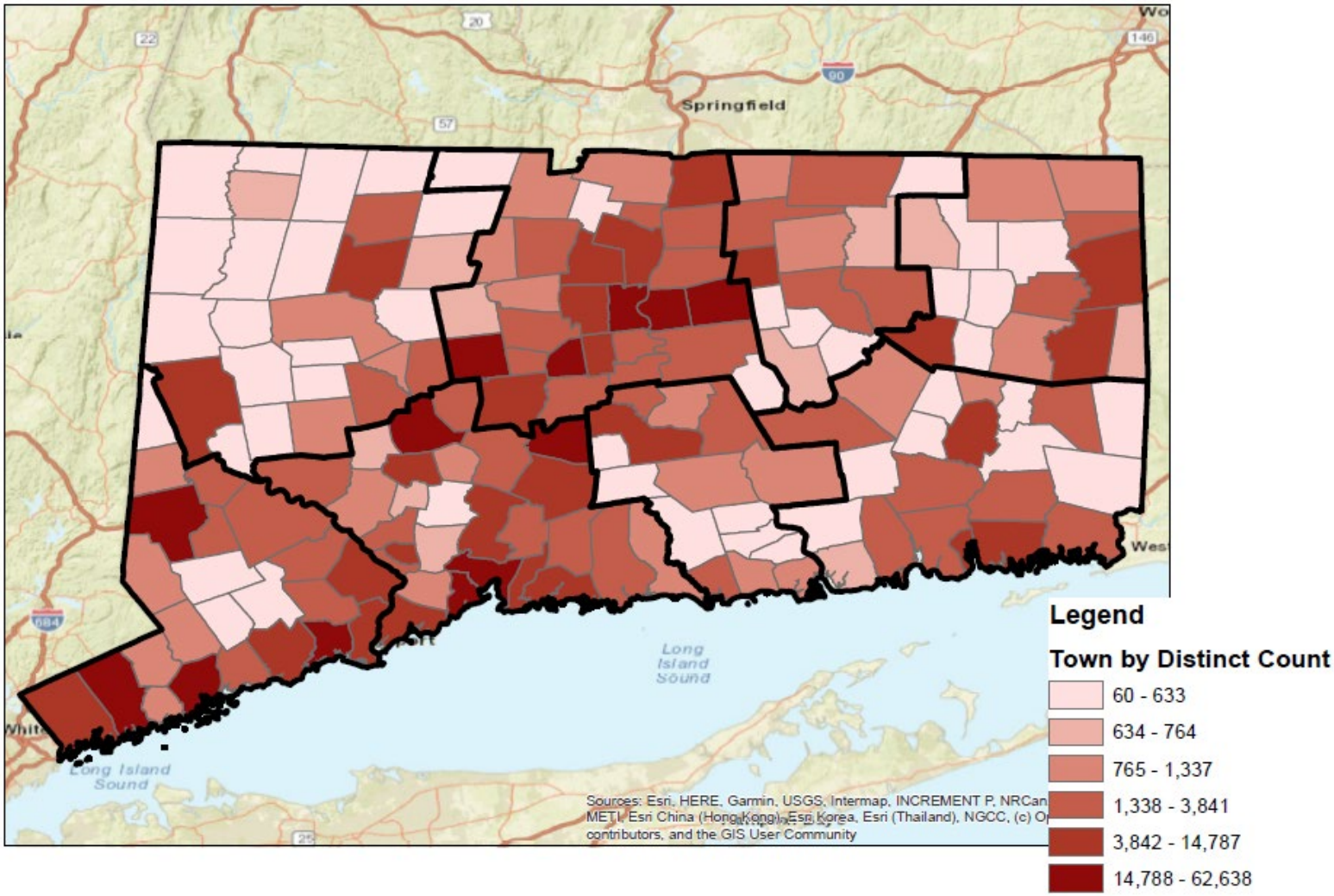
County

Connecticut has eight counties. These are solely geographic subdivisions and have no government or political function. As shown in Table 5, in CY 2017 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 (9,388) 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: 2017 vs. 2014 Enrollment by County by Program

County	HUSKY A		HUSKY C		HUSKY D		Total	
	2014	**2017**	**2014**	**2017**	**2014**	**2017**	**2014**	**2017**
Fairfield	128,701	131,832	23,387	21,517	46,901	65,206	198,989	218,555
Hartford	150,664	151,616	35,212	32,447	60,646	80,864	246,522	264,927
Litchfield	23,045	22,536	4,845	4,510	9,103	12,686	36,993	39,732
Middlesex	16,258	15,453	4,313	4,022	7,866	10,572	28,437	30,047
New Haven	154,314	155,888	32,770	29,797	61,400	83,926	248,484	269,611
New London	42,402	40,691	8,205	7,512	16,228	21,972	66,835	70,175
Tolland	13,417	12,925	2,475	2,463	5,106	7,357	20,998	22,745
Windham	21,982	21,030	4,182	3,766	7,801	10,302	33,965	35,098
Total	**552,244**	**551,971**	**115,606**	**106,034**	**215,373**	**292,885**	**883,223**	**950,890**

Figure 9: Map of CT Counties and Members (2017)



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, CHNCT sends all members a Welcome Guide summarizing all covered services available through HUSKY Health, a list with important contact information and member rights & responsibilities. Accompanying the Welcome Guide is the member's unique HUSKY ID card. Through the Welcome Guide, members are directed to the HUSKY Health website, where the user will find additional detailed information about the HUSKY Health program, including a searchable provider directory to find a suitable provider by a number of search criteria. Some of the additional information that can be found on-line includes member handbooks with detailed information about covered benefits, wellness programs, community services and supports, how to appeal a denial of service, how to get support for managing their healthcare, and basic information about how to apply or renew health coverage.

Shortly after enrollment in the HUSKY Health Program, new members also receive an automated welcome call prompting them to be on the lookout for their Welcome Packet in the mail, and are reminded to call HUSKY Health if they need help choosing a primary care provider.

New HUSKY Health members also receive a live phone call from a contracted vendor to conduct a health risk questionnaire. Responses indicating that a member needs assistance with a health or non-health-related concern are automatically referred to the appropriate CHNCT staff who reaches out personally to the member to offer help.

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 benefit from
- 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 complaint (defined as any expression of dissatisfaction) with CHNCT. CHNCT's Call Center receives and logs all member and provider complaints. Those issues not amenable to a first call resolution process are forwarded to the Quality Management (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), a 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 that 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. CHNCT is contractually required to meet an established performance standard timeframe for member complaint resolution of within 45 days of receipt or risk a financial penalty. The vast majority of complaints are resolved on the day of the call or within a week.

If a provider has an access to care complaint they may forward such complaint to the ASO, DXC Technology (the fiscal intermediary) 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 Beacon was charged with developing a provider network and a system of care to provide autism spectrum disorder (ASD) services consistent with the 2014 CMS guidance that required states to cover behavioral health ASD treatment services for Medicaid members under age 21. In accordance with the state's approved state plan regarding this service, ASD services must be conducted by a licensed clinician, MD, APRN practicing within his or her scope of practice, a Board Certified Behavior Analyst (BCBA) and a behavior technician and or Board Certified Assistant Behavior Analyst (BCaBA) working under the direct observation and direction of either the licensed clinician or the BCBA.

The ASD services provider network began with six CMAP enrolled providers in the first quarter of 2015. The network as of 2018 consists of 91 unique practices and 227 individual providers, 214 of whom provide direct treatment services while the others more exclusively conduct Autism Diagnostic Evaluations. Beacon continues to identify and outreach to potential providers to further develop the network and facilitate referrals.

Additionally, Beacon has launched a new opioid initiative entitled "Changing Pathways." Changing Pathways is a pilot under which Beacon is currently working with two inpatient detoxification providers to initiate Medication Assisted Treatment (MAT). This MAT approach involves starting methadone, buprenorphine, or naltrexone while individuals are withdrawing from opioids in a safe, controlled environment, and then warm transferring those individuals to a community provider for ongoing MAT and substance use disorder treatment. This is a major shift in practice for treatment providers.

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 its 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 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

Veyo 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, Veyo will investigate and respond. Members are able to submit information regarding specific issues or complaints via an on-line form or by contacting the Quality Assurance staff at Veyo via phone.

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 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. Q4 2018 CMAP Grievance Report

Q4 2018			
	Medical ASO	Behavioral Health ASO	Dental ASO
Total Grievances	686	113	67

Table 7. Dental ASO Call Center Report – Updated Data for Q4 2018

Reporting Period: Calendar Year 2018	
Program: CTDHP	
Provider Access	
No access location, closed panel, selection, no par provider in area, etc.	#
PCD	
Specialist	1
Clinic	
Other	
Total	1
Delayed access/wait time to appointment	
PCD	
Specialist	
Clinic	
Other	
Total	0
Quality of Provider Services	
Quality of ASO CSR	5
Member Materials	
Interpreter Services (lack of quality)	
Referral/Authorization Issue	32
Care Coordination/ICM	
Provider Search Engine Info.	
Website - Provider Portal	
Website - Customer Portal	
Total	37
Financial	
Member Billed	
Cost Share	
Premium	
Total	0
Other	
Fraud - Member	
Fraud - Provider	
Behavioral Health	
Medical	
Pharmacy	
Transportation	
ID Care (lost/misuse)	
Other (Benefit Limitation)	5
Other (Claim Payment Issue)	6
Other (DSS Appeal/NOA Process)	1
Other (DSS Lack of Response)	
Other (CTDHP Communications)	1
All Others	16
Total	29
Grand Total	67

Table 8. Medical ASO - – Member Grievance Report Q4 2018

HUSKY	Q4	
	#	/1000 MM
Provider Access - No access: location, closed panel, selection, no prvdr in area, etc.		
PCP Sub-total	10	0.0039
Adult	8	0.0031
Pediatrics	2	0.0008
Specialist Sub-total	67	0.0261
Allergy	2	0.0008
Audiology/Hearing Aids	0	0
Dermatology	14	0.0054
DME	4	0.0016
Endocrinology	2	0.0008
ENT	5	0.0019
Gastroenterology	1	0.0004
Home Health Care	1	0.0004
MULTIPLE (specify specialist types)	2	0.0008
Neurology	3	0.0012
OB/Gyn	8	0.0031
Orthopedic	8	0.0031
Orthopedic Surgeon	2	0.0008
OTHER (specify type of specialist)	2	0.0008
Pain Management	4	0.0016
Podiatry	1	0.0004
Rehab (PT, OT, ST, AT, Physiatry)	3	0.0012
Rheumatology	1	0.0004
SURGEON (specify type of surgeon)	3	0.0012
Transgender/Reassignment Surgery	0	0
Urology	1	0.0004
Vision (vision exams, glasses or contacts)	1	0.0004
Total	78	0.0303
Delayed access/ wait time to appt.		
PCP: Delay in obtaining appointment	4	0.0016
PCP: Wait time w hile in office	5	0.0019
Specialist: Delay in obtaining appointment	3	0.0012
Specialist: Wait time w hile in office	3	0.0012
Hospital	1	0.0004
Total	16	0.0062
Quality of Provider Services		
Assistance w ith specialist referral	6	0.0023
Bias	12	0.0047
Condition of office/facility	3	0.0012
Cultural	1	0.0004
Inappropriate care/disagreement	73	0.0284
Language barrier	2	0.0008
Privacy violation	1	0.0004
Provider Conduct/professionalism (including staff)	60	0.0233
Total	158	0.0614
Quality of ASO Services		
ICM	4	0.0016
Other Clinical Staff	1	0.0004
Quality of ASO customer service	6	0.0023
Total	11	0.0043
Financial		
Member billed	198	0.077
Total	198	0.0770
Other		
Behavioral Health	18	0.007
Dental	28	0.0109
Fraud - Member	3	0.0012
Fraud - Provider	3	0.0012
Pharmacy	12	0.0047
Transportation (NEMT)	161	0.0626
Total	225	0.0875
Total Grievances	686	
Total Member Months	2,571,381	

Table 9. Behavioral Health ASO – Member Grievance Report Q4 2018

Annual Number of Complaints/Grievances by Reason	2018
Total	**81**
Services Issues	35
Provider	5
Adult Member	21
Youth Member	6
Other	3
Access Issues	34
Provider	1
Adult Member	28
Youth Member	5
Other	
Quality of Care	8
Provider	
Adult Member	7
Youth Member	1
Other	
Reimbursement/Billing	2
Provider	
Adult Member	1
Youth Member	
Other	1
Quality of Practitioner Office Site	1
Provider	
Adult Member	1
Youth Member	
Complaints about Beacon	1
Provider	
Adult Member	
Youth Member	
Other	1

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 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. 2018 Medical ASO Mystery Shopper Results

Table 10. Medical ASO 2018 Mystery Shopper Results				
Practice Type	Unique Sites in Sample	Number of Surveys Completed	Sites Accepting New Patients	Sites Accepting new **HUSKY** Patients (of those accepting new pts)
Adult Primary Care Physician (PCP)	500	178	132 (74.2%)	112 (84.8%)
Pediatrician	228	121	102 (84.3%)	91 (89.2%)
OB/GYN	223	135	111 (82.2%)	96 (86.5%)
Cardiologist	113	75	61 (81.3%)	54 (88.5%)
Otolaryngologist (ENT)	31	30	23 (76.7%)	17 (73.9%)
Total	**1,095**	**539**	**429 (79%)**	**355 (82%)**

Table 11. 2017 Dental ASO Mystery Shopper Results

CT Medicaid Access Review Plan **Mystery Shopper Results** **Dental Services** **Survey Date: CY 2017**					
Dental Appointment Availability					
Provider Type	Surveys Completed	Accept new patients		Accept new patients and new HUSKY patients	
		%yes	%no	%yes	%no
General & Pediatric	638	87%	13%	81%	19%
Endodontist	8	86%	14%	80%	20%
Oral Surgery	40	89%	11%	68%	32%
Orthodontist	53	98%	2%	n/a	n/a
All Practices	739	88%	12%	81%	19%

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 2018 medical mystery shopper results, almost 90% of enrolled adult PCPs who were identified as accepting new patients reported that they will accept CMAP members. Further, over 86% 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 2016, CY 2017 and CY 2018. 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 adequacy 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 adequacy via a GEO-access standardized report. The GEO-access report is generated and submitted semiannually (or more often, as requested by DSS) and defines network adequacy as at least one primary care provider and OB GYN provider within 15 miles of a HUSKY 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.

The CHNCT Provider Engagement Team analyzes utilization data, GEO-Access, member demographics, complaint data, survey data, and feedback from provider organizations to determine outreach and retention efforts needed for specific provider types and/or regions of the state. In 2018, Provider Engagement Representatives made over 5,000 visits to providers many of whom were targeted for recruitment.

CHNCT generates and submits a quarterly network statistics to DSS showing quarterly trends of the number of CMAP providers in the network broken out by type and specialty.

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 geographic network analysis tool, Quest Analytics Suite, 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 a mystery shopper analysis, which is performed bi-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)

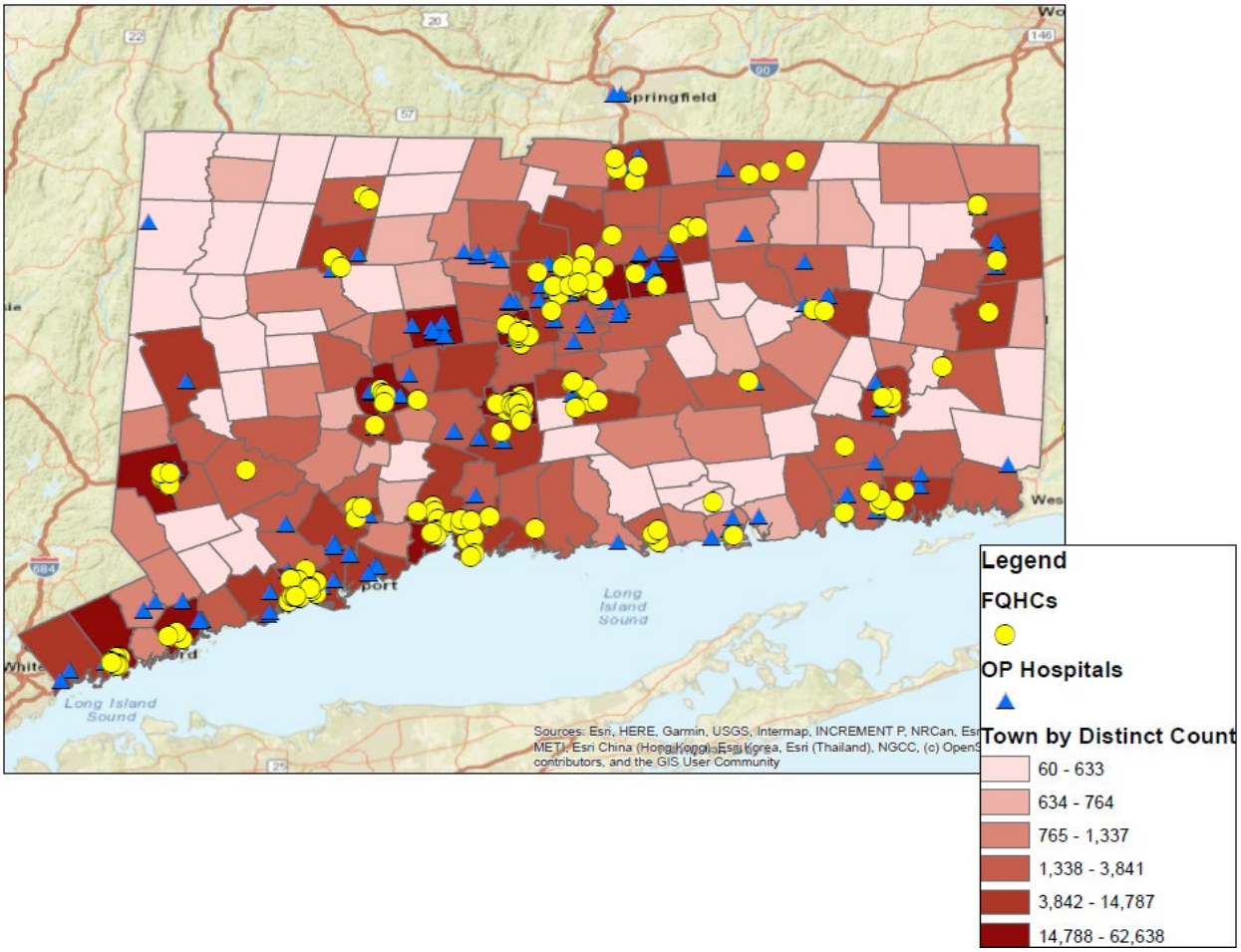
Connecticut residents have access to primary care services in a variety of settings from various provider types including Federally Qualified Health Centers (FQHC), outpatient clinics/departments operated by enrolled hospitals (will be referred to as outpatient hospitals), free-standing medical clinics, 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 2017, there were seventeen medical FQHCs, sixteen behavioral health FQHCs and seventeen dental FQHCs enrolled in CMAP, an increase from the numbers reported for 2014. Figure 11 below outlines service sites associated with outpatient hospitals and FQHCs enrolled under CMAP. Please note that the service sites included in the map below 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 represent the physical address locations where a member may receive a health service (i.e., business office related addresses were excluded).

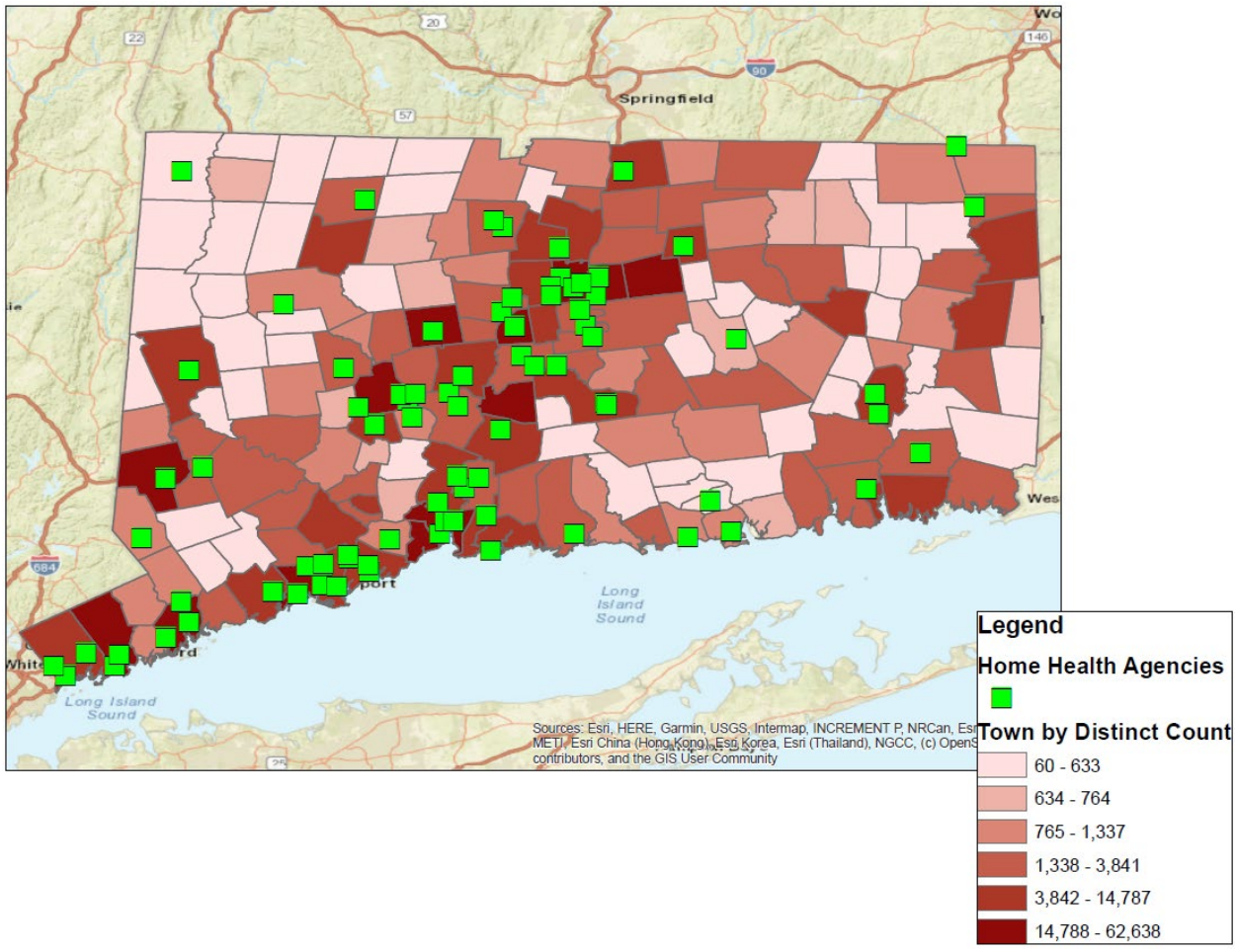
Figure 11: CT Members and FQHC / Outpatient Hospital Service Locations



Home Health Agencies

There were 85 Home Health Agencies enrolled in CMAP serving CMAP members as of CY 2017. This data is up from the reported 82 in CY 2014. 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 in accordance with the statutory definition of medical necessity for the Medicaid program, section 17b-259b of the Connecticut General Statutes. The practical difference is that when medically necessary, CMAP covers home health services for as long as necessary, often 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 update to the AMRP, CMAP continues to use 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.

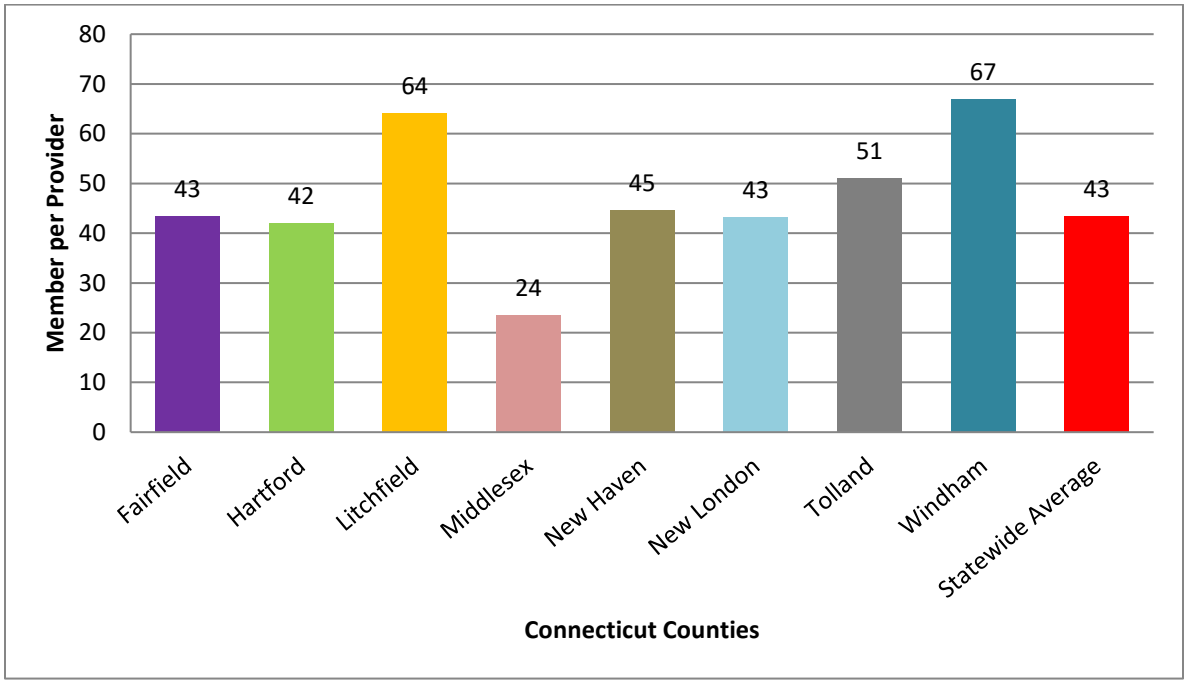
The provider categories of home health, medical outpatient hospital and dental outpatient hospital were excluded from this analysis due to discrepancies within the data collected for those categories. Out-of-state providers and members with unknown residencies are also excluded from this analysis.

