CONNECTICUT VOICES FOR CHILDREN

Preventive Care For Children in HUSKY A: 2007

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Preventive Care Utilization by Children Enrolled in HUSKY A: 2007

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Health supervision for children is care that is aimed at "actively promoting the physical, emotional, mental, and social well-being of children, adolescents, and their families."[1] Well-baby and well-child visits at regularly scheduled intervals throughout childhood include interviews with children and parents, physical examinations, age-appropriate laboratory tests and immunizations, and developmental surveillance. Each visit is also an opportunity for risk-appropriate health education and anticipatory guidance. Comprehensive care for children throughout their lives includes promoting healthy families; optimal child development and mental health; healthy weight, nutrition and physical activity; good oral health; healthy sexual development; safety and injury prevention.[2] Preventive care is based on guidelines that are more "consensus based than evidence based." [3]

Children in HUSKY A (Medicaid managed care) should receive regularly scheduled preventive care according to a schedule adopted by the Connecticut Department of Social Services and required under contracts with participating managed care plans. The Early and Periodic Screening, Diagnostic and Testing (EPSDT) periodicity schedule[4] calls for:

KEY FINDINGS

- Well-child care utilization in HUSKY A decreased in 2007 among all but the youngest children and in all health plans; only six in ten children 2 to 19 received well-child care in a one-year period.
- Preventive dental care utilization increased in 2007 in all age groups and in all health plans but Preferred One; however, one of every two children 3 to 19 did not receive preventive care and only 35 percent of those with any care had two or more visits, in accordance with the EPSDT periodicity schedule.
- About one in ten children 2 to 19 went the entire year without any health services, despite having been enrolled for 12 months in health plans.
- Preventive care rates continue to fall short of professional recommendations and expectations for HUSKY Program and health plan performance.
- The impact of HUSKY Program transition and policy changes can be determined by comparing utilization rates for 2008 to preventive care rates and trends reported annually since 1999.

[1] Green M, Palfrey JS, eds. Bright futures: guidelines for health supervision of infants, children, adolescents (2nd ed., rev.). Arlington, VA: National Center for Education in Maternal and Child Health, 2002.
[2] Hagan JF, Shaw JS, Duncan PM, eds. Bright futures: guidelines for health supervision of infants, children, and adolescents (3rd ed.). Arlington, VA: American Academy of Pediatrics, 2008.
[3] Bethell C, Reuland CHP, Halfon N, Schor EL. Measuring the quality of preventive and developmental services for young children: national estimates and patterns of clinicians' performance. Pediatrics, 2004; 113(6): 1982.
[4] Connecticut Department of Social Services. EPSDT periodicity schedule of preventive health services (rev.) Hartford, CT: DSS, 2006. Available at: www.ctkidslink.org under HUSKY Health/HUSKY Outreach Tools.

- **Well-child visits:** Nine well-baby exams between birth and 18 months of age; annual well-child exams for children aged 2 to 5 and 11 to 19, with exams every other year for children 6 to 10;
- **Developmental and behavioral assessment**: Developmental screening at each well-baby and well-child visit throughout childhood, with specific objective developmental testing if screening results indicate the need for further investigation;
- **Preventive dental care**: Preventive dental care twice yearly at 6 month intervals for all children beginning with an initial exam at age 2.

School requirements and professional guidelines also influence receipt of preventive care. The Connecticut Department of Education requires health assessments prior to enrollment in public school (children 5 years of age for kindergarten) and in grades 6 or 7 (children 11 to 12) and in grades 10 or 11 (adolescents 15 to 16).[5] The American Academy of Pediatrics (AAP) recently issued guidelines that call for standardized developmental testing for children 9-, 18- and 24- or 30-months of age.[6] Oral health professionals recommend dental sealants for children when their permanent molars erupt at age 6 and 12.[7]

PURPOSE

This report from Connecticut Voices for Children describes preventive care utilization in HUSKY A (Medicaid managed care).[8] Rates for calendar year 2007 are compared with rates for previous years. Specifically, the purpose of this study is:

- To describe preventive care utilization by health plan and by selected factors that may affect access to care;

- To evaluate utilization trends in order to identify improvements or problems with access to care.

METHODS

Data and Analytic Approach

Using HUSKY A enrollment data, children who were continuously enrolled (any plan) between January 1 and December 31, 2007 were identified.[9] Depending on the type of care, children were grouped by age to determine utilization rates and trends.

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[5] Conn. Gen. Stat. §10-206.

[6] American Academy of Pediatrics. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics, 2006; 118(1): 405-420.

[7] Casamassimo P. Bright futures in practice: oral health. Arlington, VA: National Center for Education in Maternal and Child Health, 1996. Centers for Disease Control and Prevention. National Oral Health Surveillance System. Frequently asked questions: dental sealants. Available at: http://www.cdc.gov/nohss/guideDS.htm.

[8] Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on preventive care utilization was prepared under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant from the Hartford Foundation to Connecticut Voices. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared by Mary Alice Lee, Ph.D. and Amanda Learned, B.A. (MAXIMUS, Inc.) This publication does not express the views of the Department or the State of Connecticut. The views and opinions expressed are those of the authors.

