CHILDREN'S HEALTH COUNCIL

Health and Health Care in HUSKY A For Children in the Care and Custody of The Connecticut Department of Children And Families

January 2002

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INTRODUCTION

In Connecticut, there are more than 8,000 children in the care and custody of the Department of Children and Families (DCF) who are enrolled in HUSKY A. Enrollment in this Medicaid managed care program is mandatory for children in state custody. HUSKY A provides foster care and adoptive families with access to the health care these children need. Although children in foster care and other protective out-of-home placements make up less than five percent of children enrolled in HUSKY A, their health care needs and circumstances constitute a significant challenge for the health care system. Their health concerns are extensive, commonly the result of abuse or neglect, and often including chronic diseases and significant developmental and psychiatric problems.[1 – 7]

Despite the complex and often severe nature of the health conditions experienced by children in out-of-home care, studies have indicated that these high-risk children do not always receive basic health care services while in protective placement. Their health problems sometimes go unrecognized. A 1995 study by the US General Accounting Office (GAO) revealed that almost a third of foster care children in three major cities (New York City, Philadelphia, Los Angeles) had health care needs that were identified but not served.[8] Another third had not received required immunizations and some children had not even been evaluated. Similarly, a study conducted in Connecticut showed that some community-based providers who assessed the health of children entering foster care in one region did not recognize the full spectrum of conditions affecting the children they evaluated nor did they refer children to specialists in many cases where referral was warranted.[3] In addition, several studies examining the health care utilization of Medicaid-reimbursed services by foster care children revealed that disproportionate usage of health care, especially mental health services, is common for children in state custody. In 1992, foster care children in California accounted for just 4% of all Medicaid-eligible children, but they incurred 43% of all mental health expenditures.[9] In 1990, foster care children in Washington were eight times more likely to utilize mental health care services and the state spent on average about $2,500 more on health care for children in foster care, compared to children on cash assistance.[10] These studies and others indicate that children in out-of-home placement have a high level of need and that Medicaid and the health care delivery system may not fully identify or serve their needs.[11]

BACKGROUND

Children with Special Health Care Needs and Medicaid Managed Care

Under federal Medicaid waiver requirements in the Balanced Budget Act of 1997 (BBA), Connecticut and other states that mandate Medicaid managed care enrollment for children with special health care needs are required to establish safeguards for ensuring that these children receive the care they need. Children with special health care needs are defined in the BBA as children under 19 who are:

- Blind/disabled children and related populations who are eligible for Supplemental Security Income (SSI) under title XVI of the Social Security Act;[i]
- Children in out-of-home placement who receive federal foster care or adoption assistance under title IV-E of the Social Security Act;
- Children in foster care or out-of-home placements funded from other sources;
- Children who receive services in programs for children with special health care needs under title V section 501 (a)(1)(D) of the Social Security Act;
- Children who live at home but would qualify for Medicaid under section 1902(e)(3) of the Social Security Act if institutionalized.[ii]

This definition is based on qualification for benefits in other publicly funded programs and does not include all children with special health care needs.[iii] Children in foster care and children eligible for SSI are enrolled in Medicaid managed care in 30 and 31 states, respectively, and the District of Columbia.[12] Nationwide data on Medicaid managed care enrollment of children in title V and other programs are not available, in part because they cannot be readily identified by state Medicaid agencies.

Medicaid Eligibility in Connecticut

Children in protective custody in Connecticut are eligible for federally funded Medicaid coverage in several Medicaid coverage groups, depending on whether they would have been eligible for Medicaid had they remained with their biological families. Most children who enter state custody are already enrolled in HUSKY A, that is, living in families with income less than

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[i] In Connecticut and 10 other states, children who meet federal standards for SSI do not automatically qualify for Medicaid. See: US General Accounting Office. Medicaid managed care: challenges in implementing safeguards for children with special needs (GAO/HEHS-00-37). Washington, DC: US GAO, 2000.

[ii] Connecticut does not mandate managed care enrollment for children who receive Medicaid under the Katie Beckett state plan option for children living at home who would be eligible for Medicaid if they were institutionalized.

[iii] The DHHS Health Resources and Services Administration, the American Academy of Pediatrics, and the Association of Maternal and Child Health Programs have endorsed a more inclusive definition of children with special health care needs: "Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." This definition is not dependent on qualification for or enrollment in another publicly funded program. Under this definition, an estimated 18% of children in the United States have special health care needs. See: Paul Newacheck et al. An epidemiologic profile of children with special health care needs. Pediatrics, 1998; 102(1): 117-123.

185% of the federal poverty level (FPL). These children are placed in either a Medicaid coverage group for children who are title IV-E eligible (D01) or in a Medicaid coverage group for children in low-income families (F25). An interagency agreement between DSS and DCF covers procedures for timely processing of Medicaid eligibility by DCF caseworkers. DCF notifies DSS when a child is taken into protective custody; those who were in families that receive Temporary Family Assistance (TFA) are removed from their families' assistance units and assigned to the Medicaid coverage group for federally subsidized coverage. Eligibility for federally subsidized Medicaid is re-determined every year. Children are at risk of losing coverage if placement changes result in address changes that are not captured in eligibility files and notices do not reach new foster families.

Children who are not already in Medicaid are placed temporarily in a state-funded Medicaid coverage group (D02) until the DSS Central Processing Unit receives and processes the Medicaid application forwarded by DCF. D02 coverage is then retroactively replaced with another Medicaid coverage group (F25) if family income is less than 185% FPL.[iv]

When children leave state custody, DCF workers terminate Medicaid eligibility in DCF-related coverage categories. Enrollment transition problems can occur if DSS is not notified of the change in custody status and does not evaluate a child for coverage in a less restrictive Medicaid eligibility coverage group. In most cases, biological families must reapply in order to reconnect their children to family assistance units or to request eligibility determination for coverage in another Medicaid coverage group. None of the children in state-funded Medicaid remain eligible when they return to their families. Unlike other children enrolled in HUSKY A, children in state-funded Medicaid are not granted 12 months continuous eligibility.

A few children who are enrolled in HUSKY A have other third party coverage (5.5% in June 2001), that is, coverage under their families' policies or, more commonly, coverage held by adoptive families.[v] Adoptive families with third party coverage may decide not to use Medicaid coverage at all. In June 2001, children in state-funded Medicaid were more likely to have other coverage (8.8%, compared to 4.1% for children in federally subsidized Medicaid).

Health Care in HUSKY A (Medicaid Managed Care)

Once Medicaid has been processed, all health care for children in state custody is provided by DSS and participating HUSKY A health plans.[vi] While the DCF Medical Director and staff have responsibility for oversight and intervention in health care matters, DCF does not provide direct health services. DCF caseworkers and foster care or adoptive parents select health plans for children in state custody. A change in placement can result in a change in health plans and providers, at least in part because of geographic considerations for the foster care family.

[iv] According to DCF staff, as the Bush Administration tightens the interpretation of title IV-E eligibility, DCF will place an even greater percentage of children in the F25 Medicaid coverage group.

[v] Third party coverage for children in state custody, June 2001, according to a source at the Connecticut Department of Social Services.

[vi] Health plans that participate in HUSKY A: BlueCare Family Plan, Community Health Network, Health Net (formerly Physicians' Health Services), and Preferred One (formerly FirstChoice and Yale Preferred One).

DCF case workers and foster care or adoptive parents are responsible for obtaining the care their children need. Under contracts with DSS, participating HUSKY A health plans provide all preventive and medically necessary health care as well as enabling services.[13] These contracts require health plans to execute memoranda of understanding (MOU) with DCF in order "to cooperatively coordinate and arrange for the provision of high quality health care services to children and families enrolled in MCO's HUSKY Part A managed care program."[14] The MOU outlines the responsibilities of each entity and calls for developing "effective communication between them in order to reduce access barriers, avoid duplication of services and effectively coordinate care/service." One important opportunity for coordination of care occurs when DCF convenes administrative case reviews 30 to 45 days after placement and every six months thereafter: representatives of the health plans and behavioral health subcontractors are invited to meet with caseworkers and families. In addition to custodial considerations, health care status is reviewed at the administrative case reviews. Another important responsibility of the health plan is to cover a comprehensive multi-disciplinary examination when a child is initially placed in state custody. This exam is conducted in a single day at a single location, in existing health care facilities that serve as foster care clinics in each region. The exam includes a full evaluation of the child's functional, medical, developmental, educational, and mental health status; the child is also referred for dental care. Results of this exam are communicated to each child's assigned primary care provider as soon as possible.