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 2017 based on where the members reside by county. The subsequent tables display data from CY 2016, through CY 2018, 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 2017. *Please note this AMRP update includes a major correction to the prenatal and postnatal obstetric care category provider counts and member to provider ratios. Please refer to Table 22 and Figure 21 and the subsequent narrative for more information.*

Table 12: Total Statewide Count of Connecticut CMAP Performing Providers for Medical Services, Dental Services, Behavioral Health, Prenatal and Postnatal Obstetric Care, Calendar Year 2017 by County

Connecticut Counties	Statewide Count of Performing Providers
Fairfield	5,045
Hartford	6,311
Litchfield	616
Middlesex	1,263
New Haven	6,034
New London	1,626
Tolland	445
Windham	520
Total	**21,860**

Figure 13: CMAP Health Care Members-to-Provider Statewide Average for Medical Services, Dental Services, Behavioral Health, Prenatal and Postnatal Obstetric Care, Calendar Year 2017



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through May 2019.

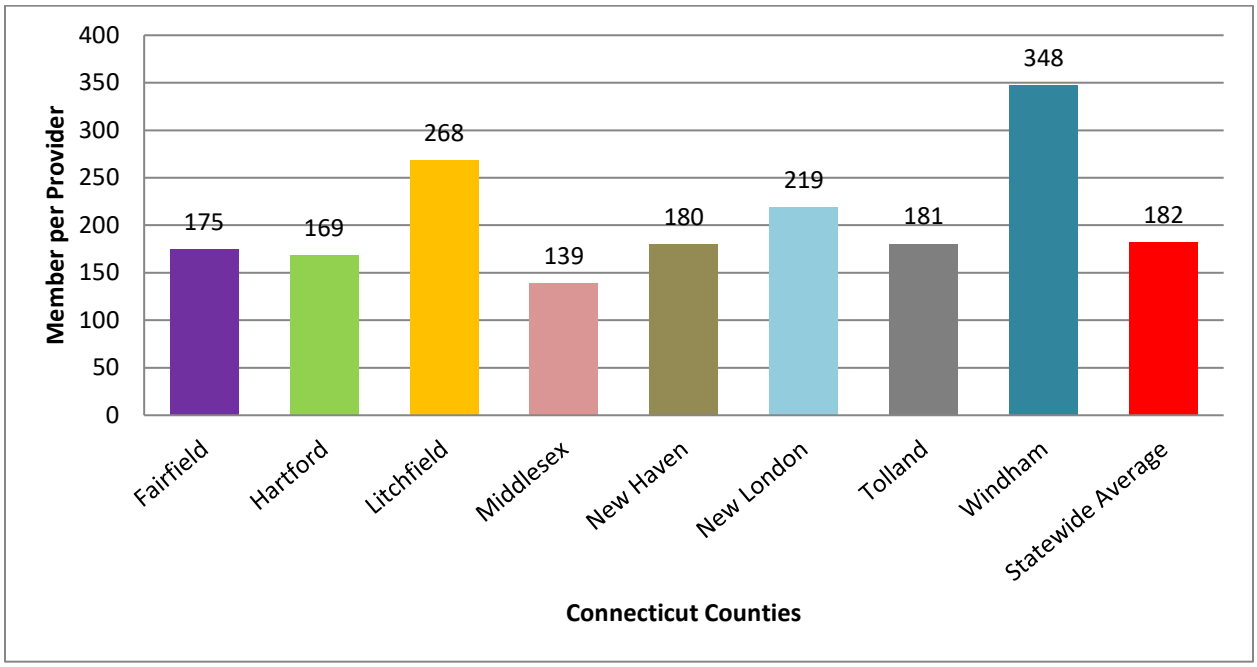
As shown in Fig.13, the member-to-provider ratios by county ranged from 24 to 67 members per provider among health service providers (i.e., medical and dental primary care providers, physician specialists, performing providers within medical, dental and behavioral health federally qualified health centers, behavioral health and prenatal and postnatal obstetric care providers), with the average overall ratio of 43. Similarly to the data reported in the first iteration of the AMRP, Windham and Litchfield counties continue to have the highest ratios while Middlesex

continues to have 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 2016 through 2018

Physicians, APRNs and Physician Assts.	**Statewide Performing Provider Count**		
	CY 2016	**CY 2017**	**CY 2018**
Provider County			
Fairfield	1,177	1,248	1,334
Hartford	1,480	1,570	1,688
Litchfield	154	148	149
Middlesex	211	216	211
New Haven	1,437	1,499	1,537
New London	299	320	322
Tolland	113	126	124
Windham	97	101	102
Statewide Total Performing Providers	**4,968**	**5,228**	**5,467**

Figure 14: CMAP Health Care Members-to-Provider Statewide Average of CMAP Physicians, Advanced Practice Registered Nurses and Physician Assistants, Calendar Year 2017



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through May 2019.

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 182 members to one provider and ranges from 139 to 348 members per provider. The counties of New Haven and Tolland are close to the statewide average. Fairfield, Hartford, and Middlesex fall below the overall ratio. Similar to Figure 14 above, the counties of Litchfield, New London and Windham have the highest ratio of members to one provider.

Table 14: Counts of CMAP Physician Specialists, Calendar Years 2016 through 2018

Physician Specialists	**Statewide Performing Provider Count**		
	CY 2016	**CY 2017**	**CY 2018**
Provider County			
Fairfield	1,743	1,961	1,960
Hartford	1,708	1,871	2,113
Litchfield	141	154	158
Middlesex	154	161	162
New Haven	1,799	1,905	1,921
New London	417	425	466
Tolland	59	75	85
Windham	148	162	166
Statewide Total Performing Providers	**6,169**	**6,714**	**7,031**

Figure 15: CMAP Health Care Members-to-Provider Statewide Average of CMAP Physician Specialists Calendar Year 2017

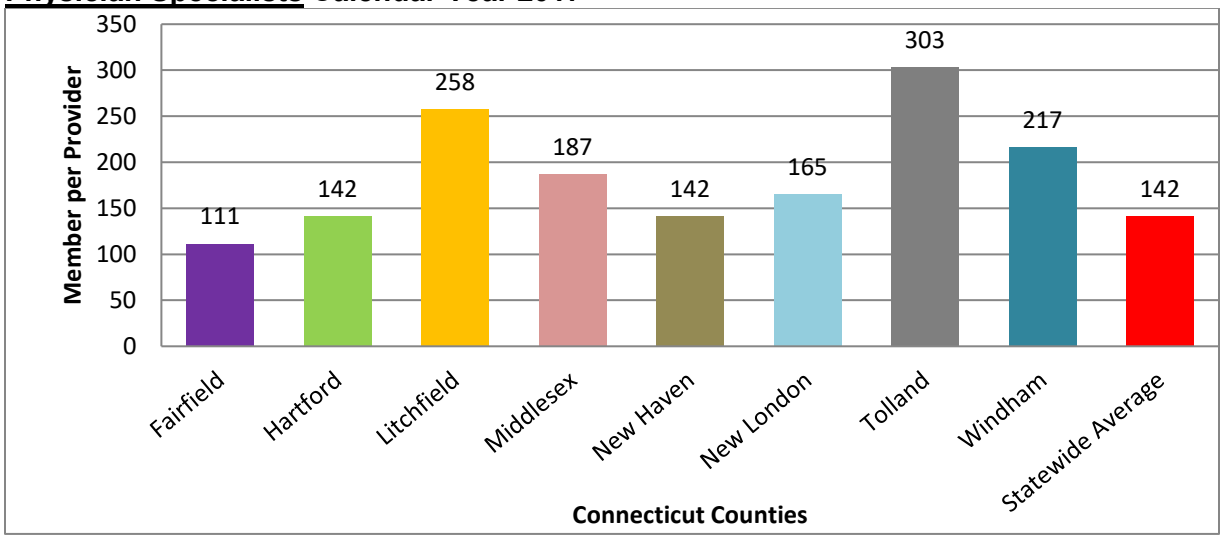


Figure 15 above shows the number of members to one provider in each Connecticut County, within the category of Physician Specialist. The category of Physician Specialists included cardiology, dermatology, orthopedic, urology, allergy, pulmonary, neurology and gastrostomy. From the data presented, the overall average ratio is 142 members to one provider, with counties ranging from 111 to 303. This data is slightly better than the ratio of member to provider ratios reported for CY 2014 for the first iteration of the AMRP. 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, which is not unique to the Medicaid population. In comparison, Hartford County had 1,871 performing providers in calendar year 2017, an approximately 11% increase from the total reported performing providers for CY 2014. Fairfield County had the lowest ratio of 111, showing the greatest availability of specialists, which is possibly a result of Fairfield's close proximity to New York. As shown in Table 14, while only 154 performing providers provided services in Litchfield, 75 performing providers in Tolland and 162 performing providers in Windham in calendar year 2017, these reported numbers of performing providers have increased in these counties since CY 2014.

Table 15: Counts of CMAP Medical Federally Qualified Health Centers, Calendar Years 2016 through 2018

Medical Federally Qualified Health Centers	**Statewide Performing Provider Count**		
	CY 2016	**CY 2017**	**CY 2018**
Provider County			
Fairfield	152	154	166
Hartford	80	87	103
Litchfield	10	14	11
Middlesex	150	161	175
New Haven	105	112	113
New London	18	18	22
Tolland	0	0	0
Windham	25	30	28
Statewide Total Performing Providers	**540**	**576**	**618**

Figure 16: CMAP Health Care Members-to-Provider (per Site of Service) Statewide Average of CMAP Medical Federally Qualified Health Centers, Calendar Year 2017

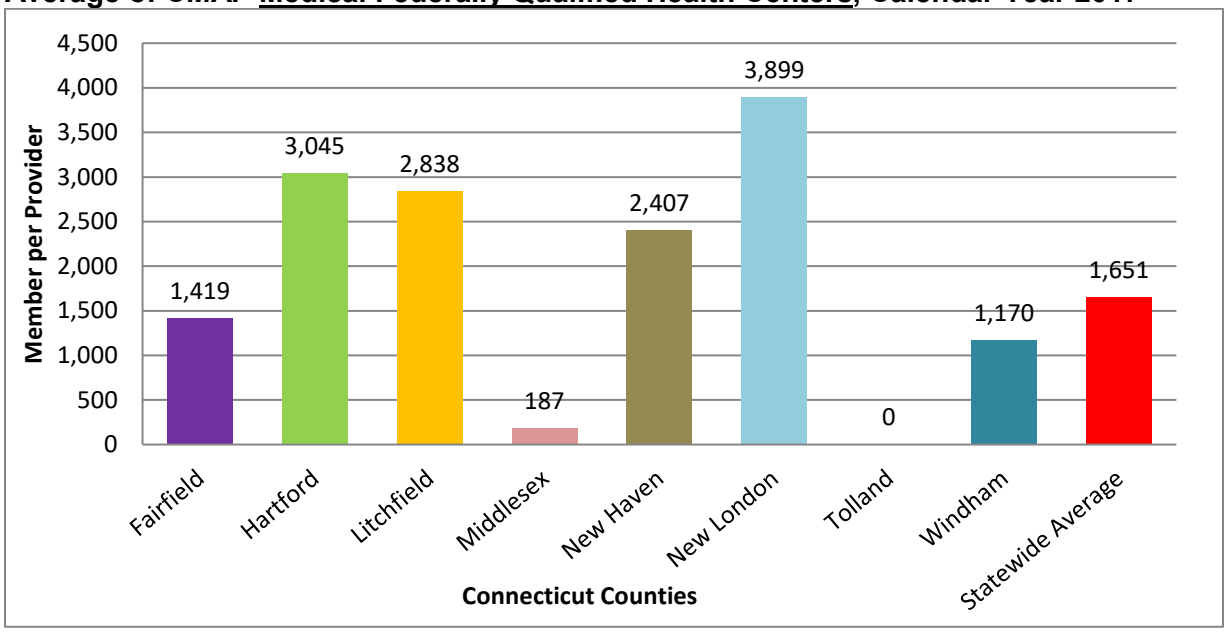


Figure 16 above shows the number of members per provider in each Connecticut County, in the category of Medical Federally Qualified Health Center (FQHCs) services of for primary care. In the case of FQHCs, the number of performing providers includes the number of performing providers at each FQHC site. The overall average ratio is 1,651 members to one provider, ranging from 0 to 3,899. Fairfield County has a ratio that is the closest to the statewide average, of 1,419. The counties of Litchfield and New London 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 187 members per one service site in calendar year 2017. Tolland County had no data of FQHC service sites, therefore, had a ratio of 0, however, members in that county have access to physician and other practitioner groups and outpatient hospitals.

Table 16: Counts of CMAP Independent Dental Practitioners, Calendar Years 2016 through 2018

Independent Dental Practitioners	**Statewide Performing Provider Count**		
Provider County Description	**CY 2016**	**CY 2017**	**CY 2018**
Fairfield	320	292	295
Hartford	388	368	366
Litchfield	36	38	40
Middlesex	51	48	45
New Haven	367	352	351
New London	60	61	60
Tolland	31	25	21
Windham	28	29	29
Statewide Total Performing Providers	1,281	1,213	1,207

Figure 17: CMAP Health Care Members-to-Provider Statewide Average of CMAP Independent Dental Practitioners, Calendar Year 2017

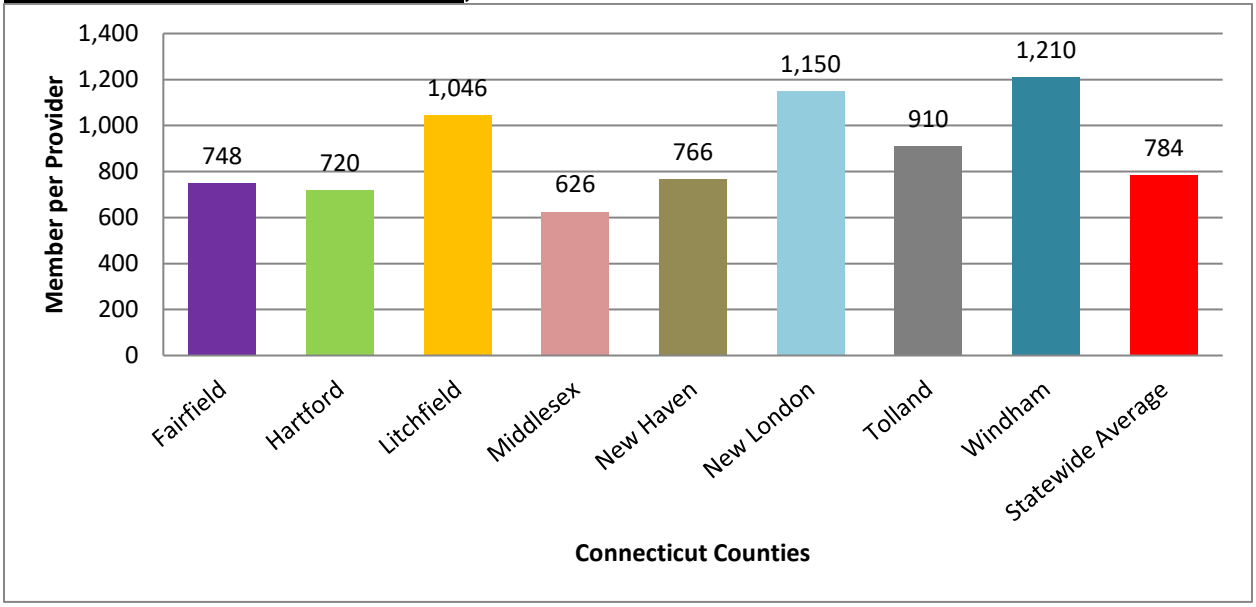


Figure 17 above shows, by county, the number of members per provider in the category of Individual and Group Independent Dental Practitioners. The statewide average ratio is 784 members per provider (an increase since CY 2014), with a range from 626 to 1,210. Windham County has the highest ratio at 1210 due to the limited number of dental practitioners available in this particular county. At 748, 766, and 720 Fairfield, New Haven and Hartford had ratios that were in closest to the statewide average, members per providers. Middlesex County had 626 members per one provider, showing greater availability in calendar year 2017. This is change from the data reported in CY 2014 that showed Hartford County with the greatest availability.

Table 17: Counts of CMAP Dental Federally Qualified Health Centers, Calendar Years 2016 through 2018

	Statewide Performing Provider Count		
Provider County Description	**Calendar Year 2016**	**Calendar Year 2017**	**Calendar Year 2018**
Fairfield	21	23	24
Hartford	35	39	39
Litchfield	6	10	9
Middlesex	25	24	24
New Haven	41	44	49
New London	15	15	15
Tolland	0	0	0
Windham	11	12	12
Statewide Total Performing Providers	**154**	**167**	**172**

Figure 18: CMAP Health Care Members-to-Provider Statewide Average of CMAP Dental Federally Qualified Health Centers, Calendar Year 2017

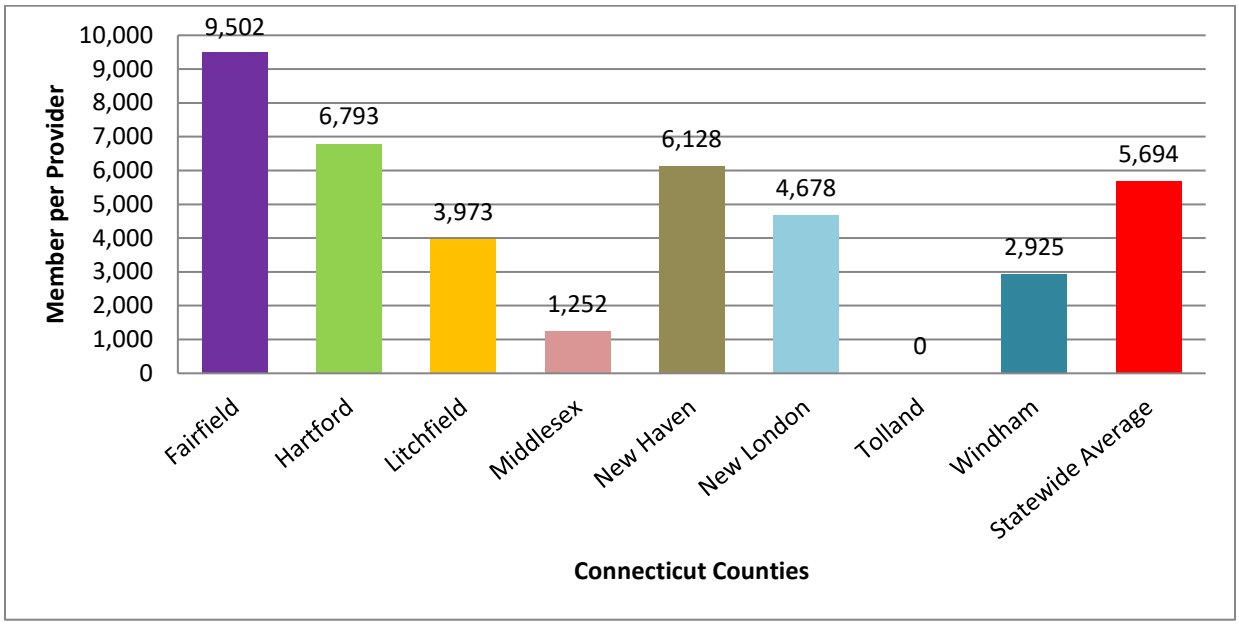


Figure 18 shows the number of members per provider in each county, within the category of Dental Federally Qualified Health Center (FQHCs) services of primary care. In the case of FQHCs, the number of performing providers is accounted for per site of service. The statewide average ratio is about 5,684 members per provider, with individual county numbers ranging from 0 to 9,502. New Haven County has a ratio that is the closest to the statewide average of 4,678. Fairfield, Hartford and New Haven counties have the highest ratios, due to the low number of FQHC service sites within those counties. In comparison, Middlesex County had 1252 members at one service site in calendar year 2017. 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 2016 through 2018

Behavioral Health-Independent Practitioners	**Statewide Performing Provider Count**		
Provider County Description MAP	**Calendar Year 2016**	**Calendar Year 2017**	**Calendar Year 2018**
Fairfield	696	821	937
Hartford	1,103	1,278	1,487
Litchfield	133	171	208
Middlesex	228	249	236
New Haven	1,043	1,243	1,377
New London	389	441	484
Tolland	136	132	136
Windham	86	97	140
Total Performing Providers	**3,814**	**4,432**	**5,005**

**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 2016 through 2018

	Statewide Performing Provider Count		
Provider County Description MAP	**Calendar Year 2016**	**Calendar Year 2017**	**Calendar Year 2018**
Fairfield	148	146	135
Hartford	168	169	182
Litchfield	54	38	27
Middlesex	42	25	29
New Haven	247	241	252
New London	40	56	72
Tolland	19	19	20
Windham	35	41	39
Total Performing Providers	**753**	**735**	**756**

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

Table 20: Counts of CMAP Behavioral Health Enhanced Care Clinics, CY 2016 – 2018

Behavioral Health-Enhanced Care Clinics (ECC)	**Statewide Performing Provider Count**		
Provider County Description MAP	**Calendar Year 2016**	**Calendar Year 2017**	**Calendar Year 2018**
Fairfield	56	59	58
Hartford	213	223	237
Litchfield	25	24	26
Middlesex	2	1	3
New Haven	60	79	62
New London	33	28	31
Tolland	14	15	14
Windham	5	2	1
Total Performing Providers	**408**	**431**	**432**

Figure 19: Members-to-Provider Ratio for CY2017 for Behavioral Health Services

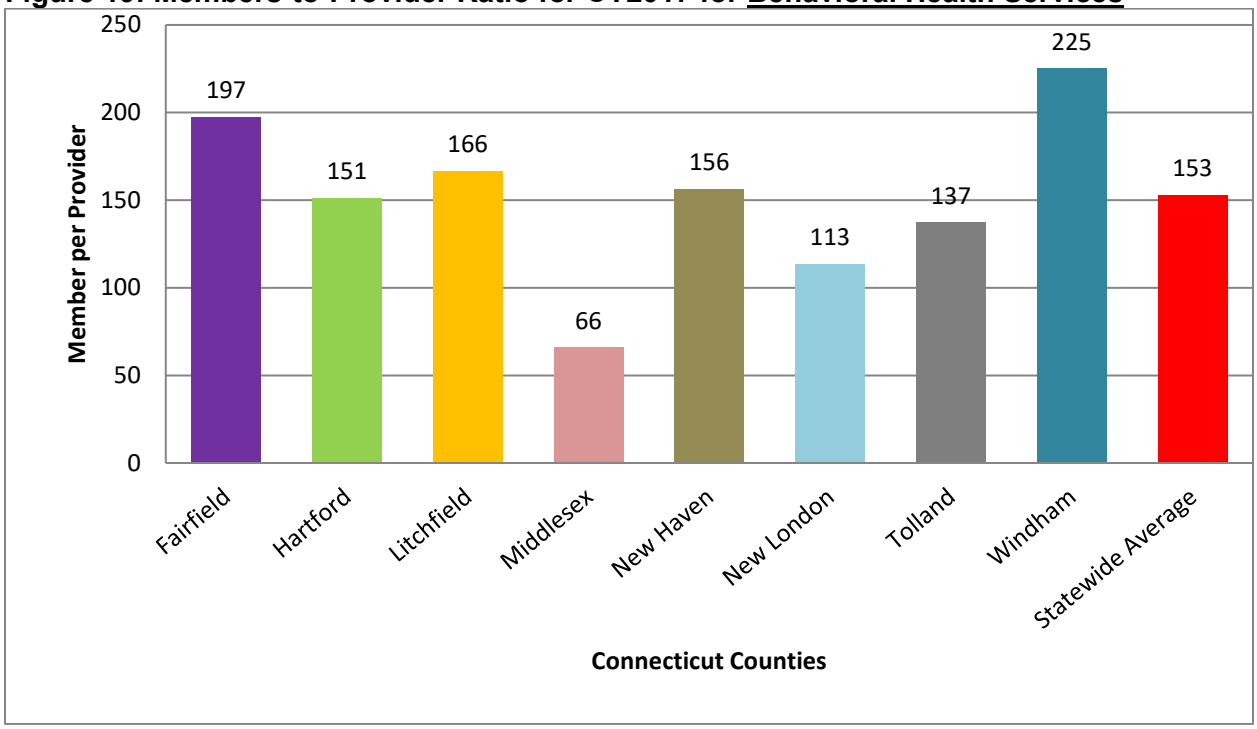


Figure 19 shows the number of members per provider in each county, within the category of Behavioral Health. The statewide average ratio is 153 members per provider (a reduction from the data reported in CY 2014), with ratios for individual counties ranging from 66 to 225. New Haven and Hartford Counties have a ratio in close proximity to the statewide average. Windham County has the highest ratio at 225, due to the small number of behavioral health providers in that county. In comparison, Middlesex had a ratio of 66 members to providers in calendar year 2017, showing the greater availability of providers per members within that county.