[9] This report is based on health services utilization by continuously enrolled v. ever enrolled children for the following reasons: 1) all children had uniform periods of observation, 2) the utilization measure (percentage of children with care) is relatively simple to calculate and easy to communicate to policy makers, 3) HUSKY Program

HUSKY A encounter data, collected from the participating health plans and compiled by the Department's data vendor, were searched for selected types of care, using procedure codes reported by providers to the health plans.

- **Well-child care:** HUSKY A encounter data were searched for records corresponding to annual well-child visits for children 2 to 19 during the one-year period.[10] Utilization rates for well-child care were determined by comparing the number of children who received well-child care to the number who were continuously enrolled.[11] Utilization rates for well-child care were determined by age, gender, age, race/ethnicity,[12] primary language, residence, and health plan. Unadjusted rates for subgroups were compared to rates for all other children (rate ratio). Trends in well-child care utilization were reported for the 1999-2007 period. For this study, an annual well-baby visit rate for children under 2 was not determined because a simple annual rate would not capture adherence to EPSDT and professional recommendations for visits every few weeks and months during the early years of life.[13]

  HUSKY A encounter data were searched for records corresponding to developmental screening received by children under 6 in 2007.[14] Utilization rates for developmental screening were determined by comparing the number of children who received a screen to the number who were continuously enrolled.

- **Dental care:** HUSKY A encounter data were searched for records corresponding to dental care received by children 3 to 19 in 2007 in the following categories: preventive dental care, dental treatment, and any dental care.[15] Utilization rates for care were determined by comparing the number of children who received dental care to the number who were

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and participating managed care plans can be held accountable for children who were enrolled for one entire calendar year and not those who may have lost coverage for part of the year or changed plans. Utilization rates for continuously enrolled children are likely to be higher than rates for children with part-year coverage, especially those with unintended gaps in coverage.

[10] Well-child care (EPSDT screening exams): 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) and clinic codes (510, 515) when accompanied by well-child diagnosis (v20 series, v70, v70.0, v70.3-v70.9).

[11] The annual visit rate for children 6 to 10 is expressed as a percentage of all continuously enrolled children 6 to 10 who had a well-child visit and is not adjusted for the EPSDT schedule that calls for screening exams every other year. For children 6-10, the timing of the visits probably varies from child to child, with some having had annual exams and others with less frequent visits at varying intervals. Participating managed care plans report that they reimburse providers for well-child visits even if the visits occur more frequently than every other year.

[12] Other race/ethnicity groups include: Asian, Eskimo, Native American, and Pacific Islander. Children of unknown race/ethnicity were excluded from relative risk calculations.

[13] According to the EPSDT schedule, well-baby visits should occur at 2-4 days and 2 weeks, then 2, 4, 6, 9, 12, 15 and 18 months of life. Infant health care was described in a recent report based on HUSKY A enrollment and encounter data linked with birth certificate data. See Connecticut Voices for Children. The impact of pregnancy-related and maternal factors on well-baby care in HUSKY A for babies born in 2003. New Haven, CT: CT Voices, June 2007. Available at: www.ctkidslink.org.

[14] Developmental screening: Encounter records with CPT-4 codes for developmental examinations (limited testing--96110 or extended testing--96111) when accompanied by any diagnosis code.

[15] Preventive dental care: Encounter records with a HCFA Common Procedure Coding (HCPC) system code ranging from D1000 through D1999 or ADA codes 01000 – 01999; Dental treatment: Encounter records with a HCPC code ranging from D2000 through D9999 or ADA codes 02000-09999; Any dental care: Encounter records with a HCPC code ranging from D100 through D9999 or ADA codes 0100-09999. This definition includes all preventive dental care and dental treatment codes outlined above plus additional HCPC codes between D0100 and D0999 or ADA codes 0100-0999.

continuously enrolled. The proportion of children who received sealants was calculated.[16] Utilization rates for any dental care, preventive dental care, and dental treatment were determined by age, gender, age race/ethnicity, primary language, residence, and health plan.[17] Unadjusted rates for subgroups were compared to rates for all other children (rate ratio). Trends in dental care utilization were reported for the 2000-2007 period. For this study, dental care utilization for children under 2 is not reported as the percentage who receive any care is typically very small and would affect comparisons with previous years.[18]

- **No care:** The percentage of children 2 to 19 who did not receive any care at all in the one-year period (no encounter records for care in 2007) was also determined. This rate was compared with numbers and rates from 2003 when reporting on this measure began. This rate would undoubtedly be lower if children under 2 were included because they are far more likely than older children to receive care.

Data Quality Problems

In 2007 at the direction of the Department of Social Services, managed care plans in the HUSKY Program began using the National Provider Identifier (NPI). The NPI is a 10-digit unique identifier for health care providers that is used in all electronic transmissions of health data.[19]

According to sources at the Department of Social Services and the Department's data vendor, three of the four HUSKY health plans successfully implemented the NPI; BlueCare Family did not. The result was that the Department's data vendor rejected most of the encounter records (67%) submitted by BlueCare for the period September to December 2007. BlueCare has apparently been unable to correct the data or use the work-arounds recommended by the data vendor.

Usually, Connecticut Voices waits 180 days to allow for submission of encounter records and corrections, as needed. For 2007 data, we waited an extra 90 days to obtain as complete a dataset as possible for 2007 utilization reporting.[20] We then counted records by health plan by month for each type of service (dental, office visits, clinic visits, and inpatient) for each of the past 3 years to determine the extent of the problem:

- For BlueCare, the 2007 annual total and the monthly average number of encounter records overall was considerably lower for all types of service except dental care, compared with 2005 and 2006. For Community Health Network, Health Net, and Preferred One, the 2007 monthly average number of encounter records varied just slightly from month to month and was consistent with monthly and annual totals for 2005 and 2006 for each type of service.