Children assigned to DCF Medicaid coverage groups (D01, D02) can be readily identified by health plans because HUSKY A enrollment case records contain information about coverage group. Children in other Medicaid coverage groups cannot be identified as easily. HUSKY A enrollment records for these children contain fields that identify their authorized representatives, usually DCF caseworkers and DCF office addresses, but not all children with authorized representatives are in DCF custody. Identification of children in Medicaid coverage groups other than D01 and D02 must be done manually. To date, health care performance monitoring conducted by the Children's Health Council has focused on utilization by children who can be readily identified using HUSKY A enrollment data, that is, children in Medicaid coverage groups D01 and D02. DSS and DCF have supported this approach to performance monitoring, even though the resulting description of utilization is incomplete. In addition, enrollment data do not indicate which children in state custody are medically fragile.

Many children in the care and custody of DCF have behavioral health care needs. In a special report to the Connecticut General Assembly in February 2000, DSS showed that 22,300 children in HUSKY A (12%) used one or more behavioral health services in a one year period.[15] Children in DCF custody who have severe behavioral health disorders are treated at the facilities maintained by DCF (Riverview Hospital, High Meadows Residential Treatment Center) and by other qualified institutional providers. Health plans are contractually responsible for determining the medical necessity of all hospital admissions and for the full cost of the first fifteen days of medically necessary care. DSS provides reinsurance at increasing rates for hospitalizations that exceed 15 days; DSS pays in full after sixty days.[13] Health plans are required to work with DCF and to notify DSS when hospitals identify discharge planning difficulties. When DCF has difficulty finding a foster home or residential placement for a hospitalized child, the length of stay may exceed the medical necessity for inpatient care and delay the child's transition to therapeutically appropriate levels of outpatient care.

In addition to the outreach and care coordination that health plans are required to provide as needed, DCF Health Care Advocates have been working to assist caseworkers and foster families in each of the five DCF regional offices since July 2000.[16] Their responsibilities include facilitating enrollment, training DCF staff and foster parents on Medicaid managed care, facilitating communication between families and health plans, and working with families and social workers to ensure that children receive timely well-child care. Each month, the Children's Health Council provides the Health Care Advocates with a list of children due for or overdue for well-child visits and other services (lead screening, initial dental referral); this information is used to prioritize outreach and follow-up with caseworkers and families.

PURPOSE OF THIS STUDY

Ensuring the health and well being of Connecticut children in state custody is enormously challenging and highly dependent on effective communication and cooperation between two large state agencies, regional foster care clinics, four health plans and provider networks, caseworkers and foster parents. Health care for these children can be complex, intensive, and very costly. Educational and social service needs tend to overlap with health care needs.

In order to better understand how these children fare in HUSKY A, the Children's Health Council reviewed and compiled enrollment and utilization data for children in state custody in HUSKY A. The objectives of this study were:

- To describe enrollment patterns for children in state custody;
- To describe access to and utilization of health services by children in state custody, compared to all other children enrolled in HUSKY A;
- To describe satisfaction with health services for children in state custody, compared to other children with special health care needs enrolled in HUSKY A;
- To formulate policy recommendations aimed at improving health and health care for children in state custody.

METHODS

Since the implementation of Medicaid managed care in 1995, the Children's Health Council has monitored enrollment, health status, and children's health services utilization using HUSKY A enrollment and encounter data.[17] The Council's objectives for ongoing performance monitoring and for special studies of health services are to track services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, shed light on access problems, and identify emerging health issues. Prevalence estimates and utilization rates reported by the Children's Health Council are based on the experience of children who were continuously enrolled for a specified period of time, usually one year.[vii] For surveys, samples are drawn from

[vii] The Children's Health Council bases performance monitoring on health care received by children continuously enrolled during a specified time period for the following reasons: 1) utilization can be reported in terms of the experience of actual children rather than averaged over "member-months" or varying periods of eligibility; 2) depending on the age groups under study, up to 80% of children ever enrolled during a one-year period were in fact enrolled for 12 months; 3) the HUSKY program and participating health plans are clearly accountable for care of

children who were continuously enrolled for the period of interest. Results of these studies are used to formulate recommendations for improving access to care and quality in HUSKY A.

For the purposes of this study, enrollment data and data from existing Children's Health Council reports were compiled to describe enrollment trends and to compare health status and health services utilization by children in DCF custody in Medicaid coverage groups D01 and D02 to utilization by other children enrolled in HUSKY A.[viii] Enrollment trends and utilization by children in state custody who were in other Medicaid coverage groups were not investigated because these children cannot be identified without manual review of enrollment records. [ix] Utilization differences are reported in terms of relative risk, that is, the direct comparison of utilization rates for children in DCF custody and rates for other children in HUSKY A; differences that were significant at $p<0.001$ are highlighted. To determine the significance of relationships between utilization and child characteristics, tests of association based on χ^2 statistics were calculated; results that were significant at $p<0.001$ are reported. In this report, HUSKY A coverage for children in DCF custody is described in terms of:

- **HUSKY A enrollment:** Eligibility and enrollment trends were tracked and analyzed using a longitudinal enrollment database created and maintained by the Connecticut Children's Health Project for the Children's Health Council. These data include information on Medicaid coverage group for each month of enrollment for each child, so the number and percentage of children in the DCF custody in Medicaid coverage groups D01 and D02 can be readily determined.[x] By checking enrollment each month during a specified monitoring period, continuously enrolled children can be identified. Newly enrolled children can be identified by searching the longitudinal database for any prior periods of enrollment back to July 1997. Enrollment data also include information about where children live, so differences in health status and health care utilization associated with DCF region can be investigated. [xi]

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these children; 4) access problems experienced by continuously enrolled children will undoubtedly have an effect on utilization by children coming into and going out of the program; and 5) results of performance monitoring can be expressed in simple and consistent terms that convey the actual experience of children in the program.

[viii] A detailed description of methods and measures used for performance monitoring is available upon request.

[ix] Expanding the definition of children in state custody to include children in coverage groups other than D01 and D02 could have an impact on utilization rates. For example, among children who were continuously enrolled in HUSKY A in FFY 2000, just 270 children out of 27,684 continuously enrolled children in F25 were in DCF custody. The well-child visit rate for children in state custody in F25 (46%) was slightly lower than the rate for children in D01 and D02 (49%). The percentage who had no care (14%) was considerably less than the rate for children in D01 and D02 (26%). In order to better monitor health care utilization and quality for children in state custody, DSS has recently proposed adding a DCF flag to Medicaid managed care enrollment data so that children in other Medicaid coverage groups can be readily identified by health plans and by the Children's Health Council.

[x] Medicaid managed care enrollment data can be used to identify some but not all children with special health care needs. Children in foster care or adoption assistance are designated by coverage group. An SSI indicator indicates which children receive SSI benefits. Children receiving services from title V cannot be identified without the cooperation of the Department of Public Health and the title V programs in Connecticut.

[xi] Children in DCF custody in Medicaid coverage categories other than D01 and D02 were not included in these analyses of enrollment trends. Identifying them would have required selecting files with authorized representatives and then manually reviewing these enrollment records to determine which children were in state custody. For example, in February 2002, there were 11,858 eligibility files for children with authorized representatives, including

- **Prevalence estimates and health care for selected health conditions:** Using encounter data corresponding to care received by continuously enrolled children, the percentage of children who received care for selected diagnoses has been used to estimate and track the prevalence of certain conditions and to describe the care these children receive:

  - **Asthma**: Beginning in federal fiscal year (FFY) 1997 and annually thereafter, the prevalence of asthma has been estimated by determining the percentage of children under 19 who received care for asthma.[18] Their care has been described annually since FFY 1997 in terms of the average number of ambulatory care visits, the percentage of children who received emergency care, and the percentage of children who were hospitalized for an asthma diagnosis.