Table 21: Counts of CMAP Behavioral Health Federally Qualified Health Centers, Calendar Years 2016 through 2018

Behavioral Health Federally Qualified Health Centers	**Statewide Performing Provider Count**		
Provider County Description	**Calendar Year 2016**	**Calendar Year 2017**	**Calendar Year 2018**
Fairfield	63	82	92
Hartford	60	82	95
Litchfield	15	6	9
Middlesex	128	182	173
New Haven	154	163	151
New London	88	95	103
Tolland	0	0	0
Windham	31	16	23
Statewide Total Performing Providers	**539**	**626**	**646**

Fig. 20: Members-to-Provider Ratio by CMAP for Behavioral Health Federally Qualified Health Center, Calendar Year 2017

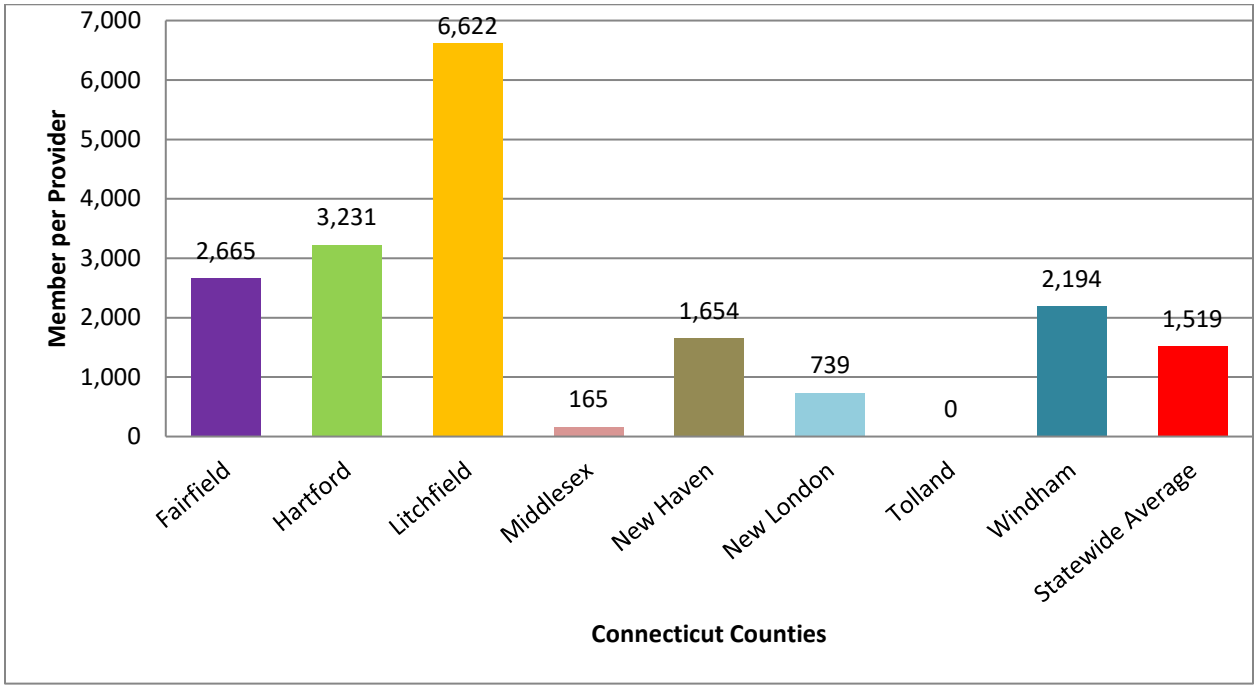


Figure 20 above shows the number of members per provider in each county, in the category of Behavioral Health Federally Qualified Health Center (FQHCs) services. In the case of BH FQHCs, the number of performing providers is counted per site of service. From the data presented, the statewide average ratio is about 1519 members to one provider, ranging from 0

to 6,622. New Haven County has a ratio of 1,654, the closest to the statewide average. Fairfield, and Hartford 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 165 members per one service site in calendar year 2017. 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 2016 through 2018

PRENATAL AND POSTNATAL OBSTETRIC CARE	Statewide Performing Provider Count		
Provider County Description	**Calendar Year 2016**	**Calendar Year 2017**	**Calendar Year 2018**
Fairfield	136	147	161
Hartford	449	511	493
Litchfield	10	11	14
Middlesex	18	25	13
New Haven	224	232	251
New London	30	45	35
Tolland	2	1	1
Windham	21	19	22
Statewide Total Performing Providers	**890**	**991**	**990**

Figure 21: Members-to-Provider Ratio by CMAP for CY2017 for Prenatal and Postnatal Obstetrics

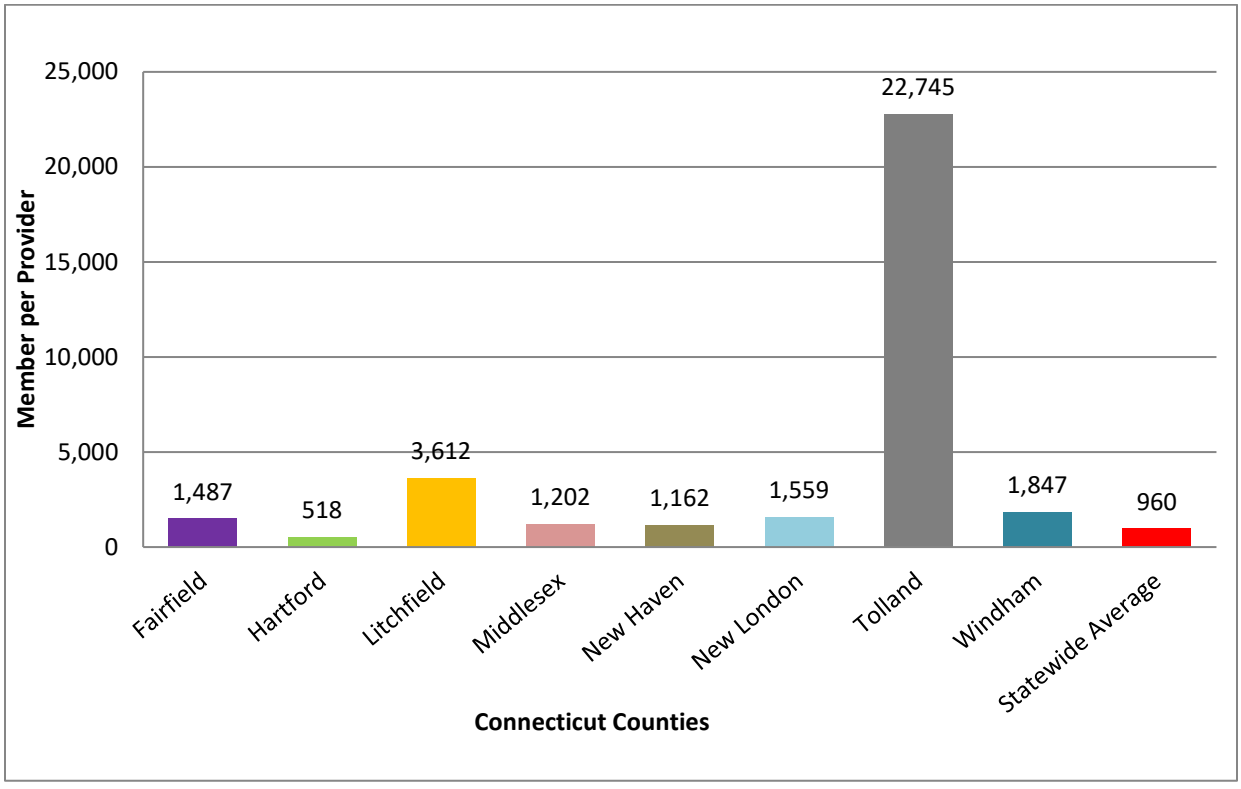


Figure 21 shows the number of members per provider in each county in the category of prenatal and postnatal obstetrics. The statewide average ratio is 960 members per one provider, with ratios for individual counties ranging from 518 to 22,745. New Haven County had a ratio of 1,162, which is in close proximity to the statewide average of 960. 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 518 members per one provider in calendar year 2017. This update includes a correction to the data reported in the first iteration of the AMRP. The first iteration reported over 18,000 providers for the Prenatal and Postnatal Obstetrics category. This data was in error and duplicated provider counts multiple times. The error was subsequently noticed in the data warehouse query design and this update has been corrected to de-duplicate the provider counts. The data shown in Table 22 and Figure 21 reflect an accurate count of the number of providers of prenatal and postnatal obstetrics care.

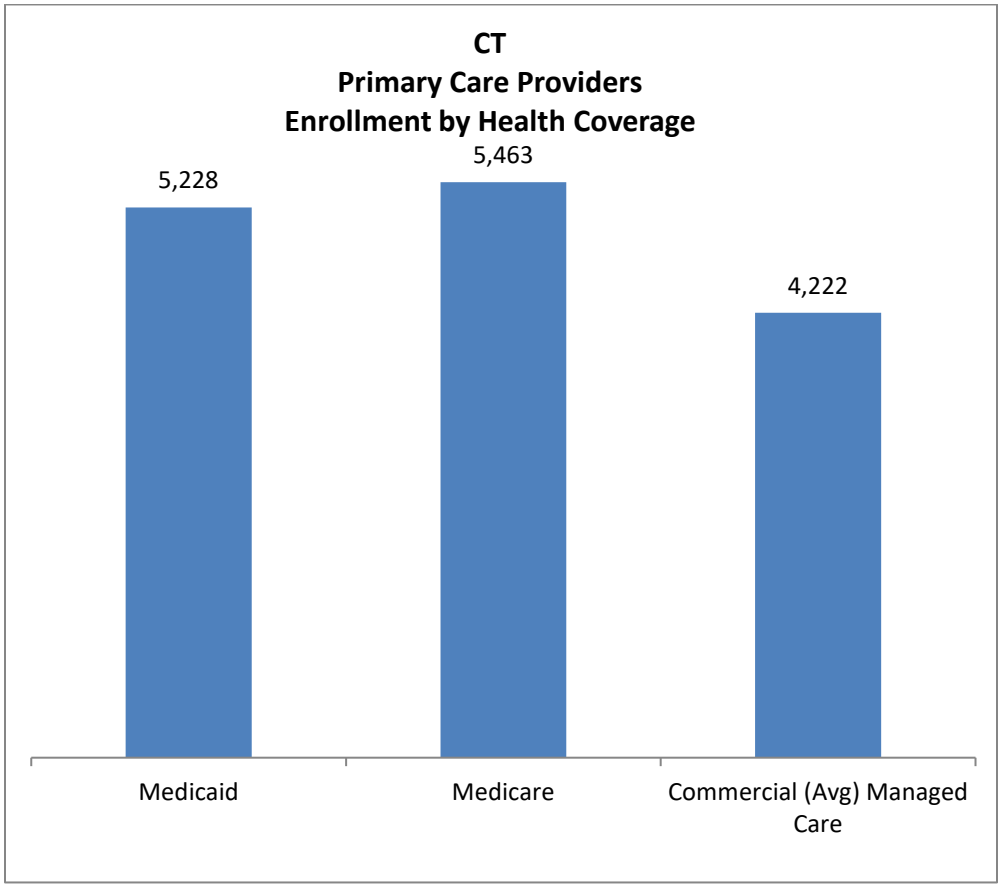
Overall, as the previous figures and tables show, there was adequate availability of providers for CMAP members throughout Connecticut in calendar year 2014. As shown, Windham and Litchfield counties have the higher member per provider ratio levels expected, due to the lower incidence of members within 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 forty-three 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 2017



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 2017 dates of service.

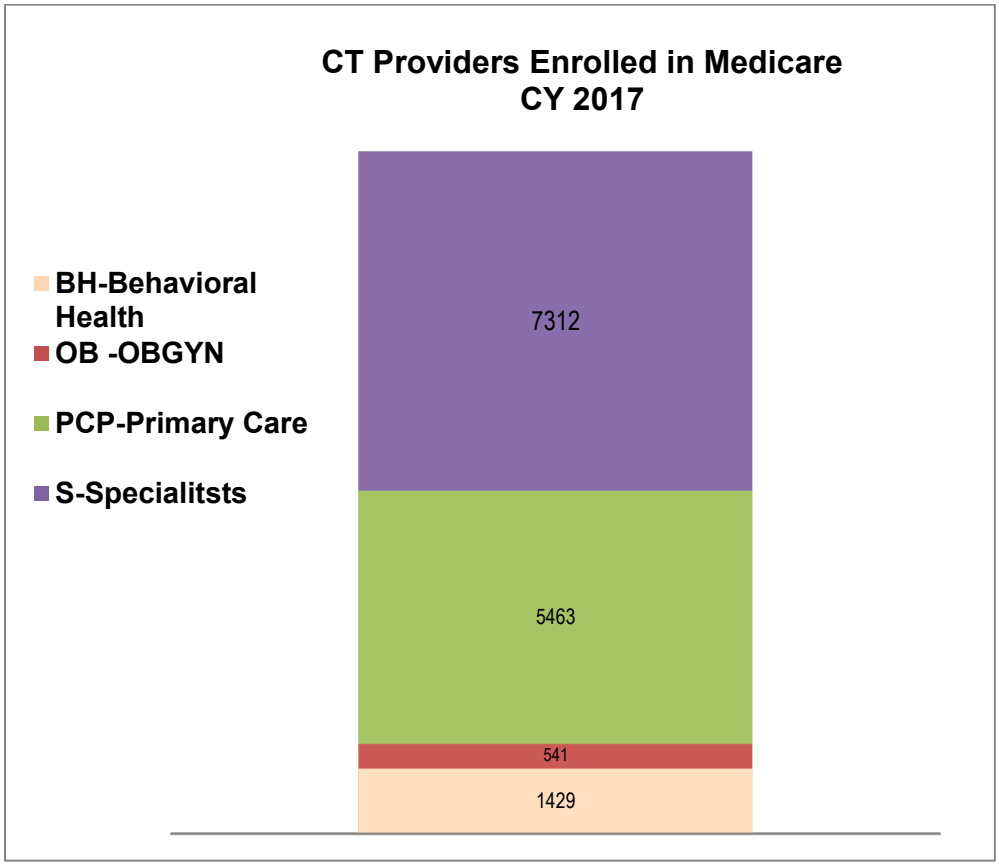
Medicare data was obtained from the Centers for Medicare & Medicaid Services (CMS)public data set, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File: Medicare Physician and Other Supplier Data CY 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends- 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 2017 by the Connecticut Department of Insurance. https://portal.ct.gov/-/media/CID/2017ConsumerReportCardpdf.pdf?la=en

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.

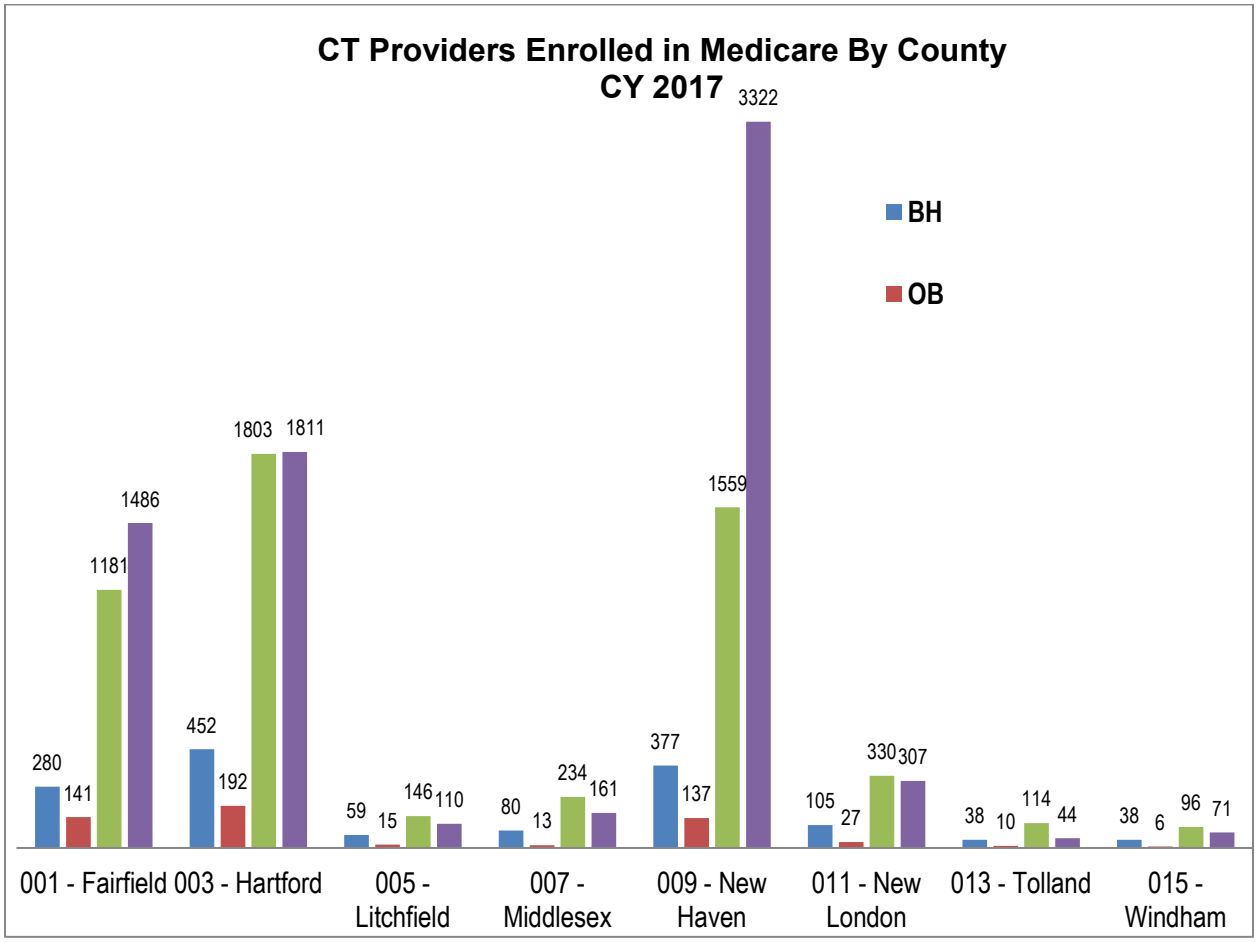
Fig. 23 CT Providers Enrolled in Medicare



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 2017



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 2017 and updated June 4, 2019

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier2017.html then go to: https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Physician-and-Other-Supplier-National-Pro/n5qc-ua94/data

The Physician and Other Supplier Public Use File (Physician and Other Supplier PUF) provides information on services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals. The Physician and Other Supplier PUF contains information on utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service. This PUF is based on information from CMS administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program. The data in the Physician and Other Supplier PUF covers calendar years 2012 through 2017 and contains

100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.

Special Note: This aggregate report is not restricted to the data reported in the Medicare Physician and Other Supplier Public Use File (PUF) but is aggregated based on all Medicare Part B non-institutional claims (excluding DMEPOS). Any aggregated records at the NPI level which are derived from 10 or fewer unique beneficiaries are excluded from this reporting to protect the privacy of Medicare beneficiaries. In addition, any beneficiary demographic sub-group counts that are based on 10 or fewer beneficiaries are suppressed. Percent of beneficiaries within each chronic condition are top-coded at 75%.
The following provider categories are/were included in the CT 2017 data set: BH=Behavioral Health; S=Specialist; PCP= Primary Care Provider; OB=OBGY."

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 2017 Medicare physician fee schedule (participating, non-facility). Exceptions to the 57.5% of 2017 Medicare include:

- dialysis services, which are reimbursed at approximately 92-94% of Medicare;
- physician administered drugs, biologics, vaccines and toxoids, which are reimbursed at 100% of the Medicare Drug Pricing File;
- fees for obstetric services, which are reimbursed at approximately 145% of the 2017 Medicare fee schedule; and,
- 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. 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 2017 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 HUSKY Health Increased Payments for Primary Care Services Fee Schedule, 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 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 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 53% of the services covered by Medicare; equal to or higher than 60% of the services covered by New York; and equal to or higher than 73% of the services covered by Massachusetts. Additionally, Connecticut reimburses for 36% more services than the Medicare program primarily because 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 96% of the most utilized primary care services delivered at medical clinics during CY 2017 were evaluation and management services (office visits) provided to established patients; the remaining 4% of evaluation and management services were provided to new patients. Connecticut's reimbursement for services provided at medical clinics average:

70% of Medicare
103% of Massachusetts
141% of New York

Table 24: Primary Care Services Provided by Medical Clinics									
Code	**Service**	**Share of Utilization**	**CT Rate**	**Medicare**		**Neighboring State Medicaid Fees**			
				NON FAC Rate	**% of Medicare**	**NY**	**% of NY**	**MA**	**% of MA**
99213	Est. patient office visit, 15min	52%	$52.15	$79.63	**65%**	$37.41	**139%**	$54.27	**96%**
99211	Est. patient office visit, 5min	19%	$18.14	$22.29	**81%**	$12.56	**144%**	$15.15	**120%**
99212	Est. patient office visit, 10min	15%	$32.58	$47.87	**68%**	$23.48	**139%**	$32.56	**100%**
99214	Est. patient office visit, 25min	10%	$78.94	$116.86	**68%**	$56.18	**141%**	$79.82	**99%**
99203	New patient office visit, 30min	4%	$80.65	$118.16	**68%**	$56.93	**142%**	$79.95	**101%**
		100%	***Average***		**70%**		**141%**		**103%**

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. New York fees for PCRI services are locality specific. 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 29% of the overall utilization of primary care service. The other 71% of overall utilization was for evaluation and management service procedure codes that do not differentiate the age of the patient. When compared to New York and Massachusetts Medicaid, CMAP's reimbursement for primary care services average:

126% 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 rate reimburses at 100% of the Medicare rate.

Table 25: Physician, APRN, PA - Primary Care Services									
				Medicare		Neighboring State Medicaid Fees			
Code	Service	Share of Utilization	CT Rate	NON FAC Rate	% of Medicare	NY	% of NY	MA	% of MA
99213	Est. patient office visit, 15min	40%	$79.19	$79.63	**99%**	$80.08	**99%**	$72.94	**109%**
99214	Est. patient office visit, 25min	32%	$116.60	$116.86	**100%**	$117.92	**99%**	$108.34	**108%**
99392	Est patient preventive exam, age 1-4	21%	$115.39			$116.71	**99%**	$83.15	**139%**
99391	Est patient preventive exam, younger 1-year	4%	$108.14			$109.33	**99%**	$78.00	**139%**
99393	Est patient preventive exam, age 5-11	4%	$114.99			$116.30	**99%**	$82.86	**139%**
		100%		***Average***	**100%**		**99%**		**126%**

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 108% more for this service. Connecticut's reimbursement for primary care dental services average:

107% of New York
100% of Massachusetts EPSDT (child) rate type
71% 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					
					NY	% of NY	MA	% of MA	MA EPSDT Rate	% of EPSDT Rate
D0120	Periodic oral eval est patient	27%	$34.30	$18.20	$25.00	**73%**	$20.00	**91%**	$29.00	**118%**
D1120	Prophylaxis-child	24%	$45.08	$23.92	$43.00	**56%**	$36.00	**66%**	$51.00	**88%**
D1208	Topical application fluoride exclude varnish	22%	$28.42	$15.08	$14.00	**108%**	$29.00	**52%**	$29.00	**98%**
D0230	Intraoral periapical each additional radiographic image	15%	$16.66	$8.84	$5.00	**177%**	$12.00	**74%**	$16.00	**104%**
D0220	Intraoral periapical first radiographic image	13%	$18.62	$9.88	$8.00	**124%**	$14.00	**71%**	$20.00	**93%**
		100%			***Ave.***	**107%**		**71%**		**100%**

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 fee schedule. New York services for specialists are reimbursed under the NYS Medicaid Medicine Services Fee Schedule.

Calendar year 2017 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:

56% of Medicare
108% of Massachusetts
99% of New York

Table 27: Physician Specialists									
Code	Service	Share of Utilization	CT Rate	Medicare		Neighboring State Medicaid Fees			
				NON FAC Rate	% of Medicare	NY	% of NY	MA	% of MA
99213	Est. patient office visit, 15min	40%	$42.93	$79.63	**54%**	$80.08	**99%**	$72.94	**109%**
99214	Est. patient office visit, 25min	37%	$64.99	$116.86	**56%**	$117.92	**99%**	$108.34	**108%**
99203	New patient office, 30 min	9%	$66.40	$118.16	**56%**	$118.89	**99%**	$109.05	**108%**
99204	New patient office, 45min	9%	$100.17	$178.41	**56%**	$182.15	**99%**	$165.90	**108%**
99212	Est. patient office visit, 10min	6%	$26.83	$47.87	**56%**	$48.17	**99%**	$43.98	**108%**
		100%	***Average***		**56%**		**99%**		**108%**

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 removed from the comparison since there is no equitable Medicare rate to compare 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.