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[16] Dental sealants: Encounter records with ADA code 01351 or state codes D1351 or 1351D (sealant-per tooth).
[17] Dental care subcontractors in CY07: HealthPlex (BlueCare, Preferred One), Benecare (CHNCT), Doral (Health Net).
[18] Despite the October 1998 change in the EPSDT periodicity schedule calling for an initial dental exam at age 2, very few children under 3 receive dental care. Among children under 3, dental care utilization continues to remain low although there has been significant improvement in recent years. The rate of having any dental care in this age group has more than doubled from 3.3% in FY01 to 7.8% in FY07. See: Connecticut Department of Social Services. Annual EPSDT report (CMS-416). Hartford, CT: DSS, 2008 and earlier years.
[19] Use of the National Provider Identifier (NPI) is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The NPI is a unique identifier for health care providers, health plans, and employers that is designed for simpler electronic transmission of health data and more efficient coordination of transactions relating to health benefits. For further information: http://www.cms.hhs.gov/NationalProvIdentStand/.
[20] Mercer created the dataset October 21, 2008.

- Compared with the earlier months of 2007, the monthly average number of BlueCare encounter records in September, October, November and December 2007 was down 55 percent for office visits, 81 percent for clinic visits, and 82 percent for inpatient care. The average number of dental care encounter records in November and December 2007 was down 77 percent for BlueCare.

As is the usual practice, we will report 2007 utilization rates separately for each of the HUSKY health plans and for children who changed plans during the year. For analysis of well-child utilization trends, we compared utilization rates from previous years to the rate for members of Community Health Network, Health Net and Preferred One combined. For dental care, BlueCare's rates were higher than rates for other plans, so they are included in the overall rate.

RESULTS

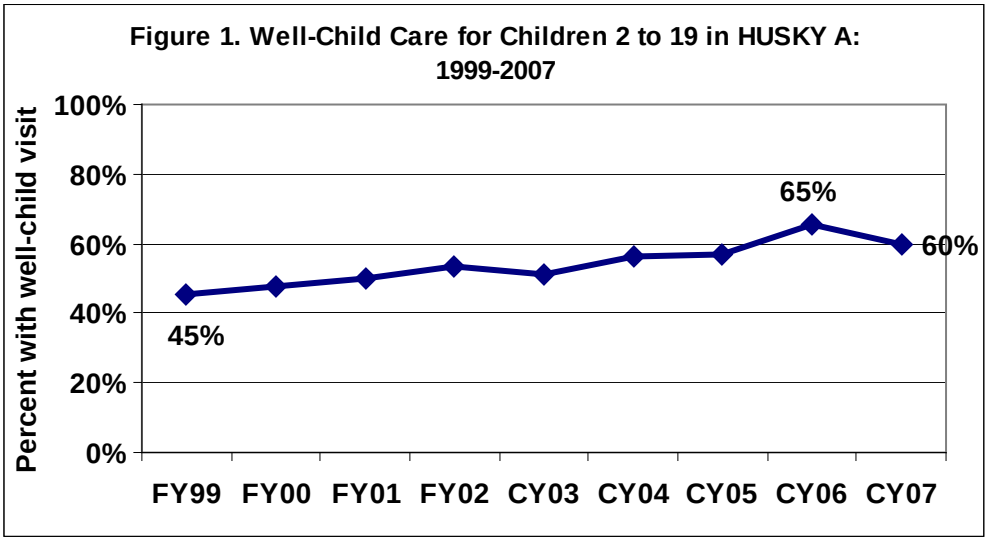
Enrollment

In 2007, 267,204 children under 21 were ever enrolled in HUSKY A for one month or more. There were 160,227 children (60.0%) who were continuously enrolled in HUSKY A for 12 months in 2007.

Well-child care

There were 146,122 children 2 to 19 who were continuously enrolled in HUSKY A in 2007. Well-child care rates are described by sociodemographic characteristics and health plan in Table 1.