  - **Serious behavioral health disorders**: For a special study of behavioral health care, the prevalence of very serious behavioral health disorders among children enrolled in HUSKY A was estimated by determining the percentage of children 6 to 19 enrolled in calendar year (CY) 1998 who were hospitalized for a behavioral health diagnosis.[19] The behavioral health care they received was studied in terms of 30-day readmission rates, 30-day ambulatory care follow-up rates after discharge, and length of stay for admissions and readmissions.

  - **Childhood injuries**: Injuries sustained by children 1 to 19 in FFY 2000 were described, using encounter records for ambulatory care, emergency care, and hospitalizations associated with injury diagnoses.[20] Their care is described in terms of the percentage who received emergency care, the percentage of children who were hospitalized, and the leading types of injuries.

- **Utilization of preventive health care and related care:** Ambulatory care utilization by children in HUSKY A was described in terms of:

  - **Annual ambulatory care utilization rates**: Since FFY 1999, ambulatory care utilization by continuously enrolled children 2-19 has been reported annually.[21] Rates are reported for children who had well-child care or episodic care only and for children who did not have an apparent usual source of care, that is, those who did not receive any ambulatory care or received only emergency care. Rates are reported by age, gender, race/ethnicity, primary language, residence (urban, non-urban), Medicaid coverage group, and health plan.

  - **Timely EPSDT screening exam rates**: Since 1997, the EPSDT On-Time Visit Rate,[xii] a measure developed by the Council for monitoring services, has been reported quarterly.[22]

5,759 in D01, 2,998 in D02, 1,656 in F25, 554 in F12, 228 in F26, and 303 in other Medicaid coverage groups. Most but not all the children in coverage categories other than D01 and D02 are in state custody.

[xii] EPSDT On-Time Visit Rate: The Connecticut Children's Health Project identifies children due for screens and notifies their respective health plans. Health plans can use this information to inform families and/or providers that children are due for well-child visits. After allowing time for the visit to occur ("on-time" window) and 180 days for encounter records to be submitted to the Project, the encounter database is searched for encounter records coded according to the Department's uniform encounter data coding and reporting requirements for children who remained enrolled during the on-time window. The window of time in which a visit is considered "on-time" varies by the age of the child and the frequency of recommended screens: For 4 month old infants, 15 days on either side of the 4

Screening rates are based on encounter data for children due for EPSDT screening exams. Rates are reported by age (4 months to 19 years), health plan, county, and, separately, for children in DCF custody.

- **Well-child care rates for newly enrolled children**: In a special report issued in 2000, the percentage of children who were seen for well-child care within the first six months after enrollment (contract standard) was reported.[23] Three, six, and 12-month utilization rates were also determined for children grouped by age (under 19 years), gender, race/ethnicity, residence, Medicaid coverage group, health plan, and plan change.

- **Utilization of dental care:** Utilization rates for preventive dental care and for treatment have been reported annually, beginning with FFY 1997.[24] Rates are reported by age for children 3 to 19, race/ethnicity, primary language, residence (urban, non-urban), Medicaid coverage group, health plan, and for children who changed health plans.

- **Satisfaction and access to care for children with special health care needs**: A statewide survey of families with children with special health care needs who were enrolled in HUSKY A in CY 1999 was conducted.[25] For the purposes of the survey, all children who were in foster care or subsidized adoptions and had been in one home for six months or more in late 1999 or the first half of 2000 were included in the sampling frame.[xiii] Other children with special health care needs who were selected for the sampling frame were children who received SSI benefits, children who received title V services,[xiv] and children who received care in CY 1999 for disabilities or chronic health conditions.[xv] Response rates for questions about access to primary and specialty care, need for and use of therapeutic and enabling services, and overall satisfaction with providers and health plans were reported separately for children in DCF custody.

RESULTS

HUSKY A Enrollment

On January 1, 2002, there were 8,496 children enrolled in the Medicaid coverage groups corresponding to foster care and adoption assistance groups (D01, D02) (Table 1). Overall, these

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month birthday (30 day window); for 6, 9, 12, 15, 18 month olds, 1 month on either side of the month in which the infant turns that age (3 month window); for annual exams between 2 to 5 and between 11 and 19, two months on either side of the birthday month (5 month window); for biennial exams between 6 and 10, two months on either side of the birthday month (5 month window). The number of children screened on time is compared to the number due for screens during that calendar quarter, yielding the on-time visit rate. The on-time visit rate is a measurement equivalent to the percentage of children who received timely well-child visits in adherence to the EPSDT guidelines.

[xiii] Children in DCF custody who had been in a home 6 months or more, that is, long enough for the parent to be familiar with their health and health care needs, were identified with the cooperation of DCF.

[xiv] Children who received title V services were identified with the approval of the Connecticut Department of Public Health Human Investigations Committee and the cooperation of the Centers for Children with Special Health Care Needs at Yale-New Haven Hospital and the Connecticut Children's Medical Center.

[xv] Chronic condition was defined as a physical condition, mental health condition, or otherwise activity-limiting condition lasting at least 12 months. Families of children identified by special diagnoses were interviewed only if they reported that the child had a chronic condition. Families of children identified by program participation (Title V or SSI) were interviewed, whether or not they reported that the child had a chronic condition.

children represented 4.6% of all children enrolled in HUSKY A, a proportion that has steadily decreased in recent years as overall enrollment has increased. The average quarterly enrollment in 1998-2000 was 8,360 children. Most children in DCF custody are eligible for federally subsidized coverage (four-year quarterly average: 72%). By way of comparison, 39,810 children in families receiving cash assistance (21.4% of children in HUSKY A) were enrolled January 1, 2002. There were also 4,891 children who were receiving SSI benefits (2.6% of children in HUSKY A), some of whom were also in DCF custody.

Eligibility periods for children in state custody varied in length. Based on analysis of longitudinal enrollment data for a recent three and a half-year period for which data were available (July 1997-November 2000), the average period of continuous enrollment for children in DCF-related coverage groups was just over 17 months. On average, children in DCF-related Medicaid coverage groups had one to two enrollment periods (range: 1 – 6).

Sociodemographic characteristics

Sociodemographic differences between children in DCF custody and other children in HUSKY A can have a significant effect on access to care and utilization. Children in DCF custody who were continuously enrolled in FFY 2000 were older, disproportionately male, more likely to be African American and less likely to be Hispanic than other continuously enrolled children (Table 2). More children than expected lived in non-urban areas and in the Eastern region of Connecticut, perhaps due to placement with families living in those areas.

Out-of-home placement can also affect health plan enrollment. Children in DCF custody made up a smaller-than-expected percentage of Community Health Network members, possibly because of placement in areas not as well served by community health centers. More than twice as many children in protective custody changed health plans during the year, probably because changes in custodial arrangements necessitated changes to health plans with provider networks closer to new foster homes.