100% of Massachusetts
113% of New York

Table 28: Behavioral Health Services - Office Setting

Code	Service	Share of Utilization	CT Rate	Neighboring State Medicaid Fees			
				NY	% of NY	MA	% of MA
90837	Psychotherapy, 60min	54%	$88.08	$72.35	**122%**	$91.72	**96%**
90834	Psychotherapy, 45min	21%	$59.61	$49.46	**121%**	$61.00	**98%**
90853	Group psychotherapy	12%	$20.95	$18.67	**112%**	$18.51	**113%**
90847	Family psychotherapy w/ patient	7%	$71.38	$65.51	**109%**	$76.65	**93%**
90791	Psychiatric diagnostic eval	6%	$96.82	$93.26	**104%**	$95.09	**102%**
		100%	***Average***		**113%**		**100%**

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
131% of Massachusetts
148% 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	% NY	MA	% MA
59025	Fetal non-stress test	69%	$66.24	$54.13	**122%**	$45.92	**144%**	$51.56	**128%**
59400	Obstetrical pre post	13%	$2,612.33	$2,343.04	**111%**	$1,720.75	**152%**	$2,173.45	**120%**
59510	Cesarean pre post care	7%	$2,950.61	$2,603.24	**113%**	$1,948.09	**151%**	$2,403.88	**123%**
59514	Cesarean delivery	6%	$1,375.77	$1,029.21	**134%**	$974.28	**141%**	$943.39	**146%**
59409	Vaginal delivery	5%	$1,164.31	$912.29	**128%**	$763.98	**152%**	$839.04	**139%**
		100%		***Average***	**122%**		**148%**		**131%**

Access Analysis by Category: Utilization Trends CYs 2016 - 2018

In order to fulfill the scope for the update of the AMRP, Connecticut Medicaid queried for utilization data from the three general categories reported on in the first iteration, *Medical Primary Care, Dental Primary Care and Behavioral Health Care services.* 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) – 2016, 2017 and 2018. 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

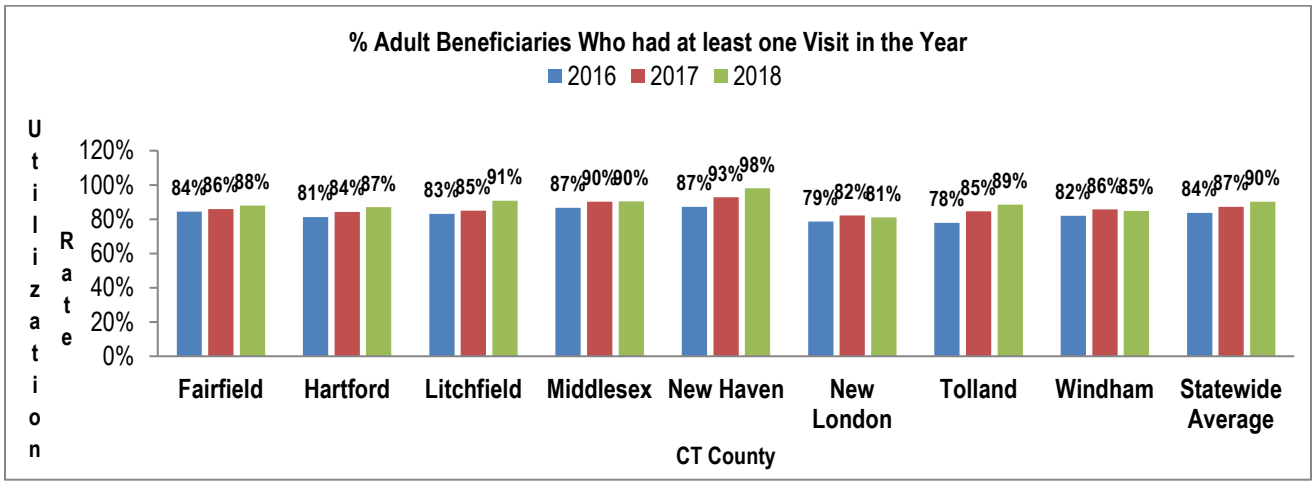
Utilization was assessed for adults and children by county for medical primary care services identified by specific procedure codes and provided by the following categories of providers: Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs and Hospital Outpatient Clinics.

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 CY2016 - CY2018

Beneficiary (Adult) County	2016		2017		2018	
	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	122,651	84.4%	125,451	85.8%	126,594	88.0%
Hartford	158,284	81.3%	160,785	84.2%	161,686	87.0%
Litchfield	24,817	83.1%	24,887	85.0%	24,763	90.7%
Middlesex	19,478	86.6%	19,579	90.2%	19,913	90.4%
New Haven	159,252	87.3%	162,160	92.8%	163,837	98.1%
New London	43,063	78.7%	43,041	82.2%	42,806	81.0%
Tolland	14,196	77.8%	14,158	84.6%	14,184	88.6%
Windham	20,846	82.0%	20,935	85.6%	20,936	84.7%
Statewide	**562,587**	**83.7%**	**570,996**	**87.1%**	**574,719**	**90.2%**

Source: CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019.

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 CY2016 - CY2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with date of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019.

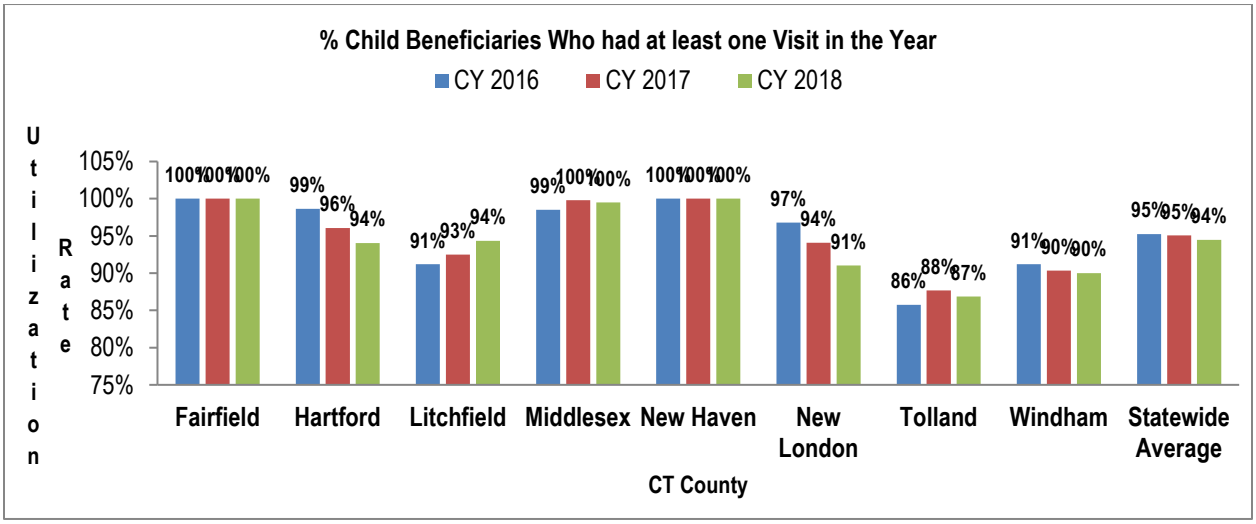
For adult beneficiaries (age 21 and above), the statewide rate of access (the percentage of adult beneficiaries who made at least one visit to a medical primary care provider in a year) increased consistently between CYs 2016 to CY 2018 (see Table 30 and Figure 25 above). All counties, except New London and Windham counties that showed a very slight decrease (~1.5% and ~1%) between CY 2017 and 2018, showed an increase in utilization over the 3 year time period analyzed. These rates of utilization for CYs 2016 through 2018 were all This trend, that ranged anywhere from a 0.2% to 8% increase over the three years, showed that Connecticut adult members are able to access medical primary care services covered under CMAP. When the statewide averages for 2016 through 2018 were compared to the statewide averages for 2013 through 2015, the data shows that the rate of adult utilization of medical primary care services for 2016 through 2018 increased between 22% and 27%.

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 2016 to 2018

Member (Children) County	2016		2017		2018	
	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	90,625	100%	93,104	100%	94,504	100%
Hartford	102,373	98.63%	104,142	96.08%	104,496	94.05%
Litchfield	14,691	91.21%	14,845	92.52%	14,777	94.33%
Middlesex	10,386	98.53%	10,468	99.79%	10,367	99.52%
New Haven	105,642	100%	107,451	100%	108,055	100%
New London	27,129	96.79%	27,134	94.08%	26,934	91.03%
Tolland	8,546	85.77%	8,587	87.67%	8,502	86.89%
Windham	13,982	91.20%	14,163	90.37%	14,242	90.00%
Statewide	**373,374**	**95.27%**	**379,894**	**95.06 %**	**381,877**	**94.48%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019.

Fig. 26: Rate of <u>Child</u> Utilization of Medical Primary Care Services provided by Physicians, APRNs, Physician Assistants, Medical Clinics, Medical FQHCs, and Hospital Outpatient Clinics, by County for CY 2016 to 2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019.

The statewide average rate of access to medical primary care for CMAP members age 0 to 20 continued to be relatively high across all counties for CYs 2016 through 2018 as seen in Table 31. A few counties showed decreases in utilization between Y 2017 and 2018 ranging less than one percent and up to 3 %, however when the data for CY 2018 was compared to the data for CY 2015 reported in the first iteration of the AMRP, it was noted that the rate of utilization in 2018 remained higher than the rates of utilization for 2015 across all of the counties.

The 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 Children and Adolescents' Access to Primary Care Practitioners, Children and Adolescents' Access to Primary Care Practitioners, Adolescent Well-care Visits, and Children and Adolescent's Access to Primary Care Practitioners. HEDIS data for CY 2018 was not available at the time of this analysis.

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 2016 to 2018

Benefit Plan (All Recipients)	CY 2016		CY 2017		CY 2018	
	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	553,750	93.11%	551,971	95.30%	548,650	96.22%
HUSKY C	109,601	40.76%	106,034	40.28%	102,501	38.27%
HUSKY D	272,610	74.46%	292,885	75.62%	305,446	76.46%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

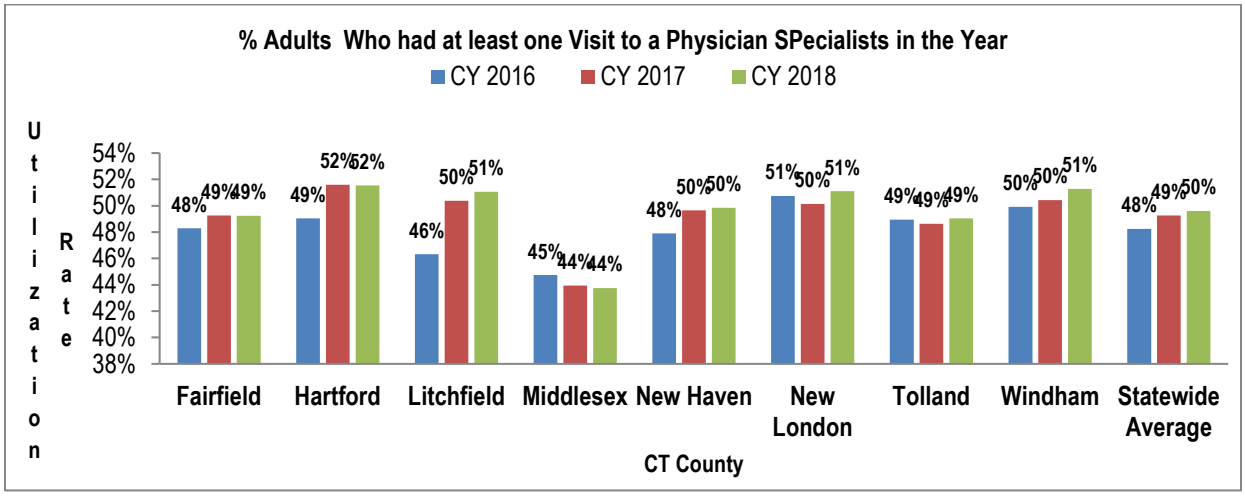
Physician Specialist Services

Table 33: Distribution of Adult Utilization of Physician Specialist Services - CY2016 - CY2018

Beneficiary (Adult) County	2016		2017		2018	
	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	122,651	48.30%	125,451	49.26%	126,594	49.23%
Hartford	158,284	49.05%	160,785	51.60%	161,686	51.55%
Litchfield	24,817	46.32%	24,887	50.38%	24,763	51.07%
Middlesex	19,478	44.74%	19,579	43.94%	19,913	43.76%
New Haven	159,252	47.89%	162,160	49.66%	163,837	49.85%
New London	43,063	50.75%	43,041	50.13%	42,806	51.10%
Tolland	14,196	48.96%	14,158	48.62%	14,184	49.04%
Windham	20,846	49.92%	20,935	50.44%	20,936	51.28%
Statewide	**562,587**	**48.24%**	**570,996**	**49.26%**	**574,719**	**49.61%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Figure 27: Rate of Adult Utilization of Physician Specialist Services – CY 2016-2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

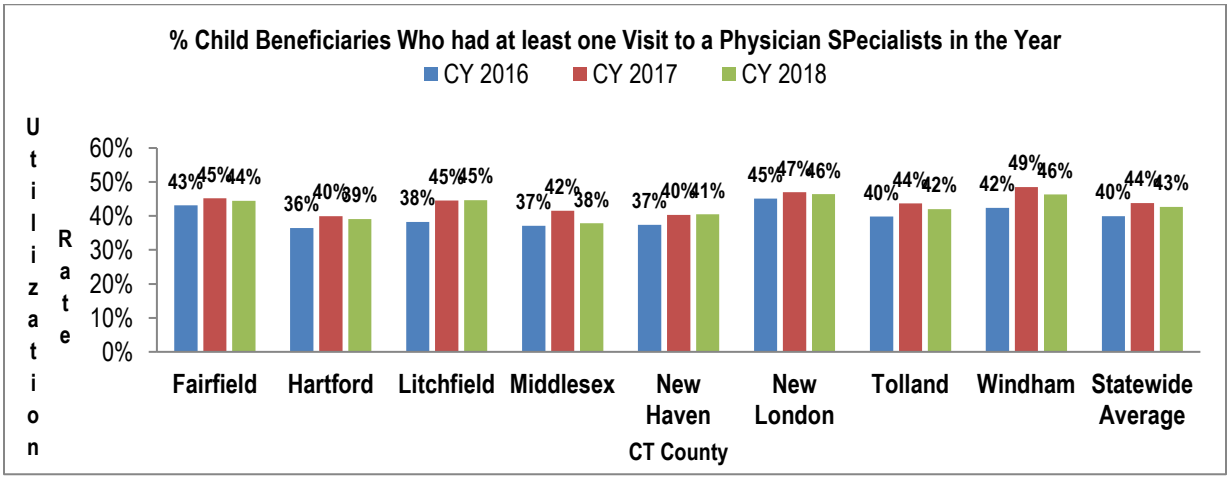
Utilization of specialist services was again queried based on a provider type and specialty not identified as a primary care, behavioral health, obstetric or home health provider, since these providers are analyzed under their respective category of care as specified in the final rule. The percentage of adult beneficiaries who received service from one of the selected specialist providers at least once during a calendar year remained consistently between 44% and 52% across all eight counties throughout CYs 2016 through 2018. For CYs 2016 through 2018 Hartford, New London and Windham counties 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. Based on Table 33 the statewide averages for the rate of adult utilization of physician specialist services for CYs 2016 through 2018 were higher than the rates reported in the first iteration for CYs 2013 through 2015.

Table 34: Distribution of Child Utilization of Physician Specialist Services - CY2016 - CY2018

Member (Children) County	2016		2017		2018	
	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	90,625	43.17%	93,104	45.20%	94,504	44.47%
Hartford	102,373	36.43%	104,142	39.97%	104,496	39.13%
Litchfield	14,691	38.23%	14,845	44.55%	14,777	44.65%
Middlesex	10,386	37.13%	10,468	41.50%	10,367	37.86%
New Haven	105,642	37.42%	107,451	40.29%	108,055	40.50%
New London	27,129	45.10%	27,134	46.95%	26,934	46.40%
Tolland	8,546	39.79%	8,587	43.66%	8,502	42.03%
Windham	13,982	42.42%	14,163	48.52%	14,242	46.34%
Statewide	**373,374**	**39.96%**	**379,894**	**43.83%**	**381,877**	**42.67%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Figure 28: Rate of Child Utilization of Physician Specialist Services - CY2016 - CY2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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

Benefit Plan (All Recipients)	CY 2016		CY 2017		CY 2018	
	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	553,750	47.55%	551,971	49.98%	548,650	49.90%
HUSKY C	109,601	32.07%	106,034	31.55%	102,501	29.96%
HUSKY D	272,610	58.15%	292,885	59.34%	305,446	59.51%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

The statewide average percent of CMAP child beneficiaries who received services from an enrolled specialist at least once during calendar years 2016 through 2018 ranged between 36% and 48%, with New London continuing to be the county with the highest individual county utilization (similar to the data reported in the first iteration of the AMRP - See Table 34 and Figure 28). The percentages across all of the counties are all increased as compared to the data reported for CYs 2013 through 2016. It can be noted that the percentage of HUSKY C members actually decreased between CYS 2016 and 2018, yet the rate of utilization increased between CY 2016 and CY 2017 and only slightly decreased between CY 2017 and CY 2018.

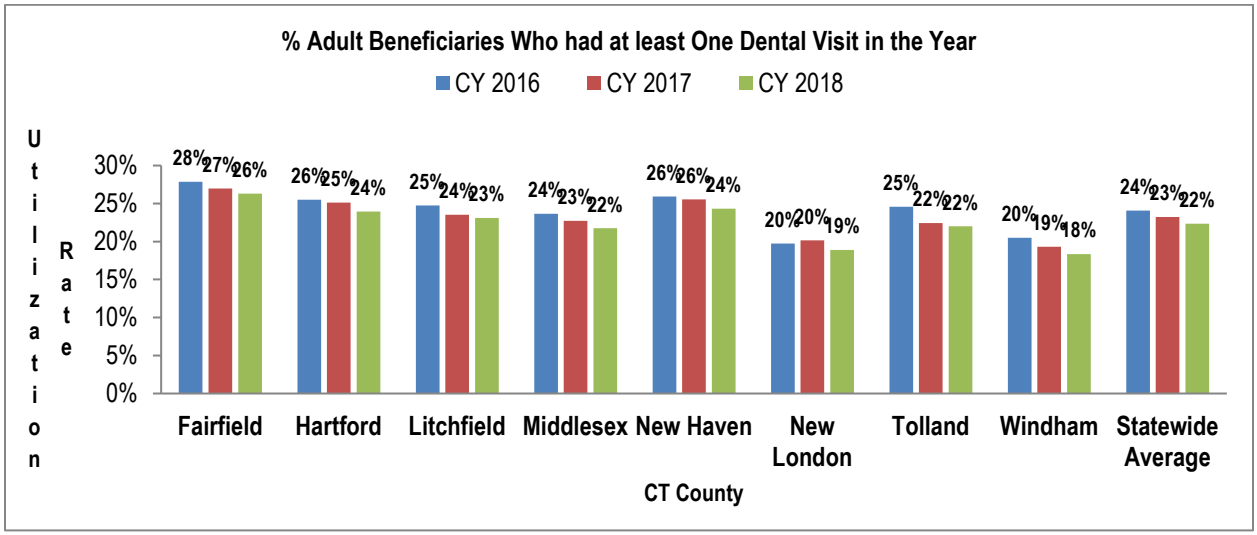
Dental Primary Care

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 2016 to 2018

Beneficiary (Adult) County	2016		2017		2018	
	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	122,651	27.84%	125,451	26.97%	126,594	26.30%
Hartford	158,284	25.52%	160,785	25.14%	161,686	23.94%
Litchfield	24,817	24.73%	24,887	23.52%	24,763	23.12%
Middlesex	19,478	23.63%	19,579	22.73%	19,913	21.76%
New Haven	159,252	25.91%	162,160	25.54%	163,837	24.32%
New London	43,063	19.73%	43,041	20.15%	42,806	18.89%
Tolland	14,196	24.57%	14,158	22.44%	14,184	22.00%
Windham	20,846	20.48%	20,935	19.33%	20,936	18.36%
Statewide	**562,587**	**24.05%**	**570,996**	**23.23%**	**574,719**	**22.34%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Figure 29: Rate of Adult Utilization of Dental Primary Care Services - CY 2016 to CY 2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

For CYs 2016 through 2018, 20% to 30% of adult CMAP members (age 21 and above) had at least one dental primary care encounter under the CMAP. Table 36 and Figure 29 above showed that the rate of adult access to dental primary care services statewide was between 29% - 30% over the three-year period. It should be noted that while Windham and New London Counties continue to have significantly lower rates of utilization as compared to the other counties, these counties (in addition to Tolland) have fewer dentists practicing in these counties

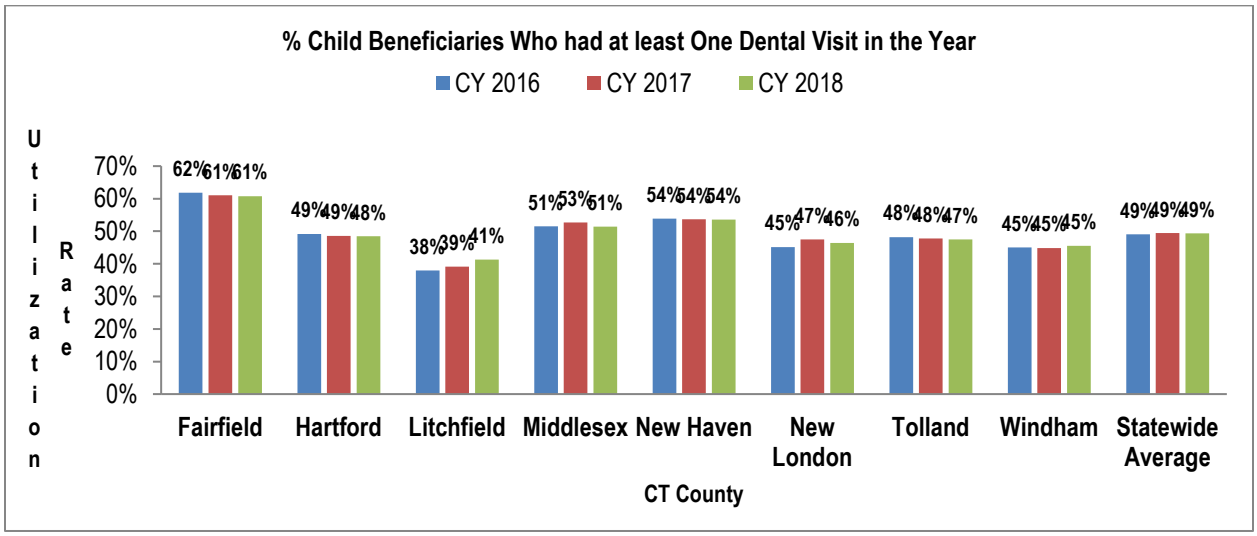
in general, a statistic that is not unique to Medicaid or necessarily unique to dental services. The rate of utilization of dental services for CYs 2016 through 2018 however has decreased as compared to the rate of utilization reported in the first iteration of the AMRP for CYs 2013 through 2015. Specific reasons for the reduction in utilization could not be identified and while the CMAP implemented a reimbursement change under the dental program in 2016, as is noted in the access monitoring analysis that is required for all rate reduction State Plan Amendments (SPA), it was determined that the SPA has not negatively impacted access to care (see Appendix).

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 2016 to 2018

Member (Children) County	2016		2017		2018	
	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	90,625	61.81%	93,104	61.07%	94,504	60.80%
Hartford	102,373	49.20%	104,142	48.61%	104,496	48.46%
Litchfield	14,691	37.94%	14,845	39.17%	14,777	41.27%
Middlesex	10,386	51.47%	10,468	52.67%	10,367	51.38%
New Haven	105,642	53.87%	107,451	53.71%	108,055	53.60%
New London	27,129	45.17%	27,134	47.46%	26,934	46.39%
Tolland	8,546	48.20%	8,587	47.78%	8,502	47.46%
Windham	13,982	45.00%	14,163	44.88%	14,242	45.48%
Statewide	**373,374**	**49.08%**	**379,894**	**49.42%**	**381,877**	**49.36%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Figure 30: Rate of Child Utilization of Dental Primary Care Services – CY 2016 to CY 2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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

Benefit Plan (All Recipients)	CY 2016		CY 2017		CY 2018	
	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	553,750	41.80%	551,971	41.67%	548,650	41.63%
HUSKY C	109,601	25.88%	106,034	24.99%	102,501	23.58%
HUSKY D	272,610	23.46%	292,885	22.76%	305,446	22.08%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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 approximately 49% all three calendar years analyzed (CY 2016, 2017 and 2018). Fairfield County continued to show the highest in member use of this service (see Figure 30 above) in this update as was seen during the first iteration for CYs 2013 through 2015. Although the data for this update showed a decrease in the utilization rates as compared to the data reported for CYs 2013 through 2015, the percentage of CMAP child members who had at least one dental primary care visit remained above the National Medicaid 50th Percentile (41.8%) at 75.8% for CY 2017 (HEDIS measures for 2018 were not available at the time of this update).