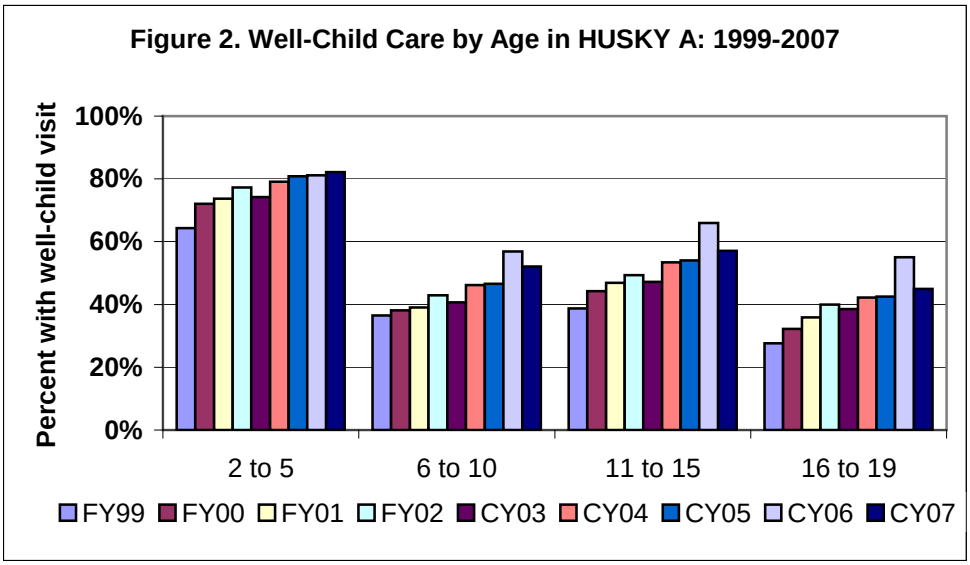
In 2007, 54 percent of children received well-child care in 2007, down considerably from 65 percent in 2006. Some of this decline was due to the lower rate for children in BlueCare Family Plan (46.9% in 2007, compared with 64.4% in 2006). However, the combined rate for children in Community Health Network, Health Net, and Preferred One was also lower (60.0% in 2007, compared with 65.9% in 2006). This rate represents a decrease of about 9 percent from the previous year (and would be even lower if the rate for BlueCare had been averaged in) (Figure 1).



Note: The rate for CY07 does not include children in BlueCare Family Plan

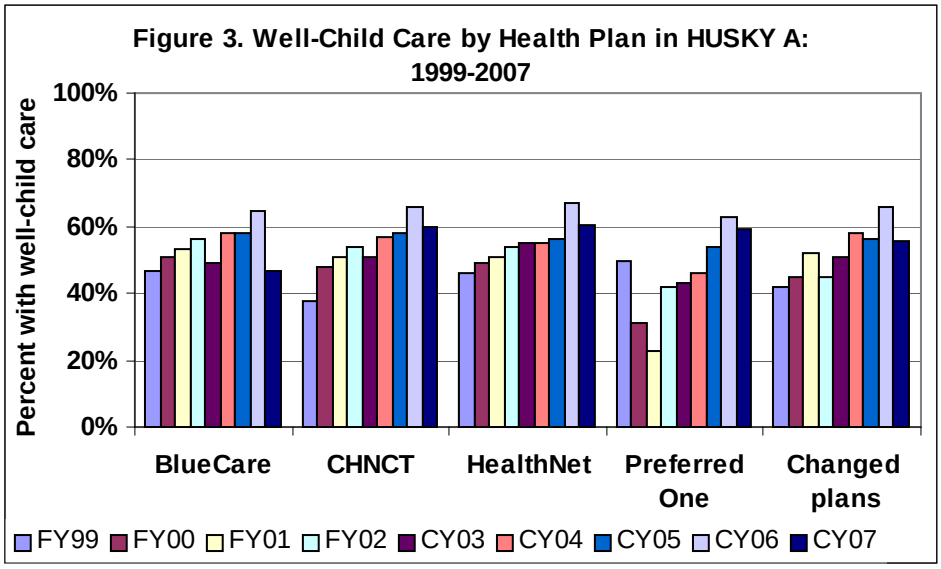
Well-child care utilization rates in 2007 varied by sociodemographic and enrollment characteristics:

- **Age:** Young children 2 to 5 were most likely to have had well-child care (82.2%, compared to 52.5% of all other children in CHNCT, Health Net and Preferred One);



Note: the rate for CY07 does not include children in BlueCare Family Plan

- **Race/ethnicity:** Well-child care utilization was just slightly lower for African American children (57.2% of those in CHNCT, Health Net and Preferred One) than the rates for White (61.0%) and Hispanic (61.0%) children, and children of other racial/ethnic identities (59.6%).
- **Primary language:** Well-child care utilization rates were higher for children in Spanish-speaking families (65.3% of children in CHNCT, Health Net and Preferred One), compared with those living in families that spoke English (59.7%) or other languages (60.6%);
- **Residence:** As in 2005 and 2006, well-child care utilization was higher in Bridgeport (65.8% of children in CHNCT, Health Net and Preferred One), compared with children living in Hartford (51.4%), New Haven (57.5%) and all other towns (60.0%);
- **Health plan:** Well-child visit rates decreased in all health plans and among children who changed plans during the year (Figure 3).