Utilization of Preventive Health Care and Related Care

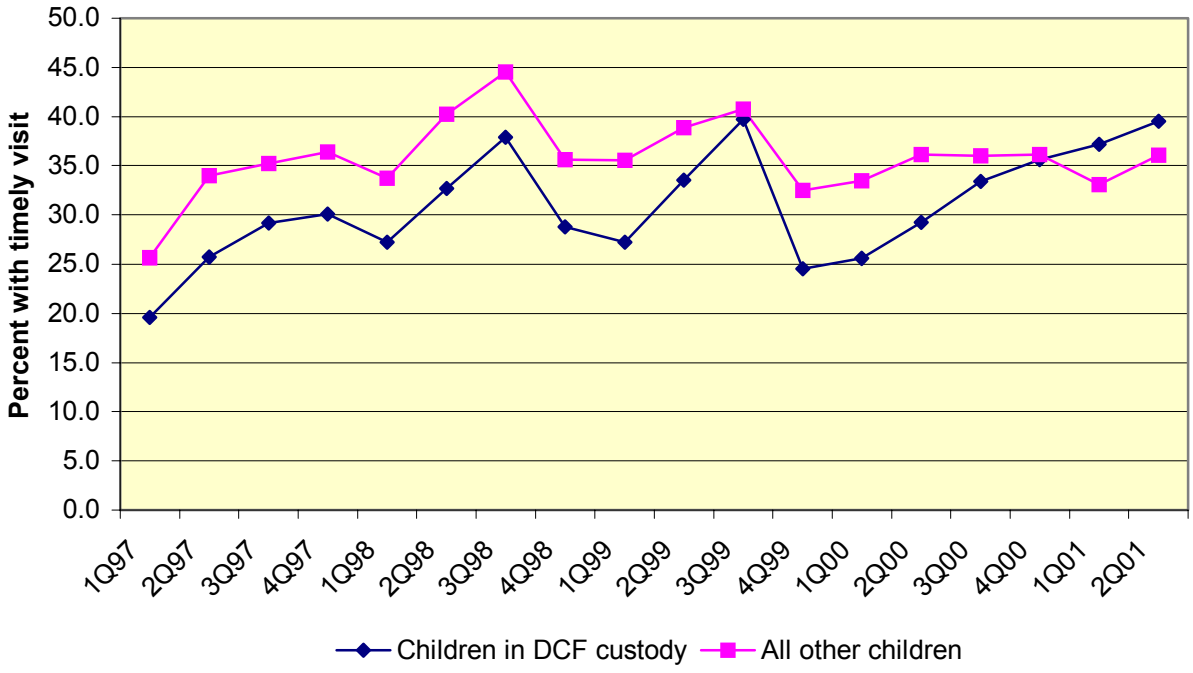
Well-child care

Annual well-child care rates for children in state custody were essentially the same as rates for other children in HUSKY A in FFY 1999 and FFY 2000 (Table 3). Compared to other children in HUSKY A, well-child care utilization was higher among younger children in DCF custody, especially children 6 to 10, and among females (data not shown). Utilization was also higher among children in state custody who lived in the Eastern region and lower among children in state custody who lived in the South Central region. Well-child care utilization was somewhat higher among children who changed plans.

Until recently, children in state custody had consistently lower rates of timely well-child visits than other children enrolled in HUSKY A (Table 4). The EPSDT On-Time Visit Rate for children in DCF custody has been about 5 to 10 percentage points lower than rates for other children in HUSKY A. Visit rates for children in state custody fluctuated seasonally, as they do

for other children in HUSKY A, probably due to the effect of school requirements for health assessments. Beginning in the third quarter 2000, the gap between visit rates began to narrow. Since the fourth quarter 2000, the EPSDT On-Time Visit Rate for children in DCF custody has been equal to or higher than the rate for other children in HUSKY A (Figure 1).

Figure 1. EPSDT On-Time Visit Rate for Children Enrolled in HUSKY A: 1997-2001



Well-child care for newly enrolled children was also studied. Despite the requirement for a multi-disciplinary exam when children are initially placed, well-child care rates for newly enrolled children in DCF custody were consistently 20 percentage points lower at three, six, and twelve months after enrollment than rates for other newly enrolled children.[xvi] At six months after enrollment (contract standard), just 32% of children in state custody had received well-child care, compared to 54% of other children.

No usual source of care

Children in DCF custody were less likely than other children in HUSKY A to have had "a medical home," that is, a usual source of care for well-child care or acute care visits (Table 3). DCF children who were at greatest risk for not having had any office visit or clinic visit or for having received only emergency care were older adolescents 16-19, males, and White children

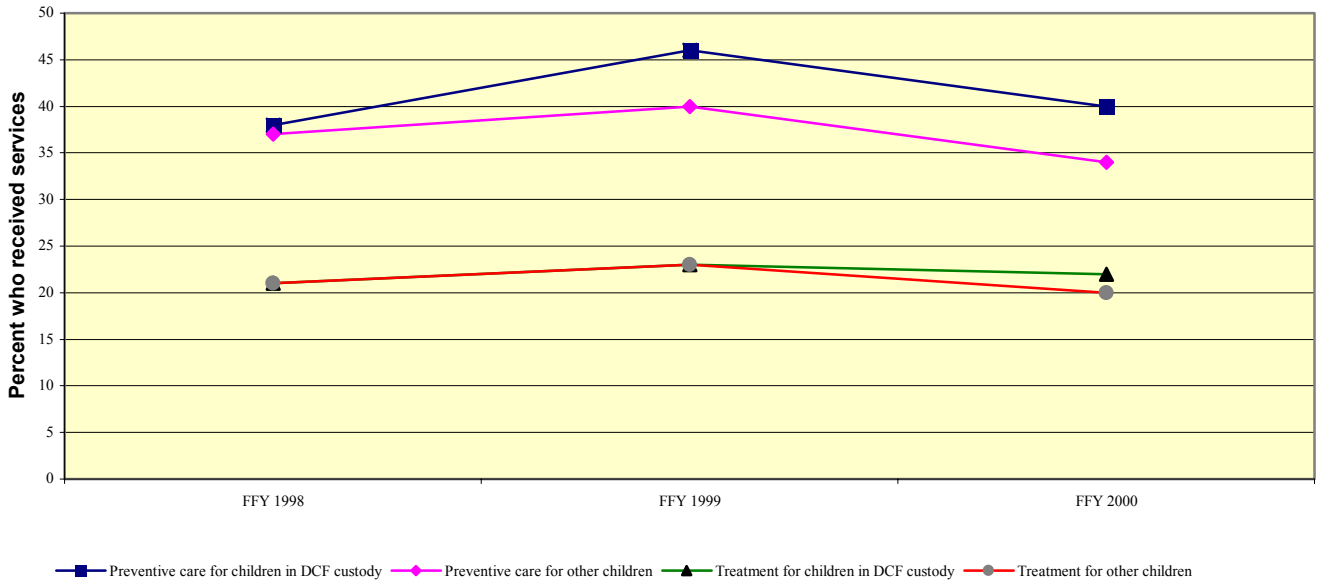
[xvi] A multi-disciplinary exam that is coded according to DCF guidelines (CPT-4 preventive medicine codes 99381-99385 with ICD-9-CM code V62.5 for legal circumstances) and submitted to the child's health plan on a timely basis is counted as a well-child visit. Lower rates for well-child care at 3 months, 6 months, and 12 months after enrollment may be due to incorrect coding by providers.

(data not shown). Compared to other children in HUSKY A, children in DCF custody who lived in non-urban areas and those living in South Central Connecticut were less likely to have had any ambulatory care.

Dental care

Annual rates for preventive dental care utilization by children in protective custody have been equal to or higher than rates for other children in HUSKY A (Table 5). Treatment rates have remained essentially the same for children in state custody and other HUSKY A enrollees (Figure 2).

Figure 2. Dental Care for Children Enrolled in HUSKY A: 1997-2000



Health Status and Health Care for Selected Conditions

Asthma

In recent years, the estimated prevalence of asthma among children in DCF custody was lower than the prevalence estimated for all other children in HUSKY A (Table 6). This difference was largely attributable to lower prevalence estimates for children aged 6 to 14 years and for White children in DCF custody.

About 25% of children who had any care for asthma received emergency care in two recent monitoring periods. Children in DCF custody and other children were equally as likely to have had emergency care.[xvii] Just fewer than 5% of children in both groups were hospitalized; hospitalization rates did not differ.[xviii]

[xvii] Emergency care for asthma: In 1998, $RR_{DCF:others} = 0.92$ (0.79, 1.08); in 1999, $RR_{DCF:others} = 0.96$ (0.82, 1.12).
[xviii] Hospitalization for asthma: In 1998, $RR_{DCF:others} = 0.97$ (0.66, 1.43); in 1999, $RR_{DCF:others} = 0.97$ (0.65, 1.44).

Serious behavioral health disorders

Based on hospitalization data for CY1998, the percentage of children with very serious mental health disorders and chemical dependency was significantly higher among children 6 to 19 in DCF custody than other children enrolled in HUSKY A. Children in DCF custody were seven times more likely to have been hospitalized than other children (Table 7). Compared to other children of the same race/ethnicity, White children in DCF custody were five times more likely to be hospitalized; African American children were seven to eight times more likely to be hospitalized; and Hispanic children in DCF custody were ten times more likely to be hospitalized for serious behavioral health disorders.

