



Access and Quality of Care in the HUSKY Program

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Enrolling in HUSKY is just the first step toward ensuring that children receive regular, quality health care. Although annual reports by the Department of Social Services (DSS) have shown that the percentage of children receiving well-child visits has improved substantially since the transition to Medicaid managed care in 1995, the federal goal of 80% participation has not been met in Connecticut for children over one. Dental screening rates have remained at 25-30%.

This issue brief summarizes what is known about access, utilization and quality of children's health care services in HUSKY Part A (Medicaid managed care). To date, there is little comparable information with which to evaluate access and quality in HUSKY Part B.

Access to Care

- **Many children do not receive timely well-child care.** Just 45% of children 2 to 19 who were enrolled in HUSKY Part A for a year received well-child care, according to a recent study by the Children's Health Council. Least likely to receive care: African-American children and older adolescents. Utilization also varied by health plan. An earlier study of adolescent health care utilization showed that well-child care rates declined with age for both male and female adolescents, but episodic care increased with age among females and decreased with age among males.
- **Many children do not have a usual source of care.** The Children's Health Council study of ambulatory care showed that nearly one in four children enrolled in HUSKY Part A for a year did not have a usual source of care, i.e., they received only emergency care or no care at all. Least likely to have had a usual source of care: older adolescents, especially males, and African-American children. Children who do not have a usual source of care are more likely to forego care or use emergency services for conditions that might otherwise be treated in a clinic or office setting.
- **Many children do not receive dental care.** Among children enrolled in HUSKY Part A for a year, just 41% had preventive dental care. Least likely to receive preventive care: older adolescents, African-American children, and Fairfield and Tolland county residents. Utilization also varied by health plan.

Quality of Well-Child Care

- **Many children do not receive comprehensive well-child exams.** To be most effective, well-child exams should be comprehensive and age-specific. A review of 1500 children's medical records, conducted earlier this year by Qualidigm, Inc., revealed that just 29% of infants and 39% of children 5 to 11 received timely, comprehensive EPSDT screening exams. Immunizations, health education, and developmental/ behavioral assessment were the components most often missing or not documented. Less than half of all the children had had age-appropriate hearing and vision testing. Only a third of records showed that oral health was assessed or discussed. Only half of adolescents were screened for sexual activity, smoking, and substance abuse; few were assessed for exposure to violence or for depression.
- **Most very young children received age-appropriate blood lead testing.** An important component of high quality, comprehensive care for very young children is risk assessment and testing for elevated blood lead levels, as required under the EPSDT program. Two studies by the Department of Public Health (DPH) and the Children's Health Council found that over 90% of children enrolled in HUSKY Part A had been tested by 3 years of age. These rates are substantially higher than national data showing just 19% of children on Medicaid having ever been tested.

Children with Special Health Care Needs

Families with children with special health care needs face exceptional challenges when trying to obtain care in a managed care program. An estimated one in five children enrolled in HUSKY Part A has special needs, although the health and health care needs of these children vary substantially. A telephone survey commissioned by the Children's Health Council sought to assess satisfaction and access to care among these families. The results show that:

- **Families are generally satisfied with their health plans and the quality of care from providers.** They were also satisfied with the choice of primary care providers, specialists, and dentists. Most families reported being involved in care decisions for their children and well informed by providers. However, some families reported difficulties trying to obtain timely appointments with medical specialists. Some families reported that their children did not get enough approved visits for behavioral health care. While the proportion of children who needed special services was small, some families reported difficulties with physical access, obtaining special transportation, and getting interpreters. Less than 10% reported having a case manager assigned by the health plan.
- **While few families reported having experienced a cutback in services for their children, only a third of those who did said they were notified in writing.**
- **While most families said they are aware that they can make a formal complaint about health plan services, less than half of those who felt the need to complain actually did.**

Children with Behavioral Health Care Needs

The Children's Health Council analyzed health plan encounter data to investigate the follow-up care children received after hospitalization for behavioral health care.

- **Among children who were hospitalized for behavioral health care, readmission rates were high and many children did not receive ambulatory care following discharge.** In 1998, less than 1% of children enrolled in HUSKY Part A were hospitalized. The 30-day readmission rate was 25% for all children and 29% among children in custody of the Department of Children and Families (DCF). Among children who were not re-admitted

to the hospital, only half had outpatient behavioral health care within 30 days of discharge; just 39% of children in DCF custody received follow-up care.

Work In Progress to Address Access and Quality Concerns

- **Well-child care:** The Children's Health Council is working with DSS, health plans, and community-based organizations to investigate and develop approaches for bringing African-American children and adolescents in for care.
- **Dental care:** Several public and private initiatives are underway to expand the provision of dental services in the public sector. Legislators, DSS and DPH staff, providers, and others are at work on the issue. A lawsuit on behalf of families who claim to have been denied care may bring about changes in the financing and delivery of dental services.
- **Behavioral health care:** Major changes in the organization and financing of children's behavioral health care system, including the possible carve-out of services from Medicaid managed care contracts, are anticipated.

New Recommendations from the Children's Health Council

- **In order to ensure access and quality in care for children with special health care needs, the Department of Social Services (DSS) should develop a comprehensive, ongoing approach to monitoring access and satisfaction.**
- **To ensure provider participation, DSS should investigate whether current capitation rates and provider reimbursement for routine pediatric care are adequate to meet the federal goals for EPSDT participation in Connecticut.**