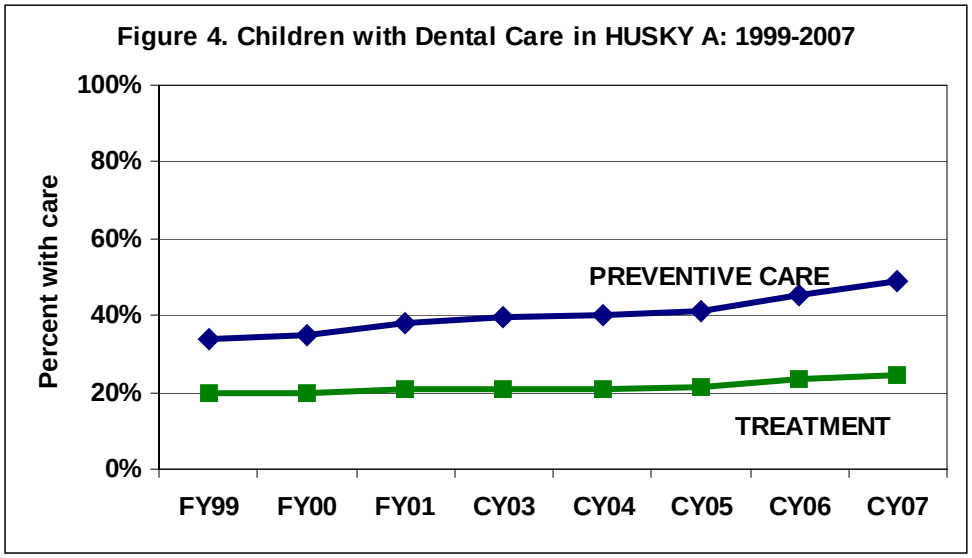


Among 49,474 children birth to less than 6 who were continuously enrolled in HUSKY A in 2007, just 999 (2.0%) had an encounter record for developmental testing (limited or extended). Just 48 children under 1 (2.9%) and 951 children 1 to 5 (2.0%) had encounter records for developmental testing. These rates are consistent with the low rates observed in previous years.

Dental care

There were 136,298 children ages 3 to 19 years continuously enrolled in HUSKY A in 2007. Dental care utilization by sociodemographic and enrollment characteristics is shown in Table 2.

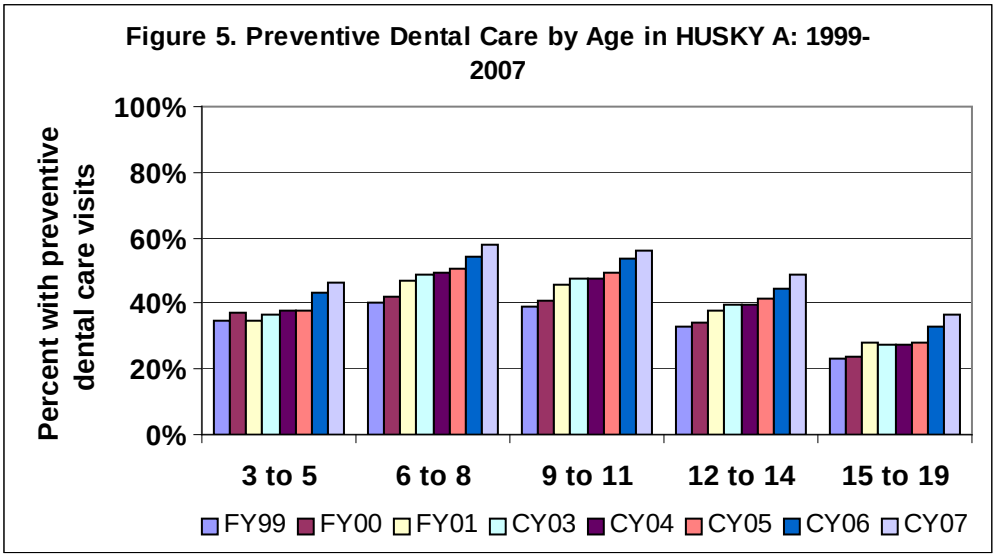
In 2007, nearly 56 percent of children had any dental care, including 49 percent with preventive care and nearly 25 percent with treatment (Table 2). Both the number (75,907) and the percentage of children who had dental care (55.7%) increased over the previous year (69,706 or 51.9% with care in 2006) (Figure 4). Despite an apparent problem with data in November and December 2007, BlueCare's dental care utilization rates increased over the previous year and were higher than rates for the other health plans.



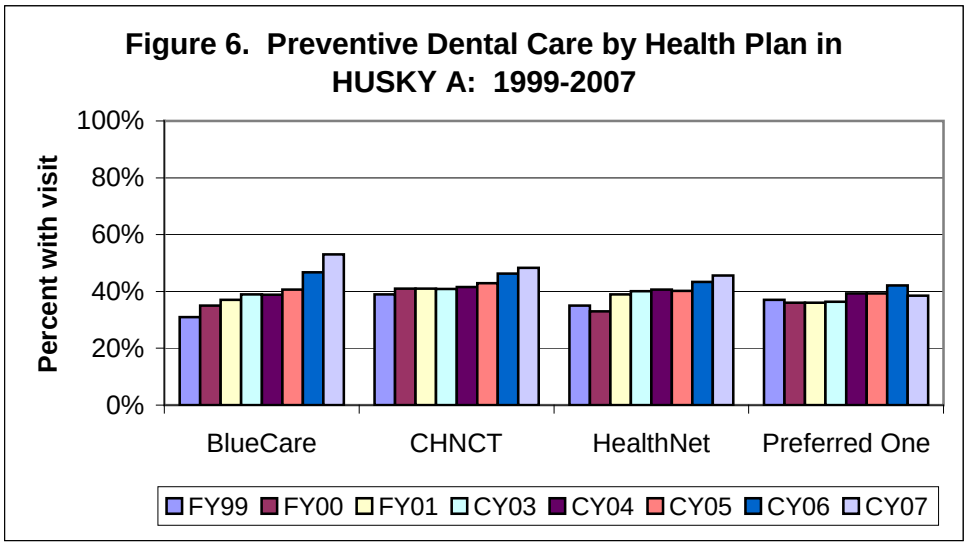
Almost half (48.7%) of children had a record corresponding to at least one preventive dental visit—that is, dental prophylaxis, fluoride treatment, sealants, and oral hygiene—compared to 45 percent in 2006 and 41 percent in 2005. The preventive dental care rate increased for all health plans but Preferred One in 2007 (Figure 5). Only 35 percent of children with any preventive care visits had two or more visits, in accordance with the EPSDT periodicity schedule. Almost one in four children (24.6%) had any dental treatment (e.g., fillings), an increase over 2006 (23.4%) and the previous year (21.6%).