In CY 1998, children in DCF custody were hospitalized for longer periods of time, and were more likely to be admitted more than once, compared to other children who were hospitalized for behavioral health diagnoses. The average length of hospital stay for children in DCF custody (17 days) was significantly longer than the average length of stay for all hospitalized children (11 days). Hospital discharges for children in DCF custody were more likely to be followed by readmission within thirty days (29.3%, compared to 22.1% of discharges for other children). Hospital discharges for children in DCF custody were less likely to have been followed by ambulatory care in the first thirty days (39.4%, compared to 58.5% of hospitalizations for other children in HUSKY A).

In a subsequent one-year period (FFY 2000), the distribution of emergency visits and hospitalizations across diagnostic categories was compared for children in DCF custody and other children in HUSKY A.[26] A far greater percentage of emergency visits made by children in DCF custody were for mental disorders (19.1%, compared to 3.1% for other children). The difference was even more significant for hospitalizations: 62.8% of all hospitalizations for children in DCF custody were for mental disorders, compared to 8.0% of hospitalizations for all other children in HUSKY A. Among 6 to 10 year olds and 11 to 15 year olds in DCF custody, 80% to 90% of all hospitalizations that occurred in that one-year period were for mental disorders.

Injuries

The percentage of children in HUSKY A who were injured in a one-year period was estimated using encounter data for injury-related care. Children in DCF custody were treated for injuries at essentially the same rate as other children enrolled in HUSKY A (19.5%, compared to 20.3%; data not shown). The percentages of children that sustained what were perhaps more serious injuries, that is, injuries for which emergency care or hospitalization was received, were also similar (11.4%, compared to 12.5% for other children enrolled in HUSKY A).

Access to and Satisfaction with Health Care Services

The results of a statewide survey of families with children with special health care needs indicate that children in DCF custody (n=321) differ in important ways from other children with special health care needs who were enrolled in HUSKY A (n=909). Most significantly, more foster parent-respondents described their children as being in very good or excellent health (81%),

compared to parents of other children with special health care needs, that is, children receiving Title V benefits or SSI and children with intensive, chronic health care needs (61% reported to be in very good or excellent health). Fewer children in DCF custody reportedly had chronic health conditions (43%, compared to 88% of other children).

Foster parents and other parent respondents reported similar access to primary care providers, mainly pediatricians, but remarkably different utilization of health care and related services. Compared to other children with special health care needs, fewer children in DCF custody made regular visits for physical care (28%, compared to 74% of other children with special needs) or visits to specialists (23%, compared to 52%). Somewhat fewer children in DCF custody made regular visits for mental health care (30% v. 39%). Fewer children in DCF custody were seen for emergency care (34% v. 59%) and fewer were hospitalized overnight (9% v. 18%), even for mental health disorders (1% v. 4%). Reportedly, more children in DCF custody had seen a dentist (75% v. 67% of other children with special health care needs). Even though they are readily identifiable in enrollment files and other children with special health care needs are not, foster parents were no more likely than parents of other children with special health care needs to report having received case management services from their respective health plans (just 9% in each group). Foster care and adoptive parents' satisfaction with the choices and quality of primary care providers, specialists, and dentists was essentially the same as satisfaction ratings expressed by parents of other children with special health care needs. When asked to assess the overall quality of the health plan, 74% of foster or adoptive parents and 79% of other parents expressed satisfaction with their children's health plans.[xix]

DISCUSSION

Children in foster care and other out-of-home placement often have significant health problems when they enter protective custody, ranging from developmental delays to an array of physical, psychological and psychiatric conditions. The types and severity of illnesses in these children is highly variable. Some children suffer from chronic illnesses, making their needs for timely health care greater than the needs of other children. Many studies have documented the high prevalence of illness in foster care children and have shown higher health care costs associated with these needs. For example, a study of the mental health care utilization by foster care children and children on cash assistance demonstrated that Washington State's Medicaid agency spent an average of $3,075 per child in foster care in 1990, compared to $543 per child on cash assistance.[10] Expenditures were proportional to the utilization of mental health care services, with a large percentage of children in foster care considered "high-cost" (more than $10,000 per year). High-cost children included 8% of all foster care children but only 0.4% of children receiving cash assistance. Another study reported that in 1988, under California's Medicaid program, foster children had 23% greater utilization rates, 41% greater expenditures per use and 70% greater cost per eligible child compared to other children in Medicaid.[27]

With the advent of Medicaid managed care in Connecticut and other states, policy makers and health care advocates expressed their doubts about whether the needs of these vulnerable children could be met in a health care system that employs cost containment measures.

[xix] Rated health plans $\geq$8 on a 10-point scale.

Medicaid managed care may exacerbate existing problems in the mental health care system, especially for children and especially in states where more than one state agency is responsible for mental health care.[28] In 1997, Congress sought to protect children with special health care needs from the uncertainties of managed care. The Balanced Budget Act of 1997 extended the requirement for waivers for Medicaid managed care programs in states with mandatory enrollment of children with special health care needs. In January 2001, the Health Care Financing Administration (HCFA), now known as the Center for Medicaid and Medicare Services (CMS), issued revised federal review criteria to states that enroll children with special health care needs.[29] Responsibilities include ensuring a public process for input from those who treat or serve children with special health care needs, identifying children with special health care needs when they are first enrolled, monitoring and ensuring the adequacy of specialty care provider networks, ensuring needs assessment and coordination of care, monitoring quality of care and health plan operations, and developing a payment methodology that accounts for enrollment of children with special health care needs. The review criteria also require that states describe "the enrollment provisions that address the broader, unique issues occurring because of out-of-home, out-of geographic area placement" of children in foster care.

The results of this study indicate that DCF children may experience discontinuous periods of eligibility for HUSKY A. Problems can occur when a child leaves state custody and coverage is discontinued, despite eligibility in another coverage group. Some children in the care and custody of DCF are at risk for losing coverage when changes in residence or mailing address are not captured in Medicaid eligibility files and notices do not reach their families. When children are reunited with their families, coverage with HUSKY A health plans and continuity of care with providers may end, resulting in gaps in coverage and disruptions in care. Other researchers have noted the possible consequences and the policy implications of discontinuity in Medicaid coverage.[5]

The results of this study also show that children in the custody of DCF and other children in HUSKY A have different needs for and different utilization of health care services, especially behavioral health care services (Figure 3). Children in state custody were less likely to have had ambulatory care and were far more likely to be hospitalized for a mental health disorder or chemical dependency**.**

No comparable data from Connecticut's fee-for-service Medicaid program are available for evaluating the impact of managed care on children in DCF custody. However, health care utilization under fee-for-service Medicaid in other states has been described and can be compared to these findings. A recent report described care for children in foster care in fee-for-service Medicaid programs in three states (California, Pennsylvania, Florida) in 1993-95.[5] There are some important differences in comparisons of fee-for-service utilization rates from other states and utilization in Connecticut under Medicaid managed care. For example, a larger percentage of children in the foster care program in the three fee-for-service programs had seen a health care provider than all other fee-for-service Medicaid coverage groups except children on cash assistance and on SSI. Foster care children in California and Pennsylvania had the highest rates of receiving well-child care of all children in Medicaid in those states. Another study showed that 48% of children in foster care utilized health care services, compared with 39% of all other children enrolled in the California fee-for-service Medicaid program in 1988.[27]

Figure 3. Utilization Differences For Children in DCF Custody Compared to Other Children in HUSKY A

LIKELIHOOD OF HAVING:	YEAR (s)	CHARACTERIZATION OF DIFFERENCE
Timely well-child care	1997-2001	***IMPROVING***
Any well-child care	FFY 2000	**SAME**
	FFY 1999	**SAME**
Well-child care within 6 months of enrollment	CY 1999	***WORSE***
No usual source of care	FFY 2000	***WORSE***
	FFY 1999	***WORSE***
Preventive dental care	FFY 2000	***BETTER***
	FFY 1999	***BETTER***
	FFY 1998	**SAME**
Dental treatment	FFY 2000	**SAME**
	FFY 1999	**SAME**
	FFY 1998	**SAME**
Hospital admission for behavioral health	CY1998	***WORSE***
Readmission after discharge		***WORSE***
Follow-up after discharge		***WORSE***
Emergency visit for asthma	FFY2000	**SAME**
	FFY1999	**SAME**
Hospital admission for asthma	FFY 2000	**SAME**
	FFY 1999	**SAME**

As expected, children in DCF custody experienced a disproportionately high rate of hospitalization for behavioral health conditions. In a recent report to the General Assembly, DSS described the delivery and financing of children's behavioral health services in Connecticut.[15] Although children in state custody made up just 5% of children enrolled in HUSKY A, they incurred 60% of behavioral health care expenditures ($125 million) in a one-year period. Children in DCF custody accounted for 40% of expenditures for hospital stays and 79% of expenditures for residential treatment.