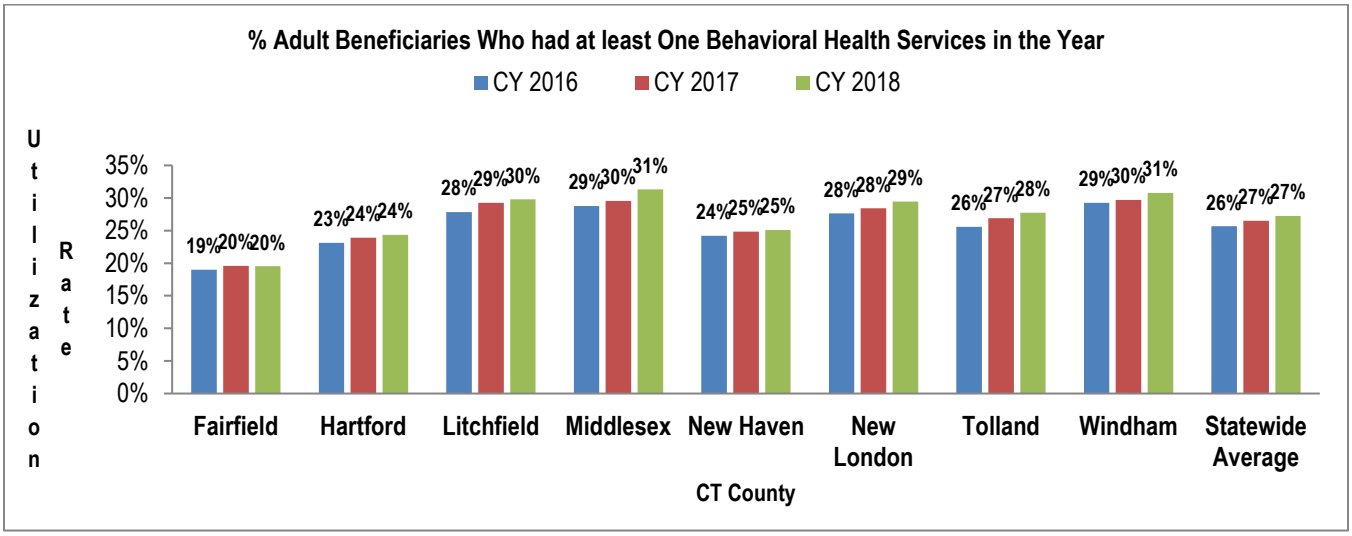
Behavioral Health Services

Table 39: Distribution of Adult Utilization of Behavioral Health Services - CY2016 - 2018

Beneficiary (Adult) County	2016		2017		2018	
	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	122,651	18.99%	125,451	19.60%	126,594	19.54%
Hartford	158,284	23.14%	160,785	23.89%	161,686	24.34%
Litchfield	24,817	27.83%	24,887	29.26%	24,763	29.81%
Middlesex	19,478	28.78%	19,579	29.56%	19,913	31.31%
New Haven	159,252	24.21%	162,160	24.82%	163,837	25.11%
New London	43,063	27.66%	43,041	28.44%	42,806	29.44%
Tolland	14,196	25.58%	14,158	26.91%	14,184	27.75%
Windham	20,846	29.24%	20,935	29.68%	20,936	30.76%
Statewide	**562,587**	**25.68%**	**570,996**	**26.52%**	**574,719**	**27.26%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Figure 31: Rate of Adult Utilization of Behavioral Health Services - CY2016 - 2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

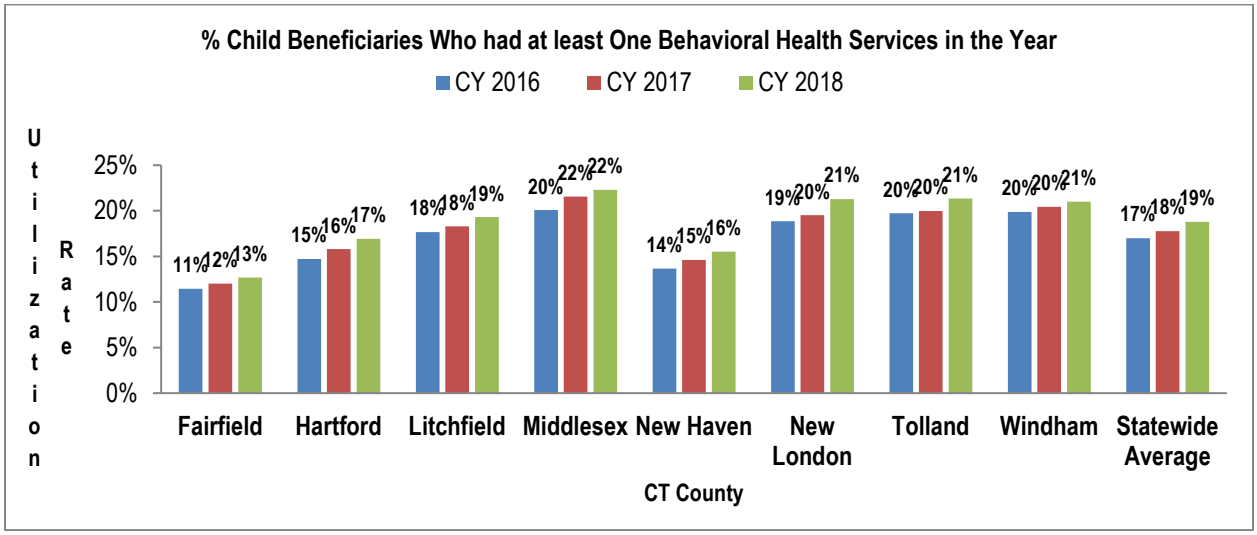
The statewide average utilization of behavioral health services by adult CMAP members was 26% in CY 2016, 27% in CY 2017 and 27% in CY 2018. These rates were comparable to the rate of utilization reported in the first iteration of the AMRP for CYs 2013 through 2015 (shown in Table 39 and Figure 31 above). Similar to the data reported for CYs 2013 through 2015 the highest utilization of behavioral health services among adult CMAP members over the three-year period between 2016 through 2018 included New London, Windham and Middlesex Counties. A change noted in the data for this update showed in addition to New London, Windham and Middlesex counties, Litchfield also showed high utilization of behavioral health services among adult CMAP members. Fairfield County continued to show the lowest utilization rates for this service over the three years analyzed.

Table 40: Distribution of Child Utilization of Behavioral Health Services – CY 2016 – 2018

Member (Children) County	2016		2017		2018	
	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	90,625	11.45%	93,104	12.01%	94,504	12.67%
Hartford	102,373	14.72%	104,142	15.79%	104,496	16.92%
Litchfield	14,691	17.68%	14,845	18.28%	14,777	19.29%
Middlesex	10,386	20.07%	10,468	21.57%	10,367	22.29%
New Haven	105,642	13.67%	107,451	14.59%	108,055	15.52%
New London	27,129	18.87%	27,134	19.51%	26,934	21.29%
Tolland	8,546	19.75%	8,587	19.97%	8,502	21.35%
Windham	13,982	19.87%	14,163	20.45%	14,242	20.98%
Statewide	**373,374**	**17.01%**	**379,894**	**17.77%**	**381,877**	**18.79%**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Figure 32: Rate of Child Utilization of Behavioral Health Services – CY2016 - 2018



Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

The statewide average utilization rate for Behavioral Health service among child CMAP members was between 17% and 19% for the three calendar years of 2016 through 2018. Similar to the data reported for CYs 2013 through 2015, Fairfield County continued to report the lowest use of behavioral health services among CMAP child members over the three year period – 11% in CY 2016, 12% in CY 2017 and 13% in CY 2018 (see Table 40 and Figure 32 above). Similarly New Haven and Hartford counties also show lower utilization of BH services as compared to the other counties across the state (New Haven County - 16%, Hartford - 15% in CY 2018). Of note, similar to the data reported in the first iteration, the rates of utilization for Behavioral Health service increased from year to year over the three year period analyzed.

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

Benefit Plan (All Recipients)	CY 2016		CY 2017		CY 2018	
	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	553,750	15.68%	551,971	16.50%	548,650	17.34%
HUSKY C	109,601	19.39%	106,034	19.09%	102,501	17.84%
HUSKY D	272,610	27.52%	292,885	27.92%	305,446	28.43%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Pre- and Post-natal Obstetric Services

The utilization pattern was 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 2016 to 2018. The results of this analysis are in Table 42, 43 and 44. Table 42 below depicts the total number of CMAP deliveries by county (based on claims that were paid). Undocumented mothers and their deliveries were excluded. The utilization rate showed that approximately 74% of women who gave birth to a child in calendar year 2017 received pre-and post-natal care. The trend for the three year period analyzed showed that that the rate of women who gave birth and also received pre-and post-natal care increased from approximately 71% to 75% between CYs 2016 through 2018. Table 45 compares CT HEDIS Measures with the measures obtained for the National 50th percentile. As shown CT measures for CY 2017 for the two measures (percentage of deliveries that had one timely prenatal visit and percentage of deliveries that had one timely post-partum visit) were higher than the reported National 50th percentile measures. This trend was consistent with the data reported in the first iteration of the AMRP and suggests that women who give birth in CT has appropriate and adequate access to OB/GYN providers to support access to prenatal and post-natal care. It should be noted however, that the CT reported percentage of women receiving timely postpartum visits decreased from 70.3% to 66.4% when the data from 2014 is compared to the data from 2017. While the CT data is still higher than the National 50th percentile, the CMAP should note this reduction for potential monitoring.

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

Member County	2016 Number of CMAP Members Who Received Pre- and Post- Partum Care	2017 Number of CMAP Members Who Received Pre- and Post- Partum Care	2018 Number of CMAP Members Who Received Pre- and Post- Partum Care
Fairfield	1,718	1,704	1,804
Hartford	3,089	3,100	3,220
Litchfield	455	458	429
Middlesex	289	269	237
New Haven	2,801	3,176	3,069
New London	1,006	945	848
Tolland	251	253	244
Windham	425	439	395
Statewide Totals	**10,034**	**10,339**	**10,246**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Table 43: Number of CMAP Deliveries by County

Member County	2016 Number of CMAP Members Who had Live Deliveries	2017 Number of CMAP Members Who had Live Deliveries	2018 Number of CMAP Members Who had Live Deliveries
Fairfield	3,553	3,569	3,520
Hartford	3,742	3,697	3,760
Litchfield	507	494	469
Middlesex	347	319	301
New Haven	4,115	4,086	3,963
New London	1054	1,007	917
Tolland	271	288	268
Windham	493	464	442
Statewide Totals	**14,082**	**13,924**	**13,640**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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

Member County	2016 Percent of all Deliveries with Pre- and Post-Partum Care	2017 Percent of all Deliveries with Pre- and Post-Partum Care	2018 Percent of all Deliveries with Pre- and Post- Partum Care
Fairfield	48%	48%	51%
Hartford	83%	84%	86%
Litchfield	90%	93%	91%
Middlesex	83%	84%	79%
New Haven	68%	78%	77%
New London	95%	94%	92%
Tolland	93%	88%	91%
Windham	86%	95%	89%
Statewide Totals	71%	74%	75%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

Table 45. CMAP HEDIS Measures Prenatal Care and Postpartum Care

		2014		2017	
HEDIS Measure*	**Short Description**	**CT**	**Nat'l 50th percentile**	**CT**	**Nat'l 50th percentile**
Prenatal	The % of deliveries that had one timely prenatal visit	85.6%	85.2%	89.4%	81.1%
Postpartum	The % of deliveries that had one timely post-partum visit	70.3%	62.8%	66.4%	64.4%

**2018 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 and. child, who received at least one home health service across the eight counties for the past three calendar years (CYs) 2016 through 2018. The results of this analysis are displayed in Tables 46 and 47. Table 48 displays the distribution of member utilization of Home Health Services by benefit plan (HUSKY A, C and D). As displayed in Tables 46 and 47, utilization of home health services has decreased over the three year time period analyzed between 2016 through 2018 among both the adult and child populations across all counties. The reduction ranged from two to three percent for the adult population and held steady at approximately 13% reduction for the child population for the time period analyzed. While reductions were noted for both populations the CMAP has not determined there to be an access to care issue for home health services please refer to the conclusion for further discussion. Not surprisingly, the data displayed in Table 48 showed that of the benefit plans, HUSKY A, C and D, members enrolled under HUSKY C receive the predominant amount of home health services as compared to HUSKY A and D.

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

Member (Adult) County	2016 Utilization of Home Health Services	2017 Utilization of Home Health Services	2018 Utilization of Home Health Services
Fairfield	2,926	2,768	2,680
Hartford	3,609	3,632	3,489
Litchfield	567	562	543
Middlesex	431	422	384
New Haven	4,889	4,849	4,734
New London	975	843	885
Tolland	239	232	233
Windham	439	446	387
Statewide	**14,075**	**13,754**	**13,335**

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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

Member County	2016 Utilization of Home Health Services	2017 Utilization of Home Health Services	2018 Utilization of Home Health Services
Fairfield	714	576	496
Hartford	797	727	634
Litchfield	102	96	78
Middlesex	76	65	54
New Haven	831	759	639
New London	112	77	96
Tolland	45	48	47
Windham	52	33	31
Statewide	2,729	2,381	2,075

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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

Benefit Plan (All Recipients)	CY 2016		CY 2017		CY 2018	
	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	553,750	0.83%	551,971	0.75%	548,650	0.69%
HUSKY C	109,601	6.80%	106,034	6.59%	102,501	6.21%
HUSKY D	272,610	1.76%	292,885	1.72%	305,446	1.74%

Source:- CT Medicaid Data Warehouse Data from Medicaid Management Information System with data of services from January 1, 2016 through December 31, 2018 of paid claims through Aug 2019

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 continues to provide sufficient access to services and complies with the federal access regulations.

Member Characteristics

As outlined in Table 5, of the total CMAP population enrolled during CY 2017, similarly to data reported for 2014, the majority of members continue to be covered under HUSKY A (pregnant women, children and caretakers of children), with the second highest number of members enrolled under HUSKY D (low income adults) and only 11% covered under HUSKY C (aged, blind and disabled). As previously discussed enrollment under HUSKY A and D increased since 2014, with a significant increase in the enrollment under HUSKY D. As expected, the percentage of children is significantly higher under HUSKY A versus the other two eligibility groups. Slightly more women than men participate in HUSKY A and C, while with HUSKY D; the percentage of male participants was greater. Review of the percentage of 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 (7th highest nationwide in 2017 – up from 6th place previously), 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 continue to include the following:

Intensive Care Management (ICM) interventions that solicit information on social determinates of health (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; State Balancing Inventive Program No Wrong Door efforts and implementation of the PCMH+ program.

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 over 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 is comparable to the number of the primary care providers enrolled in Medicare and higher than 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, specialists, behavioral health and obstetric providers), the total number of enrolled providers increased from CY 2016 to CY 2018.

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 2017. 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 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, dental, behavioral health, obstetric and home health services for CYs 2016, 2017 and 2018 to determine if CMAP members have maintained sufficient access to care. The following highlights the conclusions related to those established categories of services.

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

In the first iteration of the AMRP it was sown that between of 66% and 76% of the adult members had at least one primary care visit in CY 2014. Data reported for this update in Tables

30 and Figure 25 show an increase in utilization of primary care among the adult population with a reported average of 84% to 92% for CY 2017. All of the counties' averages increased from CY 2016 to CY 2018, suggesting that adult's access to primary care services under CMAP has increased since the first iteration. Among children served by the CMAP, the rate of access to Medical Primary Care Services ranged statewide between 94% and 95% for the three years analyzed (CYs 2016-2018). This data for child utilization of medical primary care shows an increase in utilization as compared to the statewide averages reported for during the first iteration (91% - 93%) and suggests that children covered under the CMAP continue to have improved and sufficient access to medical primary care.

Similar to the methods used in the first iteration of the AMRP DSS also examined the utilization of medical primary care services by eligibility plan. Data analyzed for 2016 through 2018 showed that the trends displayed among the data reported for CY 2013 through 2015 were maintained and majority of the utilization of medical primary care occurred among the HUSKY A and D populations (see Table 32). The rates reported for these two eligibility categories showed increases in utilization each year reported (2016 through 2018). Similar to the data previously reported in the first iteration, when the utilization for HUSKY C was analyzed separately, it was noted that the utilization for primary care services showed an insignificant decrease in CY 2017, but overall remained stable at rates between 38% and 40%; rates that are very similar to the rates reported previously (Table 32).

Previously it was noted that 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 now referred to as the HUSKY Health Increased Payments for Primary Care policy. This policy is still in effect under CMAP and while there was a reduction to the reimbursement level for services eligible under this policy by 10% in August 2017 as a result of a resource allocation plan enacted by the then Governor of the State of Connecticut, subsequently in December 2017 the rates payable were increased by 5% due to a push from the CMAP and other stakeholders who understand the immediate and long-term benefits of investing in primary care service delivery. The CMAP continues to support the primary care initiative as well as continue to shape and support other primary care initiatives such as the Primary Care Model Home (PCMH) and the PCMH+ policies in order to continue to maintain and strengthen the CMAP provider network and access to medically necessary services.

As a result of this updated AMRP analysis and given that 1) the numbers of members who received at least one visit to a Medical Primary Care provider within a year remained consistently within the range of 84% to 90% for adults statewide and 94% to 95% for children, across the counties over the three calendar years; 2) the percentage of utilization among the HUSKY C population remained relatively stable; 3) the rates among both the adult and child populations have increased since the first iteration of the AMRP and throughout the time period analyzed, and 4) there were no unresolved complaints for access to care related issues during this period (ASO monitoring, engagement with community stakeholders and MAPOC), DSS has concluded that CMAP beneficiaries continue to have sufficient access to primary care services.

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 decrease in services between CYs 2016 and CY 2018 (32.1% vs. 31.6% vs. 30.0%, respectively). In the absence of any standards and measures against which to compare results, DSS analyzed the trend in utilization across the three years of data (2016 through 2018) 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 years; and when the data for this update is compared to the data in the first iteration, the rates of utilization statewide all increased for both the adult and child populations. DSS' conclusion is that, while DSS will continue to monitor this area, access to specialist care is adequate across the board for CMAP adult and child members.

Dental Primary Care: There continues to be lack of commercial, Medicare, or HEDIS standards to compare adult access to dental care against, therefore, similar to the first iteration of the AMRP, DSS focused on child dental access for this update.

The percentage of child members with at least one dental primary care visit during the year ranged from 37% to 61% in CY 2016, 39% to 61% in 2017 and from 41% to 61% in CY 2018 across Connecticut counties. The data analyzed for Fairfield County continued to show this county as consistently the highest in member use of dental services among children (see Table 37 and Figure 30). The overall utilization has decreased for CY 2016 through 2018 as compared to the data reported for CYs 2013 through 2015. A direct reason for this reduction has not been identified by DSS. During CY 2016 DSS did implement a change to the reimbursement for dental services that included a 2 percent reduction in the payment amounts. However the monitoring analyses performed for the three years post implementation of this SPA did not identify a negative impact to the access to dental services (see appendix for data). As previously discussed 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 75.8% for CY 2017 which was significantly greater than the National Medicaid 50th percentile average reported as 41.8% and also an increase from the HEDIS measure reported in the first iteration for CY 2014 which was 73%.

Behavioral Health: The number of enrolled behavioral health independent practitioners increased over the three year period analyzed. Consistent with this result, for all of Connecticut counties, utilization, although slight, showed an increase from CY 2016 through CY 2018 for both child and adult members. The data obtained for this update showed that the utilization of behavioral health services was stable over the three years for all of the three eligibility plans (HUSKY A, C and D), with only HUSKY C showing a slight decrease between 2017 and 2018. Similar to data reported in the first AMRP iteration, Fairfield, the most populous county in CT for CY 2017, had the lowest distribution of behavioral health utilization among both the child and adult populations for all years analyzed. An explanation for this trend in Fairfield has yet to be identified and is inconsistent with data from other categories of service that show Fairfield to be either in-line with rates for other counties or representing utilization that is higher than other counties, such as specialist and primary care services.

As previously reported DSS is committed to facilitate access to behavioral health and substance use disorder services through:

- continued support with referrals to treatment resources;
- development of a system of care for members with ASD;
- launching of the Changing Pathways initiative;

- continued strong partnerships with sister agencies (especially through the CT Behavioral Health Partnership, which is a collaboration among DSS, the Department of Children & Families and the Department of Mental Health & Addiction Services); and
- maintenance of the network of behavioral health Enhanced Care Clinics (ECCs).

Via this updated AMRP, DSS has not identified any specific access to care concerns that are specific to Medicaid that have not been resolved. DSS along with the behavioral health ASO, Beacon Health Options is committed to 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 2017 the percentage of women who had a delivery during the calendar year that also received prenatal and postnatal care ranged between 48% and 95%. This data is similar to the data reported for CY 2014 which was 51% and 95%. The results for Fairfield for this update continued to show that this county lagged behind the other CT counties with percentages ranging between 48% and 51% while the other counties ranged between 68% and 95%, although this county continued to represent the 3rd highest number of deliveries covered under CMAP. Conversely, although data from the first iteration of the AMRP also showed New Haven county with a relatively lower percentage of members who delivered to have also received prenatal and post-natal care (64% in CY 2014), the reported percentage for 2017 increased to 78% and leveled off to 77% for CY 2018. New Haven continued to represent the county with the highest number of deliveries under CMAP (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 remained comparable with or reported data higher than the National Medicaid 50th percentile (Table 45). As previously discussed the CT reported percentage of women receiving timely postpartum visits decreased from 70.3% to 66.4% when the data from 2014 is compared to the data from 2017 and represents a reduction that the CMAP did not expect and does not want to continue. However, in absence of access to care complaints from the member, provider and advocacy communities (which are all very vocal in CT), the CMAP the reduction in the HEDIS measure for post-natal visits cannot be taken solely to mean that there is an access to care issue.

As previously discussed 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 the (potentially CMAP eligible) baby. As shown above in the rate comparison, CMAP has an enhanced rate for obstetric care that is above the Medicare rate, and is also higher than neighboring states' Medicaid programs. Additionally the CMAP is issuing a fourth cycle of the Pay for Performance (P4P) in obstetrical care program designed to improve the overall care of pregnant individuals and the outcomes of their newborn and decrease the incidence of avoidable maternal mortality and morbidity by encouraging multiple activities including early entry into prenatal care and increased engagement in postpartum and ongoing primary care. This P4P program will run August 1, 2019 through June 30, 2020.

As mentioned previously, access to rates reimbursed by commercial payers could not be obtained for this analysis. Of particular note related to the Fairfield data, the AMRP (both the first iteration and the update) only included and analyzed data for in-state providers and excluded data for out-of-state providers. With Fairfield's proximity to New York and the CMAP there is a question as to whether a portion of services that members residing in Fairfield county receive is actually rendered by New York providers enrolled with CMAP as out of state providers. This would impact the utilization results analyzed as the data for those visits would have been excluded resulting in lower percentages for this county as compared to others. 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 service over the three year time period analyzed. As displayed in Table 48 the HUSKY C population (aged, blind and disabled) accounted for the overwhelming majority of members who received home health services in all three years analyzed between CY 2016 through 2018. Between this time period analyzed the number of members who received a home health service decreased in all counties, with the greatest reductions noted in New London and Windham counties (Table 46). As expected, the number of child members was far fewer than adult members receiving home health services and with the exception of the rate of utilization reported between 2017 and 2018 for New London county, the child utilization also decreased throughout the three year time period of 2016 through 2018 (Table 47).

Potential rationales for the reduction include a targeted rate reduction for medication administration services implemented in July 2016 under SPA 16-0023. This SPA was implemented in order to encourage home health providers to utilize safe alternate methods of medication administration including medication administration boxes, medication administration prompting by a home health aide, and nurse delegation to a certified home health aide who administers medication. As a result of SPA 16-0023 home health service utilization was expected to decrease as home health patients were transitioned to other methods of medication administration by their respective home health agency. DSS determined that although a reduction in services was noted as a result of SPA 16-0023, access to care was not negatively impacted (refer to appendix for more details). Additionally, as previously reported, under the ASO model, the CMAP started reviewing home health requests more rigorously as compared to previous years. This more rigorous review is completed in order to substantiate the medical necessity of home health services requested. 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:

Monitoring postnatal services among the member who delivery under CMAP. As noted above the HEDIS measure percentage of members who delivered and also had a post-natal visit decreased for CY 2017. Additionally the percentage of members who deliver in Fairfield County and received prenatal and postnatal care was significantly less the other counties. DSS should monitor the HEDIS measures and possibly compare out of state utilization for members residing

in Fairfield County. Additionally any data from the P4P in obstetrical care program should be analyzed to identify benefits of such a program and highlight the successes and areas in need of improvement.

As statutorily required DSS will continue to fulfill the requirement of the access regulations by continuing to perform 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.

APPENDIX

As required under 42 CFR 447.203(6)(ii) the State was required to establish procedures in its access monitoring review plan to monitor continued access to care after the implementation of state plan service rate reductions or payment restructuring. This access monitoring was conducted at a minimum of annually and included analysis of claims specific data related to the services specifically impacted by the SPA as well as monitoring for access to care concerns, complaints and issues identified via various mechanisms, including but not limited to the applicable administrative service organization, public advocacy groups, MAPOC, general inquiries from the public and provider communities.

The following analyses will provide the data necessary to demonstrate that the implemented SPAs that included a rate reduction have not negatively impacted access to care and that there remains sufficient access to medically necessary services under the Connecticut Medicaid program.

Appendix A: CT SPA 16-0023 / HOME HEALTH MEDICATION ADMINISTRATION REDUCTION
ACCESS MONITORING ANALYSIS

Appendix B: CT SPA 16-0028 and 16-0030 / DENTAL RATE REDUCTIONS
ACCESS MONITORING ANALYSIS – Years 1-3

Appendix C: CT SPA 16-0029 / AUTISM SPECTRUM DISORDER SERVICES REIMBURSEMENT
ACCESS MONITORING ANALYSIS- Years 1 – 2 (* Year 3 will be updated October 2019)

Appendix D: CT SPA 17-0007 / Medical Equipment Devices and Supplies (MEDS) Reimbursement
ACCESS MONITORING ANALYSIS - Years 1 - 2 (Year 3 will be updated in 2020)

Appendix E: CT SPA 17-0028 / ELIMINATION OF HOME HEALTH AGENCY ADD-ONS
ACCESS MONITORING ANALYSIS – Years 1-2 (Year 3 will be updated in 2020)

Appendix F: CT SPA 18-0028 / CPAP and BiPAP Supplies – ACCESS Monitoring Year 1 – (Year 2 will be updated in 2020)

Appendix A

CT SPA 16-0023 / HOME HEALTH MEDICATION ADMINISTRATION REDUCTION

ACCESS MONITORING ANALYSIS – Years 1-3

Consistent with the requirements outlined at 42 C.F.R § 447.203(b)(7)) the state is performing an access monitoring analysis to determine whether or not Medicaid State Plan Amendment (SPA) 16-0023 is demonstrating a negative impact on access to home health medication administration services. As implemented under SPA 16-0023 the rate for medication administration (billed with procedure codes T1502 and T1503) was reduced by 15% when provided by a registered nurse as part of a licensed home health agency. Specifically, this SPA reduces the rate for procedure codes T1502 (administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit) and T1503 (administration of medication, other than oral and/or injectable, by health care agency/professional, per visit) from $61.13 to $51.96 per visit.