Children who had preventive dental care in 2007 varied by sociodemographic and enrollment characteristics (Table 2):

- **Age:** Children aged 6 to 8 and 9 to 11 were most likely to have had preventive dental care;



- **Race/ethnicity:** Preventive care utilization was highest for Hispanic children (53.2%) and children from other racial/ethnic groups (53.7%) and lowest for African American children (44.4%);
- **Primary language:** Children residing in Spanish speaking households were most likely to have had preventive dental care (55.3%);
- **Residence:** Among the larger towns and cities in Connecticut, preventive care utilization was highest for children living in East Hartford (54.4%), Hartford (52.8%), New Britain (56.7%), Stamford (53.2%), and Torrington (60.8%).
- **Health plan:** Preventive dental care rates increased for children in every health plan but Preferred One and were highest for children in BlueCare (Figure 6).



Similarly, children who had dental treatment in 2007 varied by sociodemographic and enrollment characteristics. Treatment rates were highest for school-aged children (27.5%) and young teens (28.6%) and for Hispanic children (27.2%) and children of other racial/ethnic identities (30.0%).

In 2007, 9 percent of children aged 3 to 19 had at least one sealant placed, with an average of 4.41 sealants per child. Children aged 6 to 8 and 12 to 14 had the highest sealant rates (14.6 and 14.7%, respectively). The percentage of children with sealants has increased steadily over previous years (from 8.3% with an average of 3.37 sealants per child in 2006 and 7.0% with an average of 3.37 sealants per child in 2005).

No Care

In 2007, there 15,875 children 2 to 19—that is, 10.9 percent of children 2 to 19 enrolled for the entire year—who had *no records for any care at all in HUSKY A in 2007*. This rate represents an increase from 2006, when 9.1% of children had no care at all. This increase is likely due to BlueCare's data problem since the rate for the other plans was lower (9.3% overall, ranging from 8.8% for Health Net to 10.3% for Preferred One).

As in previous years, the proportion without care increased steadily with age, from 4.6 percent of pre-school children to 14.4 percent of older adolescents 16 to 19.

Limitations of the Data

These findings are subject to several important limitations and should be interpreted with the following limitations in mind: First, the findings are based on secondary analysis of HUSKY A enrollment and encounter data. Second, the completeness and accuracy of enrollment and encounter data used to describe sociodemographic characteristics and utilization by children in HUSKY A were not evaluated. Third, services received by the 40 percent of children who were enrolled in HUSKY A for 1 to 11 months were not described, so the findings do not represent all services performed in 2007. Fourth, what may appear to be increases or decreases in utilization over time may be due in part to changes in the quality of data submissions, as in BlueCare's data problem evident in late 2007. Fifth, quality of care cannot be assessed using administrative data alone. Some providers may have performed services, such as developmental screens, for which an encounter record was not submitted. Nevertheless, analyses of readily available, uniformly coded encounter

data for this large group of children provide valuable information about HUSKY A program outcomes and suggest ways in which access to preventive care can be improved.

DISCUSSION

Preventive care is the key component of health care for children enrolled in the HUSKY Program. Whether or not a child needs acute care or other services at any other time during the year, well-child and preventive dental visits provide an opportunity for early detection of health problems, for assessment of growth and development, and for building rapport with parents. Since HUSKY Program performance monitoring and reporting began and up until this year, utilization has increased steadily, albeit slowly, in all age groups and all health plans. The decline in the well-child visit rate observed in 2007 may be due to data issues; however, ongoing monitoring of this aspect of care is critically important for detecting a continuation of the downward trend and for determining how utilization has been affected by HUSKY Program policy changes and transition in 2008.

Policy Changes

In October 2008, the Department of Social Services issued two new policies that may lead to improvements in care, especially for very young children.[21]

- Citing the importance of early detection of developmental delays or disabilities, the Department informed providers they will be reimbursed for developmental screening (procedure code 96110; allowed charge $18.00) that is performed on the same day as a well-child visit. Further, the Department cites the AAP recommendation that providers use standardized instruments for developmental screening at the 9-, 18-, and 24- or 30-month visits. This policy will not affect reimbursement for federally-qualified health centers, however, because these providers bill an all-inclusive fee for each visit.

- The Department informed pediatric care providers that they can provide and bill for oral health care for very young children. Primary care providers who attend the University of Connecticut School of Dentistry's ABC Program in continuing medical education may provide and bill for the following procedures: oral evaluation and hygiene instruction for children under 3 and counseling with the primary care giver (procedure code D0145; allowable charge $25.00); and topical fluoride varnish application for children at moderate to high risk for dental caries (procedure code D1206; allowable charge $20.00).

If and when pediatric care providers adopt these two practices, care for very young children will improve.