There is clear evidence of problems with behavioral health care after hospital discharge, perhaps contributing to higher readmission rates for children in DCF custody. Access issues, some of which predate Medicaid managed care, include problems with appointment availability, transportation, or interpreter services, and lack of case management. Care coordination is critically important for these children and their families. Both DCF and health plans are

responsible for developing well-coordinated, collaborative approaches to the discharge planning needs of these children. [xx]

This high level of need for mental health care is consistent with several studies of mental health care services for children in foster care. In Pennsylvania in 1995, children in foster care were seven and a half times more likely to be hospitalized for mental health conditions and incurred mental health expenditures eleven to twelve times larger than children on cash assistance.[30] An average of $2,082 per child in foster care was spent on mental health care, compared to $181 spent for children on cash assistance. An earlier report on mental health care for children in California showed for each hospitalization, an average of $11,890 per foster child was spent, compared to $8,263 per child for children in other coverage groups.[9] Results of this study are also consistent with other reports showing that the average length of stay for children in foster care is considerably longer than that for other children hospitalized for behavioral health care. In California, foster care children spent an average of 32 days in the hospital for mental health care, compared with 24 days for other Medicaid-insured children.[27] In Connecticut, lengthy stays may be due to problems DCF has in placing children in the community or residential care. These children remain hospitalized longer than necessary and at significant cost to DSS under a negotiated reinsurance approach that has transferred risk from health plans to DSS. The negative effects on children awaiting discharge cannot be quantified.

In addition to the need for inpatient and outpatient therapy, children with behavioral health problems may have higher-than-average need for drug therapy, a growing expenditure in all health care programs. A recent study in Connecticut showed that 17.8% of children under 19 in the custody of DCF had been prescribed at least one psychotropic drug during a one year period, a rate six times that of other children in the Medicaid managed care program.[31]

There are signs that children in DCF custody are better off in some respects than other children enrolled in HUSKY A and that their care is improving. Most important, children in state custody are reportedly in better health than other children who have special health care needs. Access to primary care is reportedly fairly good. Utilization of primary care, specialty care, and other services is reportedly lower than utilization by other children with special health care needs, but so are their needs for intensive health care, compared to other special needs children. Since Health Care Advocates began working with families in July 2000, timely well-child visit rates have increased steadily and now surpass rates for other children in HUSKY A. Regional differences in timely well-child visit rates indicate that DCF may need to work with Health Care Advocates in South Central Connecticut to ensure that children in that region are linked to medical homes and receive timely well-child care. Children in DCF care and custody were also more likely to receive preventive dental care, a trend that is consistent with the literature.[5] Finally, foster care and adoptive parents were apparently satisfied with the health plans in which

[xx] In June 2000, the Connecticut General Assembly passed legislation creating the Connecticut Community KidCare, a comprehensive behavioral health program. The objectives of KidCare are to reduce the barriers to receiving care, improve access to and coordination of care on the local level, and maximize funds for behavioral health care services. This bold initiative will provide behavioral health care to children in HUSKY A outside of the managed care program. Resources of DCF and DSS will be pooled to fund the program. The program will be administered by DCF.

their children are enrolled. These findings suggest that while children in DCF custody are generally healthier and may not require the specialty care that other children with special health care needs require, utilization of behavioral health care services and other key services should be closely monitored in order to capture all the dimensions of care for this at-risk group of children.

Medicaid expenditures for health care in HUSKY A could not be estimated using existing data sources. In this program, participating health plans receive a negotiated per-member-per-month fee that takes into account the member's age, gender, and county of residence. Capitation rates are not risk-adjusted for children in DCF custody or for any other HUSKY A members expected to have higher-than-average utilization. Therefore, expenditures of state and federal dollars are proportionate to enrollment numbers and the distribution of member characteristics that affect rates.

The results of this review are useful for establishing a Medicaid managed care baseline for assessing the impact of changes in the health care environment on access to and utilization of services by children in state custody. However, conclusions drawn from results of this study are limited in several important ways. First, the findings are based on analyses of Medicaid encounter data provided by health plans for rate setting and performance monitoring; the completeness and accuracy of the data could not be assessed. Second, health care utilization by children in state custody who can be readily identified may not be representative of utilization by other children in state custody who are enrolled in other Medicaid coverage groups. Third, disease prevalence estimates based on utilization data are highly dependent on the underlying quality of the data and differences in access to care experienced by different groups and over time. Fourth, care received as part of the multi-disciplinary examination for children entering placement might have affected rates, especially preventive dental care rates, just as school physical requirements drive up well-child exam rates seasonally. Theoretically, well-child care visit rates for newly enrolled children in DCF custody should have been equal to or better than those for other newly enrolled children because of the requirement for a multidisciplinary exam at the time of initial placement; however, encounter records for the multidisciplinary exam must be coded according to DCF and DSS specifications in order to be counted as preventive care visits. Fifth, the extent to which survey responses were truly representative of all families with children with special health care needs could not be determined. Despite these limitations, the results of this review shed light on factors in Medicaid managed care that affect access to and utilization of health care services by children in protective custody.

CONCLUSIONS

- Children in the care and custody of DCF make up just under 5% of children enrolled in HUSKY A.

- Children in the care and custody of DCF are at risk for losing coverage when changes in DCF involvement affect eligibility.

- Children in the care and custody of DCF are more likely to change health plans.

- Compared to other children in HUSKY A, children in the care and custody of DCF:

- Are increasingly more likely to receive timely well-child care;
- Are more likely to have had preventive dental care;
- Are less likely to have had a usual source of care;
- Are more likely to have had emergency care or been hospitalized for behavioral health care.

- Children in the care and custody of DCF have disproportionately more behavioral health care needs than other children in HUSKY A.

- Children in the care and custody of DCF are reportedly in better health, with fewer health care needs, compared to other children with special health care needs in HUSKY A.

- Foster care and adoptive families report they are generally satisfied with HUSKY A health plans, access to care, and the quality of the care their children receive.

RECOMMENDATIONS

The Children's Health Council recommends that:

- DSS should extend 12 months continuous eligibility for HUSKY A to children in state funded Medicaid, then work with DCF and others to ensure that reunited families know how to access care for their children.

- DSS should investigate and remedy administrative procedures that can adversely affect continuous eligibility for children in DCF custody whose eligibility for Medicaid ends.

- The Children's Health Council, in consultation with DCF, should investigate and report on the effective use of directed, intensive outreach and follow-up with foster care families so that health plans and others can adopt this approach to increasing timely well-child visit rates.

- DSS should collaborate with DCF, DPH, and the Children's Health Council to develop a systematic approach to monitoring access to and quality of care for children in state custody and other children with special health care needs in HUSKY A.

- DSS, DCF, and HUSKY A health plans should work together to ensure that when Connecticut KidCare is implemented, behavioral health care services are well-coordinated with primary care services for children who receive care.