As specified under the access analysis submitted with CT SPA 16-023 – Home Health Medication Administration Reduction, the State has implemented monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures include: (1) an annual review of the number of enrolled home health agencies, (2) the number of unduplicated recipients of service, and (3) the utilization of medication administration services that were impacted by SPA 16-023. This data is compared with baseline data pulled for calendar year 2015 to analyze changes in utilization and to assess changes in the number of providers providing home health medication administration services. This data will also be analyzed to determine if a reduction of 25% or more in the number of unduplicated recipients of home health medication administration services in a calendar month compared to the same calendar month one year earlier has been triggered since the implementation of SPA 16-023. This level of reduction is the threshold for the state to further investigate potential access to care issues, unless the reduction in the number of recipients of such services is offset by increases in the utilization of alternative services for medication administration (nurse delegation services, the use of automated medication boxes, and medication prompting).

The following tables (Tables 1 – 14) will provide data related to the utilization of the medication administration services impacted by the SPA, the number of enrolled providers by county and, where applicable, the percent difference between the years monitored. Additionally the State analyzed the data to determine if there was a reduction of 25% or more in the number of unduplicated recipients of home health medication administration services in a calendar month.

Table 1: Year 1 - Utilization of Medication Administration Codes T1502 and T1503 By County (Beneficiaries Age 21 and older)

Utilization of Medication Administration Codes T1502 and T1503 By County (age 21 & Older)									
		Baseline Data				Post-Implementation Data			
County	Code	Undup Recip ID	Undup ICN Count	# of Billing Prov	Units	Undup Recip ID	Undup ICN Count	# of Billing Prov	Units
Fairfield	T1502	1568	45952	31	350,367	1,438	46,853	29	295,536
Fairfield	T1503	19	36	3	101	7	16	2	19
Hartford	T1502	2818	69199	37	595,222	2,624	73,604	30	510,253
Hartford	T1503	10	17	3	27	32	63	4	147
Litchfield	T1502	291	7005	20	44,819	263	6,626	17	36,635
Litchfield	T1503	3	3	2	4	5	6	3	6
Middlesex	T1502	304	6866	20	66,376	272	6,700	21	56,190
Middlesex	T1503	0	0	0	0	7	11	2	34
New Haven	T1502	3587	96193	40	780,667	3,525	105,727	40	645,581
New Haven	T1503	13	51	5	131	9	33	6	595
New London	T1502	371	11567	14	88,756	390	14,408	15	69,802
New London	T1503	1	1	1	1	4	14	3	82
Tolland	T1502	146	2422	17	25,897	138	2,833	15	25,241
Windham	T1502	195	2815	8	37,529	169	2,670	12	27,708
Windham	T1503	6	17	3	652	3	28	1	1,317

Table 2: Year 1 - Difference between Post and Baseline Data (age 21 & Older)

Difference between Post and Baseline Data (age 21 & Older)					
County	Code	Undup Recip ID	Undup ICN Count	# of Billing Prov	Units
Fairfield	T1502	-9.1%	0.4%	-9.7%	-17.4%
Fairfield	T1503	-63.2%	-58.3%	-33.3%	-83.2%
Hartford	T1502	-8.7%	4.0%	-21.6%	-16.2%
Hartford	T1503	170.0%	217.6%	33.3%	155.6%
Litchfield	T1502	-10.7%	-7.9%	-15.0%	-21.0%
Litchfield	T1503	66.7%	100.0%	50.0%	50.0%
Middlesex	T1502	-11.5%	-3.5%	0.0%	-16.6%
Middlesex	T1503				
New Haven	T1502	-3.4%	6.8%	0.0%	-19.8%

New Haven	T1503	-30.8%	-35.3%	20.0%	345.8%
New London	T1502	3.8%	22.4%	7.1%	-22.8%
New London	T1503	200.0%	1200.0%	100.0%	8000.0%
Tolland	T1502	-11.6%	14.3%	-23.5%	-4.5%
Windham	T1502	-15.4%	-5.8%	50.0%	-26.3%
Windham	T1503	-50.0%	58.8%	-66.7%	99.1%

Table 3: Year 1 - Utilization of Medication Administration Codes T1502 and T1503 By County (Beneficiaries Ages 0 -20 Years) – CY 2015

Utilization of Medication Administration Codes T1502 and T1503 By County (under age 21)									
		Baseline Data				Post-Implementation Data			
County	Code	Undup Recip ID	Undup ICN Count	# of Billing Prov	Units	Undup Recip ID	Undup ICN Count	# of Billing Prov	Units
001 - Fairfield	T1502	83	1788	11	12,963	64	1,166	12	7,163
003 - Hartford	T1502	76	776	12	7,835	96	1,768	13	11,430
005 - Litchfield	T1502	10	169	4	1,447	9	328	2	1,413
007 - Middlesex	T1502	14	242	4	2,593	7	143	4	1,379
009 - New Haven	T1502	79	1085	14	11,245	88	1,413	16	9,386
011 - New London	T1502	4	47	3	230	7	158	4	848
013 - Tolland	T1502	6	64	4	471	3	66	2	426
015 - Windham	T1502	3	8	3	37	1	22	1	135

Table 4: Year 1 - Difference between Post and Baseline Data (under age 21)

Difference between Post and Baseline Data (under age 21)					
County	Code	Undup Recip ID	Undup ICN Count	# of Billing Prov	Units
Fairfield	T1502	-25.3%	-35.7%	9.1%	-45.6%
Hartford	T1502	26.3%	125.8%	8.3%	44.8%
Litchfield	T1502	-10.0%	89.3%	-50.0%	-5.9%
Middlesex	T1502	-50.0%	-40.9%	0.0%	-46.8%
New Haven	T1502	7.6%	28.1%	14.3%	-18.0%
New London	T1502	25.0%	206.4%	0.0%	230.9%
Tolland	T1502	-50.0%	3.1%	-50.0%	-9.6%
Windham	T1502	-66.7%	175.0%	-66.7%	264.9%

Table 5: YR 2 & 3 -Utilization of Medication Administration Codes T1502 and T1503 By County (age 21 & Older)

		Year 2				Year 3			
County	**Code**	**Undup Recip ID Count**	**Undup ICN Count**	**# of Billing Prov**	**Units**	**Undup Recip ID Count**	**Undup ICN Count**	**# of Billing Prov**	**Units**
Fairfield	T1502	1,310	44,888	21	296,315	1,268	42,784	23	308,236
Fairfield	T1503	14	20	4	76	5	8	3	14
Hartford	T1502	2,430	78,792	32	499,802	2,176	68,418	30	462,436
Hartford	T1503	20	137	6	1,041	11	58	4	312
Litchfield	T1502	230	6,792	17	33,974	219	6,147	16	33,786
Litchfield	T1503	5	12	4	132	1	1	1	1
Middlesex	T1502	243	5,296	22	50,548	203	3,997	17	40,563
Middlesex	T1503	1	1	1	1				
New Haven	T1502	3,230	98,831	39	608,181	2,870	83,613	36	541,962
New Haven	T1503	19	60	8	662	15	56	6	396
New London	T1502	357	15,050	11	70,420	354	14,816	13	72,344
New London	T1503	3	9	2	49	3	9	1	63
Tolland	T1502	128	2,861	17	22,997	94	2,462	12	19,927
Tolland	T1503	2	3	2	3	1	1	1	1
Windham	T1502	143	2,570	11	22,686	122	2,529	10	20,678
Windham	T1503	3	18	1	796	1	1	1	44

Table 6: Difference between Year 2 & 3 (age 21 & Older)

Difference between Post and Baseline Data (age 21 & Older)					
County	**Code**	**Undup Recip ID**	**Undup ICN Count**	**# of Billing Prov**	**Units**
Fairfield	T1502	-3.2%	-4.7%	9.5%	4.0%
Fairfield	T1503	-64.3%	-60.0%	-25.0%	-81.6%
Hartford	T1502	-10.5%	-13.2%	-6.3%	-7.5%
Hartford	T1503	-45.0%	-57.7%	-33.3%	-70.0%
Litchfield	T1502	-4.8%	-9.5%	-5.9%	-0.6%
Litchfield	T1503	-80.0%	-91.7%	-75.0%	-99.2%
Middlesex	T1502	-16.5%	-24.5%	-22.7%	-19.8%
Middlesex	T1503	-100.0%	-100.0%	-100.0%	-100.0%
New Haven	T1502	-11.1%	-15.4%	-7.7%	-10.9%

New Haven	T1503	-21.1%	-6.7%	-25.0%	-40.2%
New London	T1502	-0.8%	-1.6%	18.2%	2.7%
New London	T1503	0.0%	0.0%	-50.0%	28.6%
Tolland	T1502	-26.6%	-13.9%	-29.4%	-13.3%
Tolland	T1503	-50.0%	-66.7%	-50.0%	-66.7%
Windham	T1502	-14.7%	-1.6%	-9.1%	-8.9%
Windham	T1503	-66.7%	-94.4%	0.0%	-94.5%

Table 7: Year 2 & 3 - Utilization of Medication Administration Codes T1502 and T1503 By County (Beneficiaries Ages 0 -20 Years)

		Year 2				Year 3			
County	**Code**	**Undup Recip ID Count**	**Undup ICN Count**	**# of Billing Prov**	**Units**	**Undup Recip ID Count**	**Undup ICN Count**	**# of Billing Prov**	**Units**
Fairfield	T1502	58	977	10	5,678	44	791	10	5,073
Hartford	T1502	94	2,221	12	12,452	102	2,935	12	16,635
Hartford	T1503	1	4	1	14				
Litchfield	T1502	11	249	3	1,399	9	137	4	895
Middlesex	T1502	7	121	3	1,119	14	198	5	1,482
New Haven	T1502	90	1,478	20	9,671	88	1,609	15	11,748
New Haven	T1503	1	1	1	1				
New London	T1502	4	96	2	504	2	3	1	25
Tolland	T1502	6	53	5	245	3	109	3	717
Windham	T1502	3	25	4	146	1	1	1	1

Table 8: Difference between Year 2 & 3 (under age 21)

Difference between Post and Baseline Data (under age 21)					
County	**Code**	**Undup Recip ID**	**Undup ICN Count**	**# of Billing Prov**	**Units**
Fairfield	T1502	-24.1%	-19.0%	0.0%	-10.7%
Hartford	T1502	8.5%	32.1%	0.0%	33.6%
Hartford	T1502	-100.0%	-100.0%	-100.0%	-100.0%
Litchfield	T1502	-18.2%	-45.0%	33.3%	-36.0%
Middlesex	T1502	100.0%	63.6%	66.7%	32.4%
New Haven	T1502	-2.2%	8.9%	-25.0%	21.5%
New Haven	T1502	-100.0%	-100.0%	-100.0%	-100.0%
New London	T1502	-50.0%	-96.9%	-50.0%	-95.0%
Tolland	T1502	-50.0%	105.7%	-40.0%	192.7%
Windham	T1502	-66.7%	-96.0%	-75.0%	-99.3%

As demonstrated by Tables 1-8 when the post-implementation data analyzed, it can be noted that there were both increases and decreases among the data categories dependent on the code billed. Some of the increases seen were quiet significant, such as over 8000% in the utilization for New London County for T1503 for the age 21 and older population; while majority of the decreases seen were less than 30% among the targeted categories. For the under 21 population there were decreases noted for majority of the counties for the unduplicated recipient and units of service categories; while it should be noted that there was a decrease in the number of billing providers in only 3 counties (Litchfield, Tolland and Windham). It should be noted that even with the noted decreases among the various counties, the Department and the administrative service organizations did not receive access to care complaints and additionally also noted that there was quite a significant increase in the utilization of the alternative methods such as medication prompting and used of certified home health aides for medication administration purposes. Additional analyses will be done regarding the number of unduplicated recipients receiving medication administration services to determine if the thresholds set by the State were reached.

Table 9: Year 1 - Analysis of the Number of Unduplicated Recipients – Under 21 Procedure Codes T1502, T1503 By County

Month	Recip County Description MAP	Unduplicated Recip Count
Jul-15	001 - Fairfield	42
Jul-16	001 - Fairfield	29
		(30.95%)
Jul-15	003 - Hartford	26
Jul-16	003 - Hartford	36
		38.46%
Jul-15	005 - Litchfield	3
Jul-16	005 - Litchfield	4
		33.33%
Jul-15	007 - Middlesex	6
Jul-16	007 - Middlesex	4
		(33.33%)
Jul-15	009 - New Haven	32
Jul-16	009 - New Haven	33
		3.13%
Jul-15	011 - New London	
Jul-16	011 - New London	3
Jul-15	013 - Tolland	2
Jul-16	013 - Tolland	1
		(50.00%)

Jul-15	015 - Windham	1
Jul-16	015 - Windham	1
		0.00%

Table 10: Year 1 - Analysis of the Number of Unduplicated Recipients – Over 21 Procedure Codes T1502, T1503 By County

Month	Recip County Description MAP	Unduplicated Recip Count
Jul-15	001 - Fairfield	986
Jul-16	001 - Fairfield	976
		(1.01%)
Jul-15	003 - Hartford	1,698
Jul-16	003 - Hartford	1,699
		0.06%
Jul-15	005 - Litchfield	145
Jul-16	005 - Litchfield	134
		(7.59%)
Jul-15	007 - Middlesex	190
Jul-16	007 - Middlesex	182
		(4.21%)
Jul-15	009 - New Haven	2,290
Jul-16	009 - New Haven	2,195
		(4.15%)
Jul-15	011 - New London	225
Jul-16	011 - New London	246
		9.33%
Jul-15	013 - Tolland	71
Jul-16	013 - Tolland	79
		11.27%
Jul-15	015 - Windham	106
Jul-16	015 - Windham	111
		4.72%

The monitored data for the number of unduplicated recipients included procedure codes T1502 and T1503 and the results were grouped by the recipients' age as follows: (1) number of unduplicated recipients under 21 and (2) number of unduplicated recipients age 21 and over. We compared the July 2016 data for the number of unduplicated recipients of home health medication administration services to the July 2015 data for the number of unduplicated recipients of home health medication administration services. July 2015 was included in the

baseline data pulled for calendar year 2015 for SPA 16-023. A reduction of 25% or more in the number unduplicated recipients in the under 21 group was present in following counties: Fairfield, Middlesex and Tolland.

Based on further analysis it was noted that aging out from the "Under 21" group was the main reason for a decrease in the number of the unduplicated recipients in July 2016 when compared to July 2015 (CY 2015 was the baseline data for SPA 16-023). Excluding recipients who aged out; none of the Connecticut counties experienced a reduction of 25% or more in a number of beneficiaries receiving home health medication administration services in July 2016 as compared to July 2015 baseline.

Table 11: Year 2 - Analysis of the Number of Unduplicated Recipients – Under 21 Procedure Codes T1502, T1503 By County

Month	Recip County Description MAP	Unduplicated Recip Count
Jul-16	001 - Fairfield	29
Jul-17	001 - Fairfield	25
		(13.79%)
Jul-16	003 - Hartford	36
Jul-17	003 - Hartford	41
		13.89%
Jul-16	005 - Litchfield	4
Jul-17	005 - Litchfield	6
		50.00%
Jul-16	007 - Middlesex	4
Jul-17	007 - Middlesex	3
		(25.00%)
Jul-16	009 - New Haven	33
Jul-17	009 - New Haven	43
		30.30%
Jul-16	011 - New London	3
Jul-17	011 - New London	3
		0.00%
Jul-16	013 - Tolland	1
Jul-17	013 - Tolland	2
		100.00%
Jul-16	015 - Windham	1
Jul-17	015 - Windham	1
		0.00%

Table 12: Year 2 - Analysis of the Number of Unduplicated Recipients – Over 21 Procedure Codes T1502, T1503 By County

Month	Recip County Description MAP	Unduplicated Recip Count
Jul-16	001 - Fairfield	976
Jul-17	001 - Fairfield	862
		(11.68%)
Jul-16	003 - Hartford	1,699
Jul-17	003 - Hartford	1,619
		(4.71%)
Jul-16	005 - Litchfield	134
Jul-17	005 - Litchfield	130
		(2.99%)
Jul-16	007 - Middlesex	182
Jul-17	007 - Middlesex	162
		(10.99%)
Jul-16	009 - New Haven	2,195
Jul-17	009 - New Haven	2,177
		(0.82%)
Jul-16	011 - New London	246
Jul-17	011 - New London	255
		3.66%
Jul-16	013 - Tolland	79
Jul-17	013 - Tolland	75
		(5.06%)
Jul-16	015 - Windham	111
Jul-17	015 - Windham	84
		(24.32%)

Tables 11 and 12 compared the July 2017 data of the number of unduplicated recipients of home health medication administration services to the July 2016 data of the number of unduplicated recipients of home health medication administration services. A reduction of 25% or more in the number of unduplicated recipients of home health medication administration services in July 2017 compared to July 2016 was present in the Unduplicated Recipients Under 21 group in the following counties: 007-Middlesex. The following reasons for a decrease in the number of the unduplicated recipients in July 2017 when compared to July 2016 were: (1) one recipient aged out from the "Under 21" classification to the "21 and over" classification; (2) one recipient continues to receive home health medication administration services in another CT county (009-

New Haven county). Excluding recipients who aged out an/or moved to another CT count; none of the Connecticut counties experienced a reduction of 25% or more in a number of beneficiaries receiving home health medication administration services in July 2017 as compared to July 2017 baseline

Table 13: Year 3 - Analysis of the Number of Unduplicated Recipients – Under 21 Procedure Codes T1502, T1503 By County

Month	Recip County Description MAP	Unduplicated Recip Count
Jul-17	001 - Fairfield	25
Jul-18	001 - Fairfield	23
		(8.00%)
Jul-17	003 - Hartford	41
Jul-18	003 - Hartford	46
		12.20%
Jul-17	005 - Litchfield	6
Jul-18	005 - Litchfield	2
		(66.67%)
Jul-17	007 - Middlesex	3
Jul-18	007 - Middlesex	5
		66.67%
Jul-17	009 - New Haven	43
Jul-18	009 - New Haven	48
		11.63%
Jul-17	011 - New London	3
Jul-18	011 - New London	0
		(100.00%)
Jul-17	013 - Tolland	2
Jul-18	013 - Tolland	2
		0.00%
Jul-17	015 - Windham	1
Jul-18	015 - Windham	0
		(100.00%)

Table 14: Year 3 - Analysis of the Number of Unduplicated Recipients – Over 21 Procedure Codes T1502, T1503 By County

Month	Recip County Description MAP	Unduplicated Recip Count

Jul-17	001 - Fairfield	862
Jul-18	001 - Fairfield	863
		0.12%
Jul-17	003 - Hartford	1,619
Jul-18	003 - Hartford	1,524
		(5.87%)
Jul-17	005 - Litchfield	130
Jul-18	005 - Litchfield	122
		(6.15%)
Jul-17	007 - Middlesex	162
Jul-18	007 - Middlesex	130
		(19.75%)
Jul-17	009 - New Haven	2,177
Jul-18	009 - New Haven	1,940
		(10.89%)
Jul-17	011 - New London	255
Jul-18	011 - New London	254
		(0.39%)
Jul-17	013 - Tolland	75
Jul-18	013 - Tolland	62
		(17.33%)
Jul-17	015 - Windham	84
Jul-18	015 - Windham	84
		0.00%

Further analysis of the preliminary data as shown above in tables 13 and 14, showed the following reasons for a decrease of over 25% in the number of the unduplicated recipients in July 2018 when compared to July 2017: (1) recipients aged out from the "Under 21" classification to the "21 and over" classification; (2) recipients continue to receive home health medication administration services in another CT county. Excluding recipients who aged out an/or moved to another CT county; none of the Connecticut counties experienced a reduction of 25% or more in a number of beneficiaries receiving home health medication administration services during the Year 3 post implementation of the rate reduction SPA 16-023.

Conclusion

Based on the results of the analyses, in addition to assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State has determined that SPA 16-023 is not demonstrating a negative impact on access to home health medication administration services

This concludes the State's requirement to monitor the impact of any rate reduction SPA for a minimum of three years. The State will continue to monitor through its usual monitoring mechanisms such utilization of the ASO's to identify potential access to care concerns. Any

concerns identified will be thoroughly analyzed and addressed in a timely fashion to ensure continued timely access to medically necessary services covered under the Medicaid program.

Appendix B

CT SPA 16-0028 and 16-0030 / DENTAL RATE REDUCTIONS

ACCESS MONITORING ANALYSIS – Years 1-3

Consistent with the requirements outlined at 42 C.F.R § 447.203(b)(7)) the state is performing an access monitoring analysis to determine whether or not Medicaid State Plan Amendments (SPA) 16-0028 and SPA 16-0030 are demonstrating a negative impact on access to dental services under the Connecticut Medical Assistance Program (CMAP). As implemented under SPA 16-0028 the rates for D2930 (Prefab Stainless Steel Crown (Primary), D2931 (Prefab Stainless Steel Crown Permanent), D2934 (Aesthetic Coated Stainless Steel Crown), and D8670 (Periodic Orthodontic Treatment) were reduced effective August 1, 2016 to specified amounts. Additionally, SPA 16-0028 also changed the coverage requirements to tighten the soft limits on sealants and direct placed restorations. Under SPA 16-0030 dental services provided to children were reduced by 2%, effective September 1, 2016. These changes were implemented in order to achieve the savings assumed in the State Fiscal Year 2017 state budget that was approved by the Connecticut General Assembly in Public Act 16-1 of the May 2016 Special Session.

The following tables will provide data related to the number of enrolled providers by county, the utilization of dental services, and the percent difference between the data since implementation of the SPAs. This data will be used to analyze if the thresholds of a 5% or more reduction in the number of participating pediatric dentists and a 10% or more reduction in the number of participating providers within all other dental specialties as compared to the number of enrolled dentists one year before occurred since implementation of SPA 16-0028 and 16-0030. These thresholds serve as a benchmark to analyze further for potential access to dental services concerns.

Table 1. CMAP Enrolled Dentists and Hygienists by County - Year 1

		Baeline Data			Year 1 Data					
County	Pediatric Dentist	General Dentist (GD)	Hygienist (HYG)	Sum (GD + HYG)	Pediatric Dentist	General Dentist (GD)	Hygienist (HYG)	Sum (GD + HYG)	% Diff: YR 1 / Baseline (PEDS)	% Diff: YR 1 / Baseline (GD + HYG)
FAIRFIELD	48	456	8	464	53	481	17	498	10.4%	7.3%
HARTFORD	63	468	18	486	67	485	29	514	6.3%	5.8%
LITCHFIELD	4	44	6	50	6	49	8	57	50.0%	14.0%
MIDDLESEX	8	37	0	37	9	64	3	67	12.5%	81.1%
NEW HAVEN	34	357	1	358	44	413	16	429	29.4%	19.8%
NEW LONDON	11	66	0	66	11	74	4	78	0.0%	18.2%
TOLLAND	2	28	0	28	2	33	0	33	0.0%	17.9%
WINDHAM	0	25	0	25	0	35	3	38	-	52.0%

Table 1 titled Year 1 CMAP Enrolled Dentists and Hygienists by County provides the baseline data and post implementation data regarding the number of dental providers enrolled under CMAP by County. Please note that the baseline data has been revised since the first iteration that

was sent with the access analysis. This revision includes reporting all dentists and not isolating the report to dentists working in independent settings in order to provide a more comprehensive overview of the number of dentists available to provide services to CMAP beneficiaries.

As outlined below in Table 1, since implementation of SPAs 16-0028 and 16-0030, the Year 1 data showed that the number of dentists enrolled under CMAP represented in each county has increased from three percent to seventy-three percent. The data shows that the threshold reductions of 5% or more in the number of participating pediatric dentists and a 10% or more reduction in the number of participating providers within all other dental specialties was not triggered by the implementation of these SPAs and that there remains sufficient access to dental providers throughout the counties.

Table 2. CMAP Enrolled Dentists and Hygienists by County- Year 2 vs Year 1

	Year 1 Data				Year 2 Data					
County	Pediatric Dentist	General Dentist (GD)	Hygienist (HYG)	Sum (GD + HYG)	Pediatric Dentist	General Dentist (GD)	Hygienist (HYG)	Sum (GD + HYG)	% Diff: YR 2 / YR 1 (PEDS)	% Diff: YR 2 / YR 1 (GD + HYG)
FAIRFIELD	53	481	17	498	66	458	19	477	24.5%	-4.2%
HARTFORD	67	485	29	514	68	499	30	529	1.5%	2.9%
LITCHFIELD	6	49	8	57	4	43	6	49	-33.3%	-14.0%
MIDDLESEX	9	64	3	67	9	69	5	74	0.0%	10.4%
NEW HAVEN	44	413	16	429	58	400	24	424	31.8%	-1.2%
NEW LONDON	11	74	4	78	12	75	3	78	9.1%	0.0%
TOLLAND	2	33	0	33	2	23	0	23	0.0%	-30.3%
WINDHAM	0	35	3	38	0	41	3	44	-	15.8%

Table 2 data however shows that for two counties, Litchfield and Tolland, the percent reduction among pediatric dentists and non-pediatric dentists were triggered. However, when analyzed closer the number of pediatric dentist and non-pediatric dentists in Litchfield County, while Year 3 data did reduce, the number of providers did not fall below the baseline data and in the case of general dentists and hygienists the Year 3 data still shows an increase when compared to the number of providers shown with the baseline data.