HUSKY Program Transition

Beginning January 1, 2008, the Connecticut Department of Social Services converted the HUSKY Program from a risk-based managed care program to a non-risk program with contracts for administrative services.[22] The Department assumed responsibility for provider rate-setting, prior

[21] Connecticut Department of Social Services. Physician fee schedule: incorporation of January 2008 Healthcare Common Procedure Coding System (HCPCS) changes and allowed amount changes for certain physician administered drugs (PB 2008-20). Hartford, CT: Department of Social Services, October 2008.
[22] For a summary of the policy decisions and a chronology of the events that occurred in the HUSKY Program, beginning in late 2007, see minutes from meetings of the Medicaid Managed Care Council, available at: www.cga.ct.gov/medicaid/mmcc/minutes.

authorization of services, and provider enrollment criteria. In the ensuing months, two of the four participating health plans (Health Net and Preferred One) voluntarily left the program. Anthem (BlueCare Family Plan) and Community Health Network continued in the program and were paid a per-member-per-month fee for administration of benefits and processing claims. HUSKY enrollees were also offered the option of coverage in fee-for-service Medicaid, with assistance as needed from care coordinators who staff the HUSKY Infoline.

Following through on plans for a return to managed care, the Department issued a request for proposals for participation in the HUSKY Program (managed care) linked to a new state-funded option for uninsured adults, Charter Oak. Three health plans (Aetna Better Health, AmeriChoice, and Community Health Network) were selected for participation beginning July 1, 2008. Pending approval of provider network adequacy by the Department and the Centers for Medicare and Medicaid Services, enrollment in these plans remained voluntary throughout calendar year 2008. Enrollees were also free to stay in fee-for-service Medicaid or in Anthem and CHNCT throughout the year.

Meanwhile, the Department "carved-out" pharmacy services (effective February 1, 2008) and dental care (effective September 1, 2008) from managed care. These services are now administered under non-risk contracts with administrative services organizations. In addition, the Medicaid provider fee schedule was changed for primary and specialty medical care providers (effective January 1, 2008) and for pediatric dental care providers (effective April 1, 2008).[23]

At least in the short term, the cumulative effect of these significant program changes is likely to be a decline in utilization of preventive services as a direct result of confusion among providers and families, as well as real changes in access to preferred providers due to shifting health plan affiliations. Despite intentions to increase access to care, "carved-out" services (pharmacy, dental) may be difficult to come by, at least initially, while families and providers became familiar with the new system. Dealing with new HUSKY health plans may be challenging for families and providers at first.

It is imperative that the impact of the program changes be assessed, using complete enrollment and encounter data from the current and exiting health plans and from the fee-for-service claims system. The consistent analytic methods and measures used by Connecticut Voices since 1998 to monitor program and health plan performance provide a reliable baseline of rates and trends against which the effects of 2008 program changes can be determined.

CONCLUSIONS

- **Well-child care utilization in HUSKY A decreased in 2007 among all but the youngest children and in all health plans; four in ten children did not receive well-child care in a one-year period.**

- **Preventive dental care utilization increased in 2007 in all age groups and in all health plans but Preferred One; however, one of every two children did not receive preventive dental care and only 35 percent of them had two or more visits, in accordance with the EPSDT periodicity schedule.**

[23] Connecticut Voices for Children. Medicaid provider reimbursement: recent changes to pediatric, obstetric and other selected fees. New Haven, CT: Connecticut Voices, April 2008. Available at: www.ctkidslink.org.

- **About one in ten children went the entire year without any health services, despite having been enrolled for 12 months in health plans that were paid for providing care.**

- **Preventive care rates continue to fall short of professional recommendations and expectations for HUSKY Program and health plan performance.**

- **The impact of HUSKY Program changes on access to care should be determined by comparing utilization rates for 2008 with preventive care rates and trends reported annually since 1999.**

Table 1. Well-Child Care Among Children Who were Continuously Enrolled in HUSKY A in 2007