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Table 1. HUSKY A Enrollment of Children in DCF Custody: 1998-2001

Enrollment Quarter	Children in HUSKY A (total)[a]	Children in DCF custody in HUSKY A (total) [b]	Children in federally subsidized Medicaid coverage group (D01) (percent of DCF enrollment)	Children in state-funded Medicaid coverage group (D02)
1Q1998	155,633	8,773 (5.7%)	5,661 (64.5%)	3,112 (35.5%)
2Q1998	157,019	8,734 (5.6%)	5,937 (68.0%)	2,797 (23.0%)
3Q1998	158,568	8,071 (5.1%)	6,211 (77.0%)	1,860 (23.0%)
4Q1998	160,994	8,055 (5.0%)	5,884 (73.0%)	2,171 (27.0%)
1Q1999	164,644	8,305 (5.0%)	6,130 (73.8%)	2,183 (26.2%)
2Q1999	168,583	8,314 (4.9%)	6,201(74.6%)	2,113 (25.4%)
3Q1999	170,306	8,409 (4.9%)	6,325 (75.2%)	2,084 (24.8%)
4Q1999	170,395	8,283 (4.9%)	6,221 (75.1%)	2,062 (24.9%)
1Q2000	171,963	8,393 (4.9%)	6,168 (73.5%)	2,225 (26.5%)
2Q2000	175,456	8,349 (4.8%)	6,223 (74.5%)	2,126 (25.6%)
3Q2000	173,061	8,347 (4.8%)	6,183 (74.1%)	2,164 (25.9%)
4Q2000	173,733	8,286 (4.8%)	6,079 (73.4%)	2,207 (26.6%)
1Q2001	175,399	8,357 (4.8%)	5,978 (71.5%)	2,379 (28.5%)
2Q2001	176,536	8,288 (4.7%)	5,919 (71.4%)	2,369 (28.6%)
3Q2001	176,047	8,314 (4.7%)	5,862 (70.5%)	2,452 (29.5%)
4Q2001	179,502	8,478 (4.7%)	5,720 (67.5%)	2,658 (32.5%)
1Q2002	185,733	8,496 (4.6%)	5,687 (66.9%)	2,809 (33.1%)

[a] Children under 19 enrolled in HUSKY A on the first day of the calendar quarter.

[b] Children in Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.

Table 2. Sociodemographic and Enrollment Characteristics of Children in DCF Custody in HUSKY A: FFY 2000

		Children in HUSKY A[a]	Children in DCF custody [b]	Other children in HUSKY A
Total		120,692 (100.0%)	6,602 (100.0%)	114,090 (100.0%)
Age:	**2-5**	30,597 (25.4%)	**1,095 (16.6%)**	**29,502 (25.9%)**
	6-10	40,039 (33.2%)	**2,042 (30.9%)**	**37,997 (33.3%)**
	11-15	33,759 (28.0%)	**2,341 (35.5%)**	**31,418 (27.5%)**
	16-19	16,297 (13.5%)	**1,124 (17.0%)**	**15,173 (13.3%)**
Gender:	**Male**	60,679 (50.3%)	**3,503 (53.1%)**	**57,176 (50.1%)**
	Female	60,013 (49.7%)	**3,099 (46.9%)**	**56,914 (49.9%)**
Race/ethnicity:	**African-American**	36,727 (30.4%)	**2,714 (41.1%)**	**34,013 (29.8%)**
	Hispanic	41,795 (34.6%)	**1,495 (22.6%)**	**40,300 (35.3%)**
	White	40,406 (33.5%)	**2,360 (35.7%)**	**38,046 (33.3%)**
	Others	1,764 (1.5%)	**33 (<1.0%)**	**1,731 (1.5%)**
Primary language:	**English**	112,251 (93.0%)	**6,390 (96.8%)**	**105,861 (92.8%)**
	Spanish	7,857 (6.5%)	**184 (2.8%)**	**7,673 (6.7%)**
	Other	584 (<1.0%)	**28 (0.4%)**	**556 (<1.0%)**
Residence:	**Non-urban**	74,874 (62.0%)	**4,839 (73.3%)**	**70,035 (61.4%)**
	Urban	45,818 (38.0%)	**1,763 (26.7%)**	**44,055 (38.6%)**
	Bridgeport	13,851 (11.5%)	514 (7.8%)	13,337 (11.7%)
	Hartford	18,314 (15.2%)	662 (10.0%)	17,652 (15.5%)
	New Haven	13,653 (11.3%)	587 (8.9%)	13,066 (11.5%)
Region:	**Eastern**	12,635 (10.5%)	**912 (13.8%)**	**11,723 (10.3%)**
	North Central	39,472 (32.7%)	**2,023 (30.6%)**	**37,449 (32.8%)**
	North Western	16,621 (13.8%)	**925 (14.0%)**	**15,696 (13.8%)**
	South Central	30,627 (25.4%)	**1,880 (28.5%)**	**28,747 (25.2%)**
	Southwest	21,326 (17.7%)	**861 (13.0%)**	**20,465 (17.9%)**
Plan:	**BlueCare**	45,621 (37.8%)	**2,455 (37.2%)**	**43,166 (37.8%)**
	Community Health Network	18,649 (15.5%)	**601 (9.1%)**	**18,048 (15.8%)**
	Physicians' Health Services	37,347 (30.9%)	**2,155 (32.6%)**	**35,192 (30.8%)**
	Yale Preferred One	12,858 (10.7%)	**702 (10.6%)**	**12,156 (10.7%)**
	Changed plans	6,217 (5.2%)	**689 (10.4%)**	**5,528 (4.8%)**

[a] Children 2-19 who were continuously enrolled in HUSKY A October 1, 1999 - September 30, 2000 (FFY 2000).
[b] Children in Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.
Note: Associations between child characteristics and custody status that were statistically significant (p<0.001) are shown in bold.

Table 3. Ambulatory Care Utilization by Children in DCF Custody in HUSKY A: FFY 1999, FFY 2000

	Reporting Period	Children in HUSKY A[a]	Children in DCF custody[b]	Other children in HUSKY A	
Total	**FFY 1999**	115,523	6,220	109,303	
	FFY 2000	120,692	6,602	114,090	
Type of care:			**Percent with care**		**RR (95% CI)**
Any ambulatory care	**FFY 1999**	80.3%	76.8%	80.5%	**0.95 (0.94, 0.97)**
	FFY 2000	81.4%	78.0%	81.6%	**0.96 (0.94, 0.97)**
Well-child care	**FFY 1999**	45.2%	45.5%	45.2%	1.01 (0.96, 1.06)
	FFY 2000	47.6%	49.0%	47.5%	1.03 (1.01, 1.06)
Episodic care only[c]	**FFY 1999**	35.2%	31.4%	35.4%	**0.89 (0.85, 0.92)**
	FFY 2000	33.8%	29.0%	34.0%	**0.85 (0.82, 0.88)**
No usual source of care[d]	**FFY 1999**	22.7%	23.2%	19.5%	**1.19 (1.14, 1.25)**
	FFY 2000	22.8%	22.0%	18.4%	**1.20 (1.14, 1.25)**

[a] Children 2-19 who were continuously enrolled in HUSKY A October 1 - September 30 in FFY 1999 and FFY 2000.
[b] Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.
[c] Office or clinic visits for diagnoses other than a well-child diagnosis.
[d] No usual source of care: children with no ambulatory care or with emergency visits only.
RR = relative risk, CI = confidence interval
Note: Differences that were statistically significant (p<0.001) are shown in bold.

Table 4. Timely Well-Child Care for Children in DCF Custody in HUSKY A: 1997-2001

	Children in DCF Custody[a]			Other Children in HUSKY A		
Reporting Quarter[b]	Number of screens due	Number of screens received	EPSDT On-Time Visit Rate[c]	Number of screens due	Number of screens received	EPSDT On-Time Visit Rate[c]
1Q1997	882	173	19.6%	31,544	8,090	25.7%
2Q1997	1,220	314	25.7%	29,813	10,136	34.0%
3Q1997	1,569	458	29.2%	30,065	10,591	35.2%
4Q1997	1,584	476	30.1%	31,518	11,471	36.4%
1Q1998	1,604	436	27.2%	32,181	10,850	33.7%
2Q1998	1,260	412	32.7%	26,054	10,482	40.2%
3Q1998	1,578	598	37.9%	33,447	14,892	44.5%
4Q1998	2,357	679	28.8%	40,125	14,288	35.6%
1Q1999	2,295	625	27.2%	41,188	14,639	35.5%
2Q1999	1,973	661	33.5%	40,531	15,749	38.9%
3Q1999	1,409	560	39.7%	43,564	17,753	40.8%
4Q1999	1,884	462	24.5%	42,792	13,897	32.5%
1Q2000	1,912	489	25.6%	44,031	14,724	33.4%
2Q2000	1,656	484	29.2%	40,836	14,749	36.1%
3Q2000	1,890	631	33.4%	47,200	17,003	36.0%
4Q2000	1,773	631	35.6%	41,680	15,046	36.1%
1Q2001	1,786	665	37.2%	43,586	14,618	33.5%
2Q2001	1,741	687	39.5%	43,347	15,587	36.0%

[a] Children in Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.