Table 3. CMAP Enrolled Dentists and Hygienists by County - Year 3 vs Year 2

	Year 2 Data				Year 3 Data					
County	Pediatric Dentist	General Dentist (GD)	Hygienist (HYG)	Sum (GD + HYG)	Pediatric Dentist	General Dentist (GD)	Hygienist (HYG)	Sum (GD + HYG)	% Diff: YR 3 / YR 2 (PEDS)	% Diff: YR 3 / YR 2 (GD + HYG)
FAIRFIELD	66	458	19	477	58	479	18	497	-12.1%	4.2%
HARTFORD	68	499	30	529	67	511	26	537	-1.5%	1.5%
LITCHFIELD	4	43	6	49	6	52	4	56	50.0%	14.3%
MIDDLESEX	9	69	5	74	9	71	6	77	0.0%	4.1%
NEW HAVEN	58	400	24	424	53	435	23	458	-8.6%	8.0%
NEW LONDON	12	75	3	78	15	75	4	79	25.0%	1.3%
TOLLAND	2	23	0	23	2	24	0	24	0.0%	4.3%
WINDHAM	0	41	3	44	0	41	4	45	-	2.3%

Table 3 outlines the number of enrolled pediatric dentists, general dentists and hygienists as of December 31, 2018 and represents the final year of monitoring as required by the federal access regulations. As displayed in the table there were two counties for which it was noted that a 5% or more reduction in the number of pediatric dentists was seen (Fairfield and New Haven). It should be noted that similarly to differences noted between Years 2 and 1 that while the number of pediatric dentist dropped between Year 3 and Year 2, the final resultant number of enrolled pediatric dentists for those counties still remains 20.8% and 55.9% higher than the baseline data suggesting that SPAs 16-0028 and 16-0030 have not impacted the number of enrolled pediatric, general dentists and hygienists negatively (refer to Table 1 for baseline data).

Table 4: Utilization of Dental Services by County and Age – Year 1

County	Age	Number of Unique Members	Count of Services December 31, 2015	Count of Services December 31, 2016	Percent Change in Utilization
Fairfield	A	47,705	305,575	337,322	**9.4%**
Fairfield	C	63,638	540,791	554,188	**2.4%**
Hartford	A	62,315	337,089	379,232	**11.1%**
Hartford	C	70,746	484,316	521,084	**7.1%**
Litchfield	A	9,270	52,229	58,322	**10.4%**
Litchfield	C	9,608	70,459	69,989	**-0.7%**
Middlesex	A	7,454	35,715	42,431	**15.8%**
Middlesex	C	7,033	43,443	49,455	**12.2%**
New Haven	A	61,557	314,500	414,203	**24.1%**
New Haven	C	71,224	362,130	564,650	**35.9%**
New London	A	15,576	53,983	90,114	**40.1%**
New London	C	17,214	95,818	115,678	**17.2%**
Tolland	A	5,137	29,322	32,765	**10.5%**
Tolland	C	5,239	40,936	40,131	**-2.0%**
Windham	A	8,217	29,322	46,131	**36.4%**
Windham	C	9,001	32,106	64,242	**50.0%**
Overall Total		Adult	1,157,735	1,400,520	**17.3%**
		Children	1,669,999	1,979,417	**15.6%**

Table 5. Year 2 Utilization of Dental Services by County and Age – Year 1 to Year 2

County	Number of Unique Members	Count of Services December 31, 2016	Count of Services December 31, 2017	Percent Change in Utilization
Fairfield A	47,459	335,786	321,838	0.60%
Fairfield C	64,882	552,653	524,169	0.90%
Hartford A	62,490	380,898	375,249	0.30%
Hartford C	73,974	525,133	494,320	1.50%
Litchfield A	8,933	59,497	56,015	0.20%
Litchfield C	9,920	72,484	69,820	0.60%
Middlesex A	7,307	43,219	41,294	0.40%
Middlesex C	6,962	50,151	47,235	0.70%
New Haven A	61,544	414,740	404,950	0.40%
New Haven C	72,459	569,079	538,228	0.90%
New London A	15,421	90,384	85,394	0.80%
New London C	17,650	116,281	112,023	1.00%
Tolland A	4,901	33,505	30,833	0.30%
Tolland C	5,300	41,096	38,237	0.90%
Windham A	7,906	46,606	43,775	0.40%
Windham C	9,208	65,157	63,359	0.70%
Overall Total	Adult	1,404,635	1,359,348	0.40%
	Children	1,992,034	1,887,391	0.90%

Table 6. Year 3 Utilization of Dental Services by County and Age – Year 2 to Year 3

County	Number of Unique Members	Count of Services December 31, 2017	Count of Services December 31, 2018	Percent Change in Utilization
Fairfield A	103,594	321,838	308,249	-4.2%
Fairfield C	87,511	524,169	562,645	7.3%
Hartford A	135,736	375,249	354,780	-5.5%
Hartford C	95,708	494,320	485,883	-1.7%
Litchfield A	20,853	56,015	50,565	-9.7%
Litchfield C	14,438	69,820	78,070	11.8%
Middlesex A	16,705	41,294	34,707	-16.0%
Middlesex C	9,948	47,235	45,225	-4.3%
New Haven A	138,520	404,950	387,400	-4.3%
New Haven C	99,876	538,228	539,821	0.3%
New London A	35,942	85,394	74,534	-12.7%
New London C	24,848	112,023	103,028	-8.0%
Tolland A	12,118	30,833	29,849	-3.2%
Tolland C	8,216	38,237	38,827	1.5%
Windham A	17,678	43,775	37,163	-15.1%
Windham C	13,356	63,359	60,233	-4.9%
Overall Total	Adult	1,359,348	1,277,247	
	Children	1,887,391	1,913,732	

Tables 4-6 provide utilization data for the three years SPAs 16-0028 and 16-0030 have been monitored. The data above demonstrates that since implementation of SPAs 16-0028 and 16-0029 shows fluctuations in the utilization of dental services across various counties. Years 1 and 2 showed little to no change in utilization of services, while Year 3 data shows reductions among all the counties. It should be noted that some of the reductions in utilization among adult beneficiaries seen in Year 3 may be related to the annual dental benefit maximum implemented January 1, 2018 where adult beneficiaries (21 years of age and older) have an annual dental service limit of $1000. This limit can be overridden with prior authorization and services deemed medically necessary will be granted even if the beneficiary has already reached the $1000 maximum. It should also be noted that while there have been reductions in utilization there have not been any access to care issues noted as a result of SPAs 16-0028 and 16-0030.

Conclusion

Based on the results of this analysis, in addition to assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State has determined that SPAs 16-0028 and 16-0030 are not demonstrating a negative impact on access to dental services. Based on the data displayed above regarding the number of enrolled pediatric, general dentists and hygienists and the utilization data, the State has determined that there remains sufficient access to dental services and that such access is expected to continue.

This concludes the State's requirement to monitor the impact of any rate reduction SPA for a minimum of three years. The State will continue to monitor through its usual monitoring mechanisms such utilization of the ASO's to identify potential access to care concerns. Any concerns identified will be thoroughly analyzed and addressed in a timely fashion to ensure continued timely access to medically necessary services covered under the Medicaid program.

Appendix C

CT SPA 16-0029 / AUTISM SPECTRUM DISORDER SERVICES REIMBURSEMENT

ACCESS MONITORING ANALYSIS- Years 1 – 3

Consistent with the requirements outlined at 42 C.F.R § 447.203(b)(7)) the state is performing an access monitoring analysis to determine whether or not Medicaid State Plan Amendment (SPA) 16-0029 is demonstrating a negative impact on access to ASD treatment services provided by a BCaBA or technician. As implemented under SPA 16-0029 billing codes that must be used when a technician or Board Certified Assistant Behavior Analyst (BCaBA) provides autism spectrum disorder (ASD) treatment services under the supervision of a qualified Board Certified Behavior Analyst (BCBA) or licensed practitioner were added to the ASD fee schedule effective September 1, 2016. The new codes, CPT code 0364T (adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time) and 0365T (each additional 30 minutes of technician time), are each reimbursed at $22.50 per 30-minute unit (equivalent to $45 per hour). Under the previous fee schedule, all ASD treatment services were reimbursed using code H2014 (skills training and development, per 15 minutes) in fifteen-minute units which was equivalent to $48 per hour.

As specified under the access analysis submitted with CT SPA 16-029 – Autism Spectrum Disorder Services Reimbursement, the State has implemented monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures include an annual review of utilization of ASD treatment services provided by BCaBAs and technicians that were impacted by SPA 16-029. This data is compared with baseline data pulled for calendar year 2015 to analyze changes in utilization and to assess changes in the number of providers providing ASD services.

The following tables will provide data related to the utilization of the ASD services impacted by the SPA, the number of enrolled providers by county and, where applicable, the percent difference between the baseline data and year one monitoring data.

Table 1 titled ASD Treatment Services CY 2015 Utilization - HCPCS H2014 provides the baseline data for the change specified under SPA 16-0029. It is important to note that the data displayed in Table 1 below is different than the original baseline data submitted with the access analysis submitted for SPA 16-0029. The original data submitted included data for all ASD treatment services versus targeting the service impacted by SPA 16-0029, HCPCS code H2014. This baseline data has been revised to display calendar year 2015 unduplicated recipient count, and billing provider count data for paid claims for HCPCS code H2014.

Table 1: ASD Treatment Services Calendar Year 2015 Utilization – HCPCS H2014

Recipient County Description MAP	Procedure Code	Unduplicated Recip Count	Billing Provider Count	Units of Service
Fairfield	H2014	7	6	1,519
Hartford	H2014	39	10	28,096
Litchfield	H2014	5	6	4,232
Middlesex	H2014	4	2	1,154
New Haven	H2014	33	8	16,160
New London	H2014	3	2	1,050
Tolland	H2014	3	2	252
Windham	H2014	1	1	133

Table 2 displays the utilization of HCPCS H2014 pre and post-implementation of SPA 16-0029 and the percent difference in the unduplicated recipient count, billing provider count, and units of service as compared with the baseline data. As can be seen by the data below, there were aggregate increases across the board between the baseline data and post implementation data for unduplicated recipients of service, billing provider count and paid units of service. When reviewing the data on the county level, all but two counties (Middlesex and New Haven) experienced increases between the baseline data collected and the post implementation data collected. Middlesex and New Haven both showed a decline in the paid units of service only for H2014 post implementation as compared to the baseline data, while both counties still showed increases in the unduplicated recipient count and billing provider count. SPA 16-0029 was implemented in order to appropriately reimburse practitioners based on education and experience, the State implemented new codes for practitioners who were not licensed or certified. The new HCPCS (0364T and 0365T) are to be used by technicians that do not have a license or certification. It is likely that the reduction of utilization of H2014 in Middlesex and New Haven counties is the result of technicians providing services that were formally using the H2014 code and now must use the 0364T or 0365T codes.

Specifically, in New Haven County, there was a dramatic increase in recipients who accessed ASD services and a sharp rise in Medicaid providers, but the H2014 code decreased as a result of the technicians providing the service using the technician codes referenced above instead of the H2014 code. Middlesex County has very low utilization of ASD services, but we did see an increase in recipients and an increase in providers. We will continue to monitor access metrics for Middlesex County.

Table 2: Utilization of H2014 Year 1 Data Compared to Baseline

	Baseline Data (CY 2015)			Year 1 Data (9/1/16 – 7/31/17)			% Difference b/t Year 1 & Baseline		
Recip County	**Undup Recip Count**	**Billing Prov Count**	**Units of Service**	**Undup Recip Count**	**Billing Prov Count**	**Units of Service**	**Undup Recip Count**	**Billing Provide r Count**	**Units of Service**
Fairfield	7	6	1,519	34	10	2,052	385.7 %	66.7%	35.1%
Hartford	39	10	28,096	82	18	37,360	110.3 %	80.0%	33.0%
Litchfield	5	6	4,232	21	8	17,970	320.0 %	33.3%	324.6%
Middlesex	4	2	1,154	5	3	668	25.0%	50.0%	-42.1%
New Haven	33	8	16,160	78	15	8,624	136.4 %	87.5%	-46.6%
New London	3	2	1,050	29	8	1,483	866.7 %	300.0%	41.2%
Tolland	3	2	252	8	5	961	166.7 %	150.0%	281.3%
Windham	1	1	133	5	2	460	400.0 %	100.0%	245.9%

Table 3 below shows the utilization for procedure code H2014 for the second year of monitoring (9/1/17 – 8/31/18) and compares the results to the data obtained for Year 1 monitoring. As outlined in the table utilization increased exponentially across all counties. As the Medicaid program including efforts led by the BH administrative service organization, Beacon Health Options continues to recruit and enroll autism providers to ensure timely access to medically necessary services.

Table 3: Utilization of H2014 Year 2 Data Compared to Year 1

		Year 2 Data – 9/1/17 – 7/31/18				% Difference B/t Year 2 & Year 1		
Recip County	**Code**	**Undup Recip Count**	**Billing Prov Count**	**Units of Service**		**Undup Recip Count**	**Billing Prov Count**	**Units of Service**
Fairfield	H2014	1,177	33	138,303		3361.8%	230.0%	6639.9%
Hartford	H2014	1,694	55	184,997		1965.9%	205.6%	395.2%
Litchfield	H2014	181	23	27,809		761.9%	187.5%	54.8%
Middlesex	H2014	157	26	15,710		3040.0%	766.7%	2251.8%
New Haven	H2014	1,514	50	139,491		1841.0%	233.3%	1517.5%
New London	H2014	359	29	26,509		1137.9%	262.5%	1687.5%
Tolland	H2014	128	16	9,375		1500.0%	220.0%	875.5%
Windham	H2014	250	16	23,583		4900.0%	700.0%	5026.7%

Table 4 below shows the utilization for procedure code H2014 for the third and final year of monitoring (9/1/18 – 8/31/19) as required under the Access Regulations. Table 4 compares the

results of the utilization for H2014 obtained for dates of service 9/1/18 through 7/31/19 to the data that was obtained for Year 2 monitoring. As outlined in the table, while the percentage differences are not as significant as was seen between year 1 and year 2 monitoring, all Counties with the exception of Litchfield County saw increases in utilization between ~3% and 89%. While Litchfield saw a decrease in the utilization for procedure code H2014 of ~35%, the number of recipients and number of billing providers increased by ~37% and ~22% respectively. The utilization decrease could have been of result of multiple factors including a switch in the type of service required or the number of services required by the member and the reduction by itself cannot be taken to mean that there is an access issue. The only other noted decrease was ~17% in the number of billing providers in New London County. It should also be noted that even with a 17%reduction in the number of providers in New London County during the third year monitoring, the percentage of recipients of service and the utilization both increased by ~30% and ~44% respectively, suggesting that the reduction in providers did not negatively impact access to medically necessary services for New London County.

Table 4: Utilization of H2014 Year 3 Data Compared to Year 2

		Year 3 Data – 9/1/18 – 7/31/19				% Difference B/t Year 3 & Year 2		
Recip County	**Code**	**Undup Recip Count**	**Billing Prov Count**	**Units of Service**		**Undup Recip Count**	**Billing Prov Count**	**Units of Service**
Fairfield	H2014	1,488	40	192,625		26.4%	21.2%	39.3%
Hartford	H2014	1,936	63	190,391		14.3%	14.5%	2.9%
Litchfield	H2014	248	28	18,188		37.0%	21.7%	-34.6%
Middlesex	H2014	190	30	20,994		21.0%	15.4%	33.6%
New Haven	H2014	1,901	61	171,849		25.6%	22.0%	23.2%
New London	H2014	468	24	38,094		30.4%	-17.2%	43.7%
Tolland	H2014	163	22	17,691		27.3%	37.5%	88.7%
Windham	H2014	328	22	36,451		31.2%	37.5%	54.6%

Tables 5, 6 and 7 display the unduplicated recipient counts, billing provider count and units of service, for procedure codes 0364T and 0365T throughout the three years of monitoring SPA 17-0029. Since these codes were not payable prior to implementation of the SPA 16-0029, there is no baseline data available and all comparisons are based on the post implementation obtained. The data shown below in Table 5 serves as the baseline data for HCPS 0364T and 0365T since the services did not become reimbursable until 9/1/2016. Table 5 shows the utilization for 0364T and 0365T across all CT counties.

Table 5: Utilization of HCPCS 0364T and 0365T – Year 1 Data 9/1/16 – 7/31/17

Recip County Description MAP	Procedure Code	Undup Recip Count	Billing Prov Count	Units of Service
Fairfield	0364T	58	12	4,093
Fairfield	0365T	58	12	26,375
Hartford	0364T	109	18	8,647
Hartford	0365T	109	18	53,297
Litchfield	0364T	15	9	581
Litchfield	0365T	15	9	3,587
Middlesex	0364T	7	6	409
Middlesex	0365T	7	6	2,342
New Haven	0364T	112	16	9,240
New Haven	0365T	112	16	62,109
New London	0364T	43	10	3,210
New London	0365T	43	10	17,964
Tolland	0364T	7	3	507
Tolland	0365T	7	3	3,659
Windham	0364T	11	4	727
Windham	0365T	11	4	3,966

Table 6 below shows the utilization for HCPCS 0364T and 0365T for dates of service between 9/1/17 through 7/31/18 as compared to the data obtained for dates of service 9/1/16 through 7/31/17. As can be seen in Table 6 and was expected, the number of unduplicated recipients, the number of billing providers and the units of service paid for 0364T and 0365T all increased between ~11% and ~350% across all CT counties and there were no reductions reported in any of the categories analyzed. This increase in the number of unduplicated recipient counts and billing provider counts was continued for dates of service 9/1/18 through 7/31/19 as displayed in Table 7 with the increases ranging between 11% and 229% for these two categories. It was noted in the data displayed in Table 7 that there were reductions in utilization for 0364T and 0365T between dates of service 9/1/18 and 7/31/19 across 3 counties including New Haven, New London and Windham Counties. These reductions ranged from ~15% to ~25%, but similar to the data shown in Tables 2 and 4 for HCPCS H2014, although there were noted reductions in the utilization for 0364T and 0365T, the number of unduplicated recipients of service and number of billing providers in New Haven, New London and Windham counties all increased between ~30% and ~100% for this same time period suggesting that the reduction in utilization is not indicative of an access to care issue for autism services in these counties.

Table 6: Utilization of HCPCS 0364T and 0365T – Year 2 Data Compared to Year 1

	Year 2 Data – 9/1/17 – 7/31/18	% Difference B/t Year 2 & Year

								1
Recip County	**Code**	**Undup Recip Count**	**Billing Prov Count**	**Units of Service**		**Undup Recip Count**	**Billing Prov Count**	**Units of Service**
Fairfield	0364T	102	16	10,584		75.9%	33.3%	158.6%
Fairfield	0365T	102	16	65,854		75.9%	33.3%	149.7%
Hartford	0364T	258	33	26,109		136.7%	83.3%	201.9%
Hartford	0365T	258	33	153,996		136.7%	83.3%	188.9%
Litchfield	0364T	23	10	1,987		53.3%	11.1%	242.0%
Litchfield	0365T	23	10	12,151		53.3%	11.1%	238.8%
Middlesex	0364T	18	11	1,644		157.1%	83.3%	302.0%
Middlesex	0365T	18	11	10,547		157.1%	83.3%	350.3%
New Haven	0364T	196	29	18,261		75.0%	81.3%	97.6%
New Haven	0365T	196	29	120,841		75.0%	81.3%	94.6%
New London	0364T	63	12	7,210		46.5%	20.0%	124.6%
New London	0365T	63	12	37,215		46.5%	20.0%	107.2%
Tolland	0364T	21	9	1,783		200.0%	200.0%	251.7%
Tolland	0365T	21	9	11,627		200.0%	200.0%	217.8%
Windham	0364T	19	6	1,812		72.7%	50.0%	149.2%
Windham	0365T	19	6	9,210		72.7%	50.0%	132.2%

Table 7: Utilization of HCPCS 0364T and 0365T – Year 3 Data Compared to Year 2

		Year 3 Data – 9/1/18 – 7/31/19				**% Difference B/t Year 3 & Year 2**		
Recip County	**Code**	**Undup Recip Count**	**Billing Prov Count**	**Units of Service**		**Undup Recip Count**	**Billing Prov Count**	**Units of Service**
Fairfield	0364T	104	16	4,787		79.3%	33.3%	17.0%
Fairfield	0365T	105	17	30,628		81.0%	41.7%	16.1%
Hartford	0364T	250	35	10,664		129.4%	94.4%	23.3%
Hartford	0365T	249	35	61,660		128.4%	94.4%	15.7%
Litchfield	0364T	26	10	816		73.3%	11.1%	40.4%
Litchfield	0365T	26	10	4,655		73.3%	11.1%	29.8%
Middlesex	0364T	23	19	926		228.6%	216.7%	126.4%
Middlesex	0365T	23	19	6,212		228.6%	216.7%	165.2%
New Haven	0364T	184	30	7,823		64.3%	87.5%	-15.3%
New Haven	0365T	184	30	50,240		64.3%	87.5%	-19.1%
New London	0364T	56	13	2,751		30.2%	30.0%	-14.3%
New London	0365T	56	13	14,817		30.2%	30.0%	-17.5%
Tolland	0364T	12	6	753		71.4%	100.0%	48.5%
Tolland	0365T	12	6	5,483		71.4%	100.0%	49.8%
Windham	0364T	19	8	683		72.7%	100.0%	-6.1%
Windham	0365T	19	8	2,963		72.7%	100.0%	-25.3%

Conclusion

Based on the results of the analyses, in addition to assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State has determined that SPA 16-0029 is not demonstrating a negative impact on access to ASD treatment services provided by a BCaBA or technician. In contrast based on the results of the analysis there has been an increase in the number of unduplicated recipients who have accessed care and the number of enrolled billing providers has increased throughout the entire monitoring period analyzed. While there were noted reductions in utilization for the various services throughout the monitoring time period, fluctuations in units of service can be the result of changes in physician (or APRN or PA) orders, as well as, changes in the level of care required by the member and cannot be deemed as indicative of an access to care issue. Based on the data presented above and the results showing that there was not a reduction of 25% or more providers (the threshold set for additional investigation to determine a potential access to care issue) the state that SPA 16-0029 is not resulting in a deficiency in access to care or inadequate access.

This concludes the State's requirement to monitor the impact of any rate reduction SPA for a minimum of three years. The State will continue to monitor through its usual monitoring mechanisms such utilization of the ASO's to identify potential access to care concerns. Any concerns identified will be thoroughly analyzed and addressed in a timely fashion to ensure continued timely access to medically necessary services covered under the Medicaid program.

Appendix D

CT SPA 17-0007 – Medical Equipment Devices and Supplies (MEDS) Reimbursement

ACCESS MONITORING ANALYSIS - Years 1 - 2 *(Year 3 will be updated in 2020)*

Year 1 – Access Monitoring

Medicaid State Plan Amendment (SPA) 17-0007 decreased reimbursement amounts to certain procedure codes in order to reimburse more accurately for these services and ensure continued compliance with the requirements for economy and efficiency in accordance with section 1902(a)(30)(A) of the Social Security Act. The reimbursement changes were based on pricing data obtained from several sources, including: Medicare Rates; Other states' Medicaid rates; and Pricing research conducted by the Department.

As described below, in accordance with 42 C.F.R. § 447.204(a), prior to the submission of this SPA, the state considered the data collected and analysis performed for this service and the input from beneficiaries, providers, and other affected stakeholders regarding the potential impact of this SPA. The comment period ended on March 30, 2017. This analysis incorporates the comments received by the state. Further, in accordance with 42 C.F.R. § 447.203(b)(6), the analysis below includes an access review that is being attached to the state's Access Monitoring Review Plan and monitoring procedures to ensure ongoing monitoring of access to this service. As explained below, this analysis demonstrates that there remains sufficient access to the services affected by this SPA.

Measures and Analyses

The State looked at several measures, which demonstrate that there is sufficient access to MEDS services and determined that the proposed rate reductions would not negatively impact access to members obtaining MEDS devices and/or supplies impacted by this proposed SPA. The state has determined that this SPA complies with access requirements based on an analysis of the following measures: (1) total number of Medicaid beneficiaries; (2) number of enrolled MEDS providers; and (3) utilization by MEDS providers billing for the procedure codes impacted by the proposed changes.

Table 1 below, shows the total number of Medicaid beneficiaries by program type enrolled for calendar years (CY) 2016 and CY 2017. This data demonstrates there was an increase in Medicaid eligibility across HUSKY A and HUSKY D members. In addition, there was a slight decrease in HUSKY C members in CY 2017.

Table 1. Total number of Medicaid Beneficiaries by Eligibility Type Calendar Years 2016 and 2017

MEDICAID ELIGIBILITY TYPE	Unduplicated Beneficiaries CY 2016	Unduplicated Beneficiaries CY 2017
HUSKY A	557,747	575,529
HUSKY C	109,912	108,981
HUSKY D	273,603	302,768
Sum:	**941,262**	**987,278**

HUSKY A: children, caretaker adults, and pregnant women coverage groups.
HUSKY C: aged, blind, and disabled coverage groups.
HUSKY D: low-income adult coverage groups.

Table 2 below shows the count of Medical Equipment, Devices and Supplies (MEDS) providers who were enrolled by county for calendar year CY 2016 compared to CY 2017. Based on the comparison between MEDS providers enrolled in CY 2017 vs. CY 2016, the data reflects that the number of MEDS providers enrolled in the Medicaid Program actually increased across all counties except for New Haven. More generally, the state has determined that there is sufficient access to MEDS services throughout the state because supplies and DME items are routinely shipped to the beneficiaries' home, regardless of where providers are located.

Table 2: Counts of CT Medicaid Medical Equipment, Devices and Supplies (MEDS) Providers, Comparison between Calendar Year 2016 and CY 2017.