	Had Well-Child Care		BlueCare		CHN		HealthNet		Preferred One		Changed plans	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	79,515	54.4%	28,204	46.9%	15,506	60.1%	23,170	60.2%	8,606	59.5%	4,029	55.8%
Age												
2 - 5	28,421	76.1%	10,449	68.2%	5,766	82.3%	7,482	82.2%	3,190	81.8%	1,534	75.6%
6 - 10	20,226	45.7%	6,828	37.1%	3,897	51.2%	6,183	52.6%	2,304	52.3%	1,014	48.5%
11 - 15	21,149	51.5%	7,411	44.1%	4,081	57.0%	6,487	58.1%	2,183	54.4%	987	50.5%
16 - 19	9,719	41.6%	3,516	36.8%	1,762	43.5%	3,018	46.5%	929	43.5%	494	43.2%
Total	79,515		28,204		15,506		23,170		8,606		4,029	
Gender												
Female	39,597	55.0%	13,989	47.1%	7,720	60.7%	11,599	61.2%	4,251	59.8%	2,038	57.2%
Male	39,539	53.7%	14,079	46.6%	7,720	59.3%	11,476	59.0%	4,312	59.1%	1,952	54.1%
Unknown	379	74.9%	136	63.0%	66	79.5%	95	85.6%	43	89.6%	39	81.3%
Total	79,515		28,204		15,506		23,170		8,606		4,029	
Race/ethnicity												
African-American	18,657	52.2%	5,874	44.2%	3,474	55.5%	4,936	58.4%	3,324	57.3%	1,049	54.0%
White	33,114	55.7%	13,175	49.5%	4,209	62.1%	12,081	60.5%	2,101	62.1%	1,548	57.7%
Hispanic	25,344	54.3%	8,175	44.8%	7,406	61.2%	5,381	61.2%	3,043	60.3%	1,339	54.4%
Other	2,258	55.5%	932	50.2%	391	60.2%	737	59.2%	116	59.5%	82	65.1%
Unknown	142	80.2%	48	66.7%	26	83.9%	35	92.1%	22	88.0%	11	100.0%
Total	79,515		28,204		15,506		23,170		8,606		4,029	
Primary Language												
English	67,782	54.4%	23,908	47.1%	12,480	59.3%	20,678	60.2%	7,424	59.4%	3,292	55.5%
Other	509	53.3%	185	44.2%	101	65.2%	133	61.6%	57	52.3%	33	58.9%
Spanish	7,301	56.4%	2,461	45.3%	2,360	65.3%	1,187	67.4%	889	62.6%	404	56.8%
Unknown	3,923	51.5%	1,650	46.9%	565	57.5%	1,172	54.1%	236	54.9%	300	57.1%
Total	79,515		28,204		15,506		23,170		8,606		4,029	
Town												
Bridgeport	8,858	63.8%	791	48.9%	1,743	67.6%	3,984	65.6%	1,837	64.5%	503	65.9%
Hartford	6,828	42.7%	4,018	38.6%	965	49.3%	685	52.1%	829	53.5%	331	44.0%
New Haven	7,278	54.9%	1,314	46.2%	3,274	59.5%	602	52.3%	1,648	55.7%	440	54.5%
All Other Towns	56,551	54.9%	22,081	48.8%	9,524	60.3%	17,899	59.7%	4,292	60.5%	2,755	56.3%
Total	79,515		28,204		15,506		23,170		8,606		4,029	

Source: HUSKY A enrollment and encounter data from the Connecticut Department of Social Services, analyzed by Connecticut Voices for Children.

Table 2. Dental Care for Children Who Were Continuously Enrolled in HUSKY A in 2007

			Had Dental Care					
	Population		Any Dental		Preventive		Treatment	
	#	%	#	%	#	%	#	%
Total	136,289		75,907	55.7%	66,343	48.7%	33,467	24.6%
Age								
3 - 5	27,523	20.2%	14,242	51.7%	12,777	46.4%	3,922	14.2%
6 - 8	27,142	19.9%	17,167	63.2%	15,716	57.9%	7,471	27.5%
9 - 11	25,393	18.6%	15,732	62.0%	14,282	56.2%	6,988	27.5%
12 - 14	24,599	18.0%	14,153	57.5%	11,948	48.6%	7,029	28.6%
15 - 19	31,632	23.2%	14,613	46.2%	11,620	36.7%	8,057	25.5%
Total	136,289		75,907		66,343		33,467	
Gender								
Female	67,307	49.4%	38,170	56.7%	33,316	49.5%	17,148	25.5%
Male	68,654	50.4%	37,584	54.7%	32,891	47.9%	16,284	23.7%
Unknown	328	0.2%	153	46.6%	136	41.5%	35	10.7%
Total	136,289		75,907		66,343		33,467	
Race/ethnicity								
African-American	33,611	24.7%	17,427	51.8%	14,935	44.4%	7,403	22.0%
White	54,309	39.8%	28,886	53.2%	25,703	47.3%	12,837	23.6%
Hispanic	44,484	32.6%	27,315	61.4%	23,644	53.2%	12,086	27.2%
Other	3,784	2.8%	2,247	59.4%	2,031	53.7%	1,136	30.0%
Unknown	101	0.1%	32	31.7%	30	29.7%	5	5.0%
Total	136,289		75,907		66,343		33,467	
Primary Language								
English	116,309	85.3%	63,713	54.8%	55,710	47.9%	28,096	24.2%
Other	869	0.6%	506	58.2%	428	49.3%	238	27.4%
Spanish	11,799	8.7%	7,556	64.0%	6,530	55.3%	3,259	27.6%
Unknown	7,312	5.4%	4,132	56.5%	3,675	50.3%	1,874	25.6%
Total	136,289		75,907		66,343		33,467	
Town								
Bridgeport	12,827	9.4%	6,850	53.4%	5,258	41.0%	3,208	25.0%
Hartford	14,946	11.0%	9,477	63.4%	7,887	52.8%	3,632	24.3%
New Haven	12,330	9.0%	6,174	50.1%	5,408	43.9%	2,910	23.6%
All Other Towns	96,186	70.6%	53,406	55.5%	47,790	49.7%	23,717	24.7%
Total	136,289		75,907		66,343		33,467	
Plan								
BlueCare	56,097	41.2%	33,399	59.5%	29,759	53.0%	14,718	26.2%
CHN	23,902	17.5%	13,313	55.7%	11,553	48.3%	5,811	24.3%
HealthNet	36,145	26.5%	18,957	52.4%	16,497	45.6%	8,537	23.6%
Preferred One	13,464	9.9%	6,377	47.4%	5,178	38.5%	2,646	19.7%
Changer	6,681	4.9%	3,861	57.8%	3,356	50.2%	1,755	26.3%
Total	136,289		75,907		66,343		33,467	

Source: HUSKY A enrollment and encounter data from the Connecticut Department of Social Services, analyzed by Connecticut Voices for Children.