[b] Calendar quarter corresponding to the period of continuous enrollment and utilization for the EPSDT On-Time Visit Rate.

[c] EPSDT On-Time Visit Rate (OTVR) = a measure of program and health plan performance established by the Connecticut Children's Health Project for Connecticut's Medicaid managed care program. The OTVR is the percentage of children with timely well-child care (EPSDT screening exams), as indicated by encounter records with CPT-4 codes for preventive care (99381-5, 9938R, 9938T, 99382, 99391-5, 9939R, 9939T, 99431, 9943R, or 9943T) when accompanied by any diagnosis code; UB-92 revenue codes (092, 093, 094) when accompanied by any diagnosis code; CPT-4 codes for evaluation and management (99201-5, 99211-5, 99432) when accompanied by well-child diagnosis (v20 series, v70, v70.0, v70.3-v70.9). The window of time in which a visit is considered "on-time" varies by the age of the child and the frequency of recommended screens: For 4 month old infants, 15 days on either side of the 4 month birthday (30 day window);. for 6, 9, 12, 15, 18 month olds, 1 month on either side of the month in which the infant turns that age (3 month window); for annual exams between 2 to 5 and between 11 and 19, two months on either side of the birthday month (5 month window); for biennial exams between 6 and 10, two months on either side of the birthday month (5 month window). The number of children screened on time is compared to the number due for screens and continuously enrolled during that calendar quarter.

Table 5. Dental Care for Children in DCF Custody in HUSKY A: FFY 1998, FFY 1999, FFY 2000

	Reporting Period	Children in HUSKY A[a]	Children in DCF custody[b]	Other children in HUSKY A	
Total	**FFY 1998**	98,652	6,761	9,1891	
	FFY 1999	102,749	5,778	96,971	
	FFY 2000	105,102	6,102	99,000	
Type of care:			**Percent with care**		**RR (95% CI)**
Preventive care	**FFY 1998**	36.7%	37.5%	36.6%	1.03 (0.99, 1.06)
	FFY 1999	40.8%	46.2%	40.0%	**1.24 (1.18, 1.31)**
	FFY 2000	34.2%	40.0%	34.0%	**1.18 (1.14, 1.22)**
Treatment	**FFY 1998**	21.0%	20.8%	21.0%	0.99 (0.94, 1.04)
	FFY 1999	22.7%	23.1%	23.0%	1.02 (0.97, 1.07)
	FFY 2000	20.3%	22.0%	20.0%	1.07 (1.02, 1.13)

[a] Children 3-19 who were continuously enrolled in HUSKY A October 1 - September 30 in FFY 1999 and FFY 2000.
[b] Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.
RR = relative risk, CI = confidence interval
Note: Differences that were statistically significant (p<0.001) are shown in bold.

Table 6. Estimated Asthma Prevalence for Children in DCF Custody in HUSKY A: FFY 1999, FFY 2000

		Reporting Period	Children in HUSKY A[a]	Children in DCF custody[b]	Other children in HUSKY A	
Total		**FFY 1999**	126,286	6,727	119,559	
		FFY 2000	131,207	6,900	124,307	
			Percent with asthma-related care			**RR (95% CI)**
Estimated asthma prevalence		**FFY 1999**	9.8%	8.1%	9.9%	**0.82 (0.76, 0.90)**
		FFY 2000	8.8%	7.6%	8.9%	**0.85 (0.78, 0.92)**
Age:	**< 5**	**FFY 1999**	10.7%	12.2%	10.6%	1.15 (1.01, 1.32)
		FFY 2000	10.8%	12.3%	10.7%	1.15 (0.99, 1.33)
	6-14	**FFY 1999**	9.0%	6.8%	9.2%	**0.74 (0.66, 0.84)**
		FFY 2000	8.5%	6.5%	8.6%	**0.76 (0.67, 0.86)**
	15-20	**FFY 1999**	7.4%	6.9%	7.4%	0.93 (0.76, 1.14)
		FFY 2000	6.6%	6.3%	6.7%	0.94 (0.77, 1.14)
Gender:	**Male**	**FFY 1999**	11.1%	8.9%	11.2%	**0.80 (0.72, 0.89)**
		FFY 2000	9.9%	8.3%	10.0%	**0.82 (0.74, 0.92)**
	Female	**FFY 1999**	8.5%	7.2%	8.5%	**0.84 (0.74, 0.96)**
		FFY 2000	7.7%	6.8%	7. 8%	**0.87 (0.77, 0.99)**
Race/ethnicity:	**African American**	**FFY 1999**	8.9%	7.5%	9.0%	**0.83 (0.73, 0.95)**
		FFY 2000	7.9%	7.2%	8.0%	0.91 (0.79, 1.04)
	Hispanic	**FFY 1999**	12.2%	11.5%	12.2%	0.94 (0.82, 1.09)
		FFY 2000	11.0%	10.1%	11.1%	0.91 (0.78, 1.06)
	White	**FFY 1999**	8.2%	6.8%	8.3%	**0.81 (0.70, 0.95)**
		FFY 2000	7.5%	6.4%	7.6%	**0.84 (0.72, 0.98)**
	Others	**FFY 1999**	5.9%	7.4%	5.9%	1.26 (0.33, 4.87)
		FFY 2000	6.3%	8.8%	6.2%	1.42 (0.48, 4.24)

[a] Children under 21 who were continuously enrolled in HUSKY A October 1 - September 30 in FFY 1999 and FFY 2000.
[b] Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.
RR = relative risk, CI = confidence interval
Note: Differences that were statistically significant (p<0.001) are shown in bold.

Table 7. Behavioral Health Hospitalizations for Children in DCF Custody in HUSKY A: CY 1998

		Children in HUSKY A[a]	Children in DCF custody[b]	Other children in HUSKY A	
Total		75,513	4,739	70,774	
		Percent hospitalized			**RR (95% CI)**
Hospitalization rate		0.7%	3.5%	0.5%	**7.16 (5.96, 8.60)**
Gender:	**Male**	0.8%	4.0%	0.6%	**7.22 (5.70, 9.16)**
	Female	0.6%	2.9%	0.4%	**6.82 (5.10, 9.11)**
Race/ethnicity:	**African American**	0.5%	2.7%	0.3%	**7.67 (5.41, 10.87)**
	Hispanic	0.6%	4.7%	0.4%	**10.51 (7.51, 14.72)**
	White	0.9%	3.7%	0.7%	**5.37 (4.04, 7.14)**
	Others	0.2%	4.2%	<1.0%	---
Health plans[c]:	**BlueCare**	0.8%	4.3%	0.5%	**8.24 (6.07, 11.18)**
	Community Health Network	0.6%	3.0%	0.5%	**6.00 (3.08, 11.66)**
	Physicians' Health Services	0.5%	2.6%	0.4%	**6.69 (3.24, 13.83)**
	Yale Preferred One	0.9%	4.7%	0.7%	**6.36 (3.78, 10.69)**

[a] Children 6-19 who were continuously enrolled in HUSKY A January 1 – December 31 in CY 1998.
[b] Medicaid coverage groups D01 and D02, not including children in state custody who were assigned to other Medicaid coverage groups (mainly F25) and cannot readily be identified using enrollment data.
[c] Currently participating health plans only.
RR = relative risk, CI = confidence interval
Note: Differences that were statistically significant (p<0.001) are shown in bold.

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