Medical Equipment, Devices and Supplies (MEDS) Providers	**Statewide MEDS Provider Count***	**Statewide MEDS Provider Count***
Provider County Description	**CY 2016**	**CY 2017**
Fairfield	156	158
Hartford	204	217
Litchfield	35	46
Middlesex	40	43
New Haven	224	220
New London	63	65
Tolland	0	0
Windham	23	24
Total:	**745**	**773**

** Data was obtained through the state's Data Warehouse based on paid claims for CY 2017.*

Table 3: Utilization of Medical Equipment, Devices and Supplies (MEDS) in Calendar Year 2016 and Calendar Year 2017.

Utilization Analysis SPA 17-007 - CY 2016				
County	**Unique Recipients**	**# of Billing Providers**	**Units of Service**	**Paid Amount**
Fairfield	4,638	123	10,922	$ 1,450,356
Hartford	6,566	136	12,345	$ 1,447,326
Litchfield	828	70	2,662	$ 201,036
Middlesex	598	62	1,258	$ 154,992
New Haven	6,475	168	14,837	$ 1,586,378
New London	1,760	74	4,204	$ 478,895
Tolland	492	46	928	$ 113,838
Windham	926	53	1,528	$ 198,714
Total	**22,283**	**732**	**48,684**	**$ 5,631,534**

Utilization Analysis SPA 17-007 - CY 2017				
County	**Unique Recipients**	**# of Billing Providers**	**Units of Service**	**Paid Amount**
Fairfield	4,415	124	7,440	$ 909,333
Hartford	6,911	142	10,191	$ 1,013,648
Litchfield	819	78	1,660	$ 127,107
Middlesex	589	67	862	$ 94,890
New Haven	6,744	173	10,990	$ 1,152,192
New London	1,783	79	3,127	$ 276,377
Tolland	545	55	842	$ 81,707
Windham	837	41	1,306	$ 119,923
Total	**22,643**	**759**	**36,418**	**$ 3,775,177**

Table 3 above outlines the utilization of Medical Equipment, Devices and Supplies (MEDS) procedure codes affected by the proposed reimbursement reductions in SPA 17-0007 by county.

The data in Table 3 above was extracted based on dates of service paid in calendar year 2016 and CY 2017 in order to determine if the rate reductions proposed under this SPA has negatively impacted access to these items. The data demonstrates there was actually an increase in the number of MEDS providers in all counties except for Windham. The units of service and paid amounts did decrease across all counties. However, the Department did not receive any concerns or access issues from either HUSKY beneficiaries or MEDS providers.

Table 4: Utilization of Medical Equipment, Devices and Supplies (MEDS) by Procedure Codes in Calendar Year 2016 and Calendar Year 2017.

Utilization by Procedure Code (CY 16 - CY 17)			Year over Year Comparison
Procedure Code	**CY 2016 Units**	**CY 2017 Units**	**CY 17 over CY 16**
A4630	19,294	9,621	-50%
A4670	3,627	3,885	7%
A6549	1,774	662	-63%
A7005	6,169	4,406	-29%
E0305	56	66	18%
E0310	19	20	5%
E0445	79	48	-39%
E0570	9,116	8,540	-6%
E0720	50	21	-58%
E0730	84	43	-49%
E0731	15	28	87%
E0747	12	-	-100%
E0748	135	1	-99%
L0627	358	252	-30%
L0631	49	15	-69%
L0635	1	1	0%
L0637	209	87	-58%
L0638	1	2	100%
L0640	4	2	-50%
L0641	61	71	16%
L0642	81	205	153%
L0643			0%

	1	1	
L0649	-	-	0%
L1812	353	640	81%
L1831	89	90	1%
L1832	423	354	-16%
L1834	3	-	-100%
L1840	1	1	0%
L1843	59	63	7%
L1844	19	11	-42%
L1845	140	132	-6%
L1846	126	66	-48%
L1847	-	-	0%
L1850	16	14	-13%
L3760	134	137	2%
L3807	974	706	-28%
L3809	658	1,205	83%
L3915	1	1	0%
L3918	-	2	200%
L3924	119	157	32%
L3930	2	8	300%
L4360	1,297	1,387	7%
L4361	1,591	1,997	26%
L4370	4	46	1050%
L4386	534	466	-13%
L4387			20%

	335	401		
L4397	42	19		-55%
S1040	569	538		-5%
Total	**48,684**	**36,418**		**-25%**

Table 4 above compares the utilization of Medical Equipment, Devices and Supplies (MEDS) by procedure codes affected in SPA 17-0007.

The data in Table 4 above demonstrated the following:

Medical surgical supplies (codes A4630 – replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient and A7005 – administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable) had a reduction in utilization over the established 25% threshold, however, the pricing methodology applied to these codes were higher in reimbursement than Medicare's rate and were comparable to the Medicaid fees to Connecticut's neighboring states. In addition, it was determined that reimbursement at actual acquisition cost plus twenty-five percent would provide sufficient mark-up for each unit of procedure code A6549 – gradient compression stocking/sleeve, not otherwise specified. Notably, several neighboring states do not cover procedure code A6549. The Department did not receive any concerns or access issues from any HUSKY beneficiaries.

Durable medical equipment (DME) code E0445 – oximeter device for measuring blood oxygen levels, non-invasively) had a reduction in utilization over the established 25% threshold, however, it was determined that reimbursement at actual acquisition cost plus thirty-five percent would provide sufficient mark-up for procedure code E0445.

Durable medical equipment (codes E0720 – transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation; and E0730 – TENS device, four or more leads, multiple nerve stimulation) had a reduction in utilization over the established 25% threshold, however the pricing methodology applied to these codes were higher in reimbursement than Medicare's rate. The Department did not receive any concerns or access issues from any HUSKY beneficiaries.

Durable medical equipment (codes E0747 – osteogenesis stimulator, electrical, non-invasive, other than spinal applications and E0748 – osteogenesis stimulator, electrical, non-invasive, spinal application) had a reduction in utilization over the established 25% threshold, however the decrease in utilization could be attributed to the Department's much stricter prior authorization requirements which included stricter documentation that would indicate medical necessity in the

plan of care and length of time being prescribed for these bone growth stimulators. The Department did not receive any concerns or access issues from HUSKY beneficiaries.

Orthotics for lumbar, knee, wrist-hand finger and ankle foot orthosis (codes L0637, L0640, L1834, L1844, L1846, L3807 and L4397) had reductions in utilization over the established 25% threshold, however, the reductions could be attributed to the Department's addition of prior authorization to these codes and or the Department's implementation that custom fitted orthotics required the expertise of a certified orthotist or an individual who has equivalent specialized training such as a physician, treating licensed practitioner, occupational therapist and or physical therapist in the provision of orthosis to fit the item to the individual beneficiary. The Department did not receive any concerns or access issues from either HUSKY beneficiaries or MEDS providers.

Conclusion

As described above, the Department's data regarding utilization, provider network and other relevant factors pertaining to this SPA determines that there remains sufficient access to these services and that such access is expected to continue. The State will continue to monitor access for the next year as required. If the State determines there is a deficiency in access to care or inadequate access, the State will do further analysis.

YEAR 2 – (2018) Access Monitoring

Measures and Analyses

The State looked at several measures, which demonstrate that there is sufficient access to MEDS services and determined that the proposed rate reductions would not negatively impact access to members obtaining MEDS devices and/or supplies impacted by this proposed SPA. The state has determined that this SPA complies with access requirements based on an analysis of the following measures: (1) total number of Medicaid beneficiaries; (2) number of enrolled MEDS providers; and (3) utilization by MEDS providers billing for the procedure codes impacted by the proposed changes.

Table 1 below, shows the total number of Medicaid beneficiaries by program type enrolled for calendar years (CY) 2017 and CY 2018. This data demonstrates there was an increase in Medicaid eligibility across HUSKY A and HUSKY D members. In addition, there was a slight decrease in HUSKY C members in CY 2018.

Table 1. Total number of Medicaid Beneficiaries by Eligibility Type Calendar Years 2017 and 2018

MEDICAID ELIGIBILITY TYPE	Unduplicated Beneficiaries CY 2017	Unduplicated Beneficiaries CY 2018
HUSKY A	575,529	572,872
HUSKY C	108,981	104,418
HUSKY D	302,768	314,232
Sum:	**987,278**	**991,522**

HUSKY A: children, caretaker adults, and pregnant women coverage groups.
HUSKY C: aged, blind, and disabled coverage groups.
HUSKY D: low-income adult coverage groups.

Table 2 below shows the count of Medical Equipment, Devices and Supplies (MEDS) providers who were enrolled by county for calendar year CY 2017 compared to CY 2018. Based on the comparison between MEDS providers enrolled in CY 2017 vs. CY 2018, the data reflects that the number of MEDS providers enrolled in the Medicaid Program decreased across all counties except for Fairfield. More generally, the state has determined that there is sufficient access to MEDS services throughout the state because supplies and DME items are routinely shipped to the beneficiaries' home, regardless of where providers are located.

Table 2: Counts of CT Medicaid Medical Equipment, Devices and Supplies (MEDS) Providers, Comparison between Calendar Year 2017 and CY 2018.

Medical Equipment, Devices and Supplies (MEDS) Providers	Statewide MEDS Provider Count*	Statewide MEDS Provider Count*
Provider County Description	**CY 2017**	**CY 2018**
Fairfield	158	159
Hartford	217	201
Litchfield	46	39
Middlesex	43	41
New Haven	220	217
New London	65	59
Tolland	0	0
Windham	24	22
Total:	**773**	**738**

** Data was obtained through the state's Data Warehouse based on paid claims for CY 2017.*

Utilization Analysis

Table 3: Utilization of Medical Equipment, Devices and Supplies (MEDS) in Calendar Year 2017 and Calendar Year 2018.

Utilization Analysis SPA 17-007 - CY 2017				
County	**Unique Recipients**	**# of Billing Providers**	**Units of Service**	**Paid Amount**
Fairfield	4,415	124	7,440	$ 909,333
Hartford	6,911	142	10,191	$ 1,013,648
Litchfield	819	78	1,660	$ 127,107
Middlesex	589	67	862	$ 94,890
New Haven	6,744	173	10,990	$ 1,152,192
New London	1,783	79	3,127	$ 276,377
Tolland	545	55	842	$ 81,707
Windham	837	41	1,306	$ 119,923
Total	**22,643**	**759**	**36,418**	**$ 3,775,177**

Utilization Analysis SPA 17-007 - CY 2018				
County	**Unique Recipients**	**# of Billing Providers**	**Units of Service**	**Paid Amount**
Fairfield	3,968	132	4,473	$ 619,138
Hartford	6,833	156	8,232	$ 882,962
Litchfield	687	65	794	$ 112,487
Middlesex	603	60	681	$ 86,678
New Haven	6,110	177	6,947	$ 878,484
New London	1,420	68	1,690	$ 200,836
Tolland	531	57	644	$ 81,381
Windham	762	44	1,095	$ 102,140
Total	**20,914**	**759**	**24,556**	**$ 2,964,106**

Table 3 above outlines the utilization of Medical Equipment, Devices and Supplies (MEDS) procedure codes affected by the proposed reimbursement reductions in SPA 17-0007 by county.

The data in Table 3 above was extracted based on dates of service paid in calendar year 2017 and CY 2018 in order to determine if the rate reductions proposed under this SPA have negatively impacted access to these items. The data demonstrates although the number of Medicaid recipients went down, the total number of billing providers stayed the same. The units of service and paid amounts did decrease across all counties; however, the Department did not receive any concerns or access to care issues from either HUSKY beneficiaries or MEDS providers.

Table 4: Utilization of Medical Equipment, Devices and Supplies (MEDS) by Procedure Codes in Calendar Year 2017 and Calendar Year 2018.

Utilization by Procedure Code (CY 17 - CY 18)		Year over Year Comparison

Procedure Code	CY 2017 Units	CY 2018 Units		CY 17 over CY 18
A4630	9,621	51		-99%
A4670	3,885	4,481		15%
A6549	662	806		22%
A7005	4,406	1,912		-57%
E0305	66	11		-83%
E0310	20	6		-70%
E0445	48	73		52%
E0570	8,540	7,906		-7%
E0720	21	7		-67%
E0730	43	12		-72%
E0731	28	13		-54%
E0747	-	-		0%
E0748	1	-		-100%
L0627	252	219		-13%
L0631	15	25		67%
L0635	1	10		900%
L0637	87	62		-29%
L0638	2	7		250%
L0640	2	6		200%
L0641	71	70		-1%
L0642	205	135		-34%
L0643	1	-		-100%

L0649	-	1		100%
L1812	640	728		14%
L1831	90	69		-23%
L1832	354	296		-16%
L1834	-	2		200%
L1840	1	1		0%
L1843	63	48		-24%
L1844	11	11		0%
L1845	132	152		15%
L1846	66	108		64%
L1847	-	1		100%
L1850	14	16		14%
L3760	137	114		-17%
L3807	706	696		-1%
L3809	1,205	1,526		27%
L3915	1	2		100%
L3918	2	2		0%
L3924	157	206		31%
L3930	8	2		-75%
L4360	1,387	1,430		3%
L4361	1,997	2,175		9%
L4370	46	29		-37%
L4386	466	424		-9%

L4387	401	523		30%
L4397	19	23		21%
S1040	538	159		-70%
Total	**36,418**	**24,556**		**-33%**

Table 4 above compares the utilization of Medical Equipment, Devices and Supplies (MEDS) by procedure codes affected in SPA 17-0007.

The data in Table 4 above demonstrated the following: Medical surgical supplies (codes A4630 – replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient and A7005 – administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable) had reductions in utilization over the established 25% threshold, however, the pricing methodology applied to these codes were higher in reimbursement than Medicare's rate and were comparable to the Medicaid fees to Connecticut's neighboring states. The Department did not receive any concerns or access issues from any HUSKY beneficiaries.

Durable medical equipment (DME) codes E0305 and E0310 – bed side rails, half-length and full length) had a reduction in utilization over the established 25% threshold, however, this may be attributed to DME providers no longer finding it profitable to unbundle the billing of hospital beds and rather prefer providing hospital beds with included bedside rails. The Department did not receive any concerns or access issues from any HUSKY beneficiaries.

Durable medical equipment (codes E0720 – transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation; and E0730 – TENS device, four or more leads, multiple nerve stimulation) had reductions in utilization over the established 25% threshold, however the pricing methodology applied to these codes were higher in reimbursement than Medicare's rate. The Department did not receive any concerns or access issues from any HUSKY beneficiaries.

Durable medical equipment (code E0748 – osteogenesis stimulator, electrical, non-invasive, spinal application) had reductions in utilization over the established 25% threshold, however the decrease in utilization could be attributed to the Department's much stricter prior authorization requirements which included stricter documentation that would indicate medical necessity in the plan of care and length of time being prescribed for the bone growth stimulator. The Department did not receive any concerns or access issues from HUSKY beneficiaries.

Orthotics for lumbar, knee, hand finger orthosis and pneumatic full leg splint (codes L0637, L0642, L0643, L3930 and L4370) had reductions in utilization over the established 25% threshold, however, the reductions could be attributed to the Department's addition of prior

authorization to these codes and or the Department's implementation that custom fitted orthotics required the expertise of a certified orthotist or an individual who has equivalent specialized training such as a physician, treating licensed practitioner, occupational therapist and or physical therapist in the provision of orthosis to fit the item to the individual beneficiary. The Department did not receive any concerns or access issues from HUSKY beneficiaries or MEDS providers.

Durable medical equipment (code S1040 – cranial remolding orthosis, pediatric, rigid…) had a reduction in utilization over the established 25% threshold; however the decrease in utilization could be attributed to the Department's much stricter prior authorization requirements. In addition to medical necessity, the medical policy criteria established required the provision of evidence-based clinical decision to support for the treatment of plagiocephaly. The Department did not receive any concerns or access issues from HUSKY beneficiaries.

Conclusion

As described above, the Department's data regarding utilization, provider network and other relevant factors pertaining to this SPA determines that there remains sufficient access to these services and that such access is expected to continue. The State will continue to monitor access for the next year as required. If the State determines there is a deficiency in access to care or inadequate access, the State will do further analysis.

Appendix E

CT SPA 17-0028 / ELIMINATION OF HOME HEALTH AGENCY ADD-ONS

ACCESS MONITORING ANALYSIS – Years 1-2 ***(Year 3 will be updated in 2020)***

Consistent with the requirements outlined at 42 C.F.R § 447.203(b)(7)) the state is performing an access monitoring analysis to determine whether or not Medicaid State Plan Amendment (SPA) 17-0028 is demonstrating a negative impact on access to home health services. As implemented under SPA 17-0028, the state revised the home health agency fee schedule and implemented the removal of home health agency rate add-ons.

As specified under the access analysis submitted with CT SPA 17-0028 – Elimination of Home Health Agency Add-Ons, the State has implemented monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures include: (1) an annual review of the number of enrolled home health agencies with specific emphasis on the providers impacted by SPA 17-0028 and (2) the utilization of overall home health services by the specific home health agencies that were impacted by SPA 17-0028. This data is compared with baseline data pulled for the number of enrolled providers during calendar year 2014 and overall home health utilization by the agencies approved to receive the add-on payments for state fiscal year 2016 to analyze changes. The data is specifically analyzed to determine if there has been a reduction of 25% or more in the number of enrolled providers. This level of reduction is the threshold for the state to further investigate potential access to care issues, unless (1) the reduction is due to closures that were planned prior to this proposed SPA, or (2) the reduction in number of enrolled providers is offset by the unduplicated members being successfully transferred to other home health agencies looking to increase their caseloads.

The following tables (Tables 1 – 2) will provide data related to the number of enrolled home health agencies, and the overall utilization of the home health services by the agencies formerly approved to receive add-on payments.

Table 1: Number of Enrolled Home Health Agencies

Baseline Data	Post-Implementation Data	Percent Change
82	108	31.7%

As demonstrated by Table 1 above, there has been a 31% increase in the number of home health agencies enrolled with the state Medicaid program in the time period that spans the baseline data (2014) and post-implementation (September 2017) of SPA 17-0028. Of particular note, none of the providers that were specifically impacted by SPA 17-0028 dis-enrolled from the program and continue to provide services to CT Medicaid beneficiaries.

Table 2: Home Health Providers Approved for Add-On Fees Baseline versus Post Implementation (Post Implementation 8/12/17 – 8/12/18) – Year 1

Baseline Data	Post-Implementation Data 8/12/17 – 8/12/18

Billing Provider	ICN Count	Paid Amount	Units of Serv	Recip Count	ICN Count	Paid Amount	Units of Serv	Recip Count
CONSTELLATION HOME CARE LLC	2,249	$716,036.57	51,531	191	419	$174,982.47	10,152	69
HARTFORD HEALTHCARE AT HOME	26,081	$4,526,906.26	121,426	2,129	17,982	$3,010,233.66	85,410	2,017
MASONICARE HOME HEALTH &HOSPICE INC	9,466	$3,720,349.13	151,291	1,008	6,661	$1,996,337.61	110,238	767
MASONICARE PARTNERS HOMEHEALTH AND HOSPICE	5,391	$1,829,080.20	94,324	763	3,806	$1,172,093.90	69,287	595
PEDIATRIC SERVICES OF AMERICA INC	8,477	$16,313,861.54	449,397	306	8,400	$15,121,747.46	417,805	298
VISITING NURSE SERVICES OF CONNECTICUT, INC.	14,680	$4,763,848.47	169,560	1,449	8,863	$2,560,247.13	102,127	1,194
VNA OF SOUTH CENTRAL CT	9,299	$4,345,858.11	68,129	1,246	7,518	$2,874,779.96	60,941	998
	75,643	**$36,215,940.28**	**1,105,658**	**7,092**	**53,649**	**$26,910,422.19**	**855,960**	**5,938**

Table 3: Post Implementation (Post Implementation 8/12/18 – 8/12/19) – Year 2

Billing Provider	ICN Count	Paid Amount	Units of Serv	Recip Count
CONSTELLATION HOME CARE LLC	209	$82,417.77	4,306	31
HARTFORD HEALTHCARE AT HOME	7,994	$2,428,293.70	51,664	1,969
MASONICARE HOME HEALTH AND HOSPICE	5,597	$1,751,269.94	109,158	725
MASONICARE PARTNERS HOMEHEALTH AND HOSPICE	381	$92,984.62	5,352	159
PEDIATRIC SERVICES OF AMERICA INC	7,879	$13,984,732.88	376,526	264
VISITING NURSE SERVICES OF CONNECTICUT, INC.	6,107	$1,735,085.64	72,258	534
VNA OF SOUTH CENTRAL CT	4,840	$2,665,620.65	56,916	798
	33,007	**$22,740,405.20**	**676,180**	**4,480**

It should be noted that even with the decreases among the unduplicated ICN count, units of service and recipients of service during the post-implementation period of this SPA (Year 1 and Year 2 monitoring), the state and the state's administrative service organizations have not to date received complaints related to the ability to access care for home health services. With the provider network increases of 31%, no disenrollment of any home health agency that was

directly impacted by this SPA, there remain a sufficient number of home health agencies to meet the needs of the state's Medicaid program beneficiaries.

Additionally, in response to the elimination of the home health agency add-on rates, the Department implemented SPA 17-0030 that increased the percent at which modifier TG (Complex/High Level of Care) was reimbursed from 45.7% to 47.2% when home health agencies rendered nursing care provided by a licensed practical nurse or registered nurse. Complex/high level of care is defined as nursing care required for more than two continuous, consecutive hours per visit and providers are reimbursed at a percentage of the rate for nursing care. By increasing the percentage reimbursed from 45.7% to 47.22% for complex/high level of care, SPA 17-0030 allowed the Department, (1) to use some of the savings that resulted from the elimination of the add-on fees (under SPA 17-0028) to reimburse for clinically relevant care that targeted providers that would lose the add-on fee (such as pediatric home health agencies), and (2) to off-set expenses incurred by home health agencies providing such complex/high level of care.

Conclusion
Based on the results of this analysis, in addition to assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State has determined that at this point SPA 17-0028 is not demonstrating a negative impact on access to home health services and that the member community is receiving timely access to care.

The State will continue to monitor home health data related to this SPA and if it is determined that the SPA is resulting in a deficiency in access to care or inadequate access, the State will develop and submit a corrective action plan with specific steps and timelines to remedy the deficiencies.

Appendix F

CT SPA 18-0028 of CPAP and BiPAP Supplies – Access Monitoring

ACCESS Monitoring Year 1 – *(Year 2 will be updated in 2020)*

Effective August 1, 2018, Medicaid State Plan Amendment (SPA) 18-0028 began allowing reimbursement of supplies used with Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP) respiratory assist devices **during the rental period** of CPAP and BiPAP devices. In order for that change to be feasible, the rates for these supplies were decreased to the average of the three Medicare Competitive Bidding Program rates. Procedure code impacted were the following: A4604, A7027 through A7039; A7044 through A7046; and E0561and E0562.

Measures and Analyses

Table 1: Counts of CT MEDS Providers, Calendar Year 2017.

SPA 18-028 County Data - Access Monitoring Analysis				
County	Unique Recipients	# of Billing Providers	Units of Service	Paid Amount
Fairfield	1,458	17	17,247	$ 366,998
Hartford	2,282	19	27,032	$ 558,129
Litchfield	335	11	4,386	$ 89,262
Middlesex	311	13	3,891	$ 82,860
New Haven	2,602	20	33,121	$ 711,214
New London	504	12	6,844	$ 137,637
Tolland	250	12	2,868	$ 60,807
Windham	340	11	4,264	$ 96,028
	8,082	**115**	**99,653**	**2,102,934**

Table 1 above outlines the utilization of Medical Equipment, Devices and Supplies (MEDS) procedure codes affected by the proposed reimbursement reductions in SPA 18-0028 by county. The analysis only includes procedure codes that were reduced by SPA 18-0028.

Table 2: Utilization of Medical Equipment, Devices and Supplies (MEDS) Comparison between 2017 Data and 08/01/2018 through 07/31/2019

SPA 18-028 Utilization Data Comparison - Access Analysis

Procedure Code	CY 2017 Data	August 2018 - July19 Data	Percent Difference
A4604	6,868	7,738	12.67%
A7027	6	4	-33.33%
A7028	4	2	-50.00%
A7029	2	5	150.00%
A7030	6,014	6,520	8.41%
A7031	7,835	8,708	11.14%
A7032	5,918	6,214	5.00%
A7033	5,253	4,422	-15.82%
A7034	4,207	4,468	6.20%
A7035	6,532	8,326	27.46%
A7036	339	293	-13.57%
A7037	2,905	3,082	6.09%
A7038	32,252	34,983	8.47%
A7039	2,336	2,144	-8.22%
A7045	39	81	107.69%
A7046	3,196	3,840	20.15%
E0562	11,153	8,823	-20.89%
Total	**94,859**	**99,653**	**5.05%**

Notes:

1. Data was queried by dates of service between 8/1/18 and 7/31/19.
2. The analysis only includes procedure codes that were reduced by SPA 18-028.

The data in Table 2 above demonstrates utilization for the CPAP and BiPAP supplies in 2017 compared to dates of service August 1, 2018 through July 31st 2019. The Department is aware we will not have a true picture because of claims lag but this will provide us data for utilization after the effective date of the SPA.

The data demonstrates that utilization actually went up for two thirds of the procedure codes impacted. Only three procedures codes show a reduction in utilization of 20% or more, however, neither beneficiaries nor MEDS providers have raised any concerns or access issues to the Department.

Conclusion

The Department did not receive any comments or any other feedback from either MEDS providers, HUSKY members or other stakeholders, pertaining to the reduction of fees for the CPAP and BiPAP supplies.

The State will continue to monitor access for the next two years as required. If the State determines there is a deficiency in access to care or inadequate access, the State will do further analysis.