CONNECTICUT VOICES FOR CHILDREN

The HUSKY Program in Transition: Enrollment and Health Services Utilization in 2008

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April 2011

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KEY FINDINGS

This report describes enrollment trends and children's health services utilization in the HUSKY Program in 2008. It is the first and only report on utilization during a period when the program underwent significant change in the way services were administered and financed.

In 2008, the Department of Social Services assumed responsibility for authorizing health services, setting rates, and paying claims. The four participating managed care plans operated on a non-risk basis to administer various member and provider services. Two plans exited the program within months and the other two stayed till the end of the year. During the transition year, traditional fee-for-service Medicaid was offered as an enrollment option and was the default option for HUSKY members who did not select a new plan. That year, there were also significant changes the way pharmacy and dental services were administered and delivered.

These changes affected over 345,000 children, parents, and pregnant women who were enrolled in HUSKY A and B that year. The purpose of this study was to describe enrollment and children's health services utilization in 2008 and to compare utilization with previous years to assess the impact of the program transition on access to care. Overall in 2008, enrollment grew while utilization rates remained at or near the low utilization rates observed in recent years. Key findings:

- During the transition period, enrollment in HUSKY A grew by over 21,000 adults and children (6.8%). Enrollment in HUSKY B declined by nearly 3,000 children (17%), beginning in the latter half of the year. Over 50,000 adults and children were covered in traditional Medicaid for some part of the year.

- Children's health services utilization in 2008:

    - The well-child visit rate (57.0%) increased over the previous year, but was still not back to the level observed in 2006 (65.3%).
    - The rate of developmental screening doubled, to 5.3% of children under age 6.
    - Dental care utilization was unchanged from 2007, but up significantly from 2006.
    - Rates for emergency care were just higher than rates for 2007.
    - About 16,000 children who were enrolled for the entire year had no care at all; the corresponding rate (13.7%) was greater than the rate in 2007.
    - Children who were covered in traditional Medicaid for any part of the year, i.e., not continuously enrolled with one or more of the participating health plans, were significantly less likely to have had well-child care or dental care and were more likely to have had emergency care or no care at all in the one-year period.

At the rates that children received preventive care in recent years, the program has a long way to go toward ensuring that <u>all</u> children receive timely well-child and preventive dental care and that <u>all</u> young children are screened for developmental delays. Emergency care rates remain unacceptably high. Just as the contractual process can be used to ensure transparency, the process can be used to ensure accountability for delivering essential services to the children enrolled in the HUSKY Program. Lessons learned in this transition period should be applied to ensuring uninterrupted access to care during the upcoming program overhaul.

The HUSKY Program in Transition:
Enrollment and Health Services Utilization in 2008

INTRODUCTION

This report describes enrollment trends and children's health services utilization during the year in which the program experienced significant changes in administrative responsibility and financial risk for health services. In November 2007, after months of negotiations between the Connecticut Department of Social Services and four managed care plans that participated in the HUSKY Program, the Governor called an end to contract negotiations and dissolved the Medicaid managed care program. This action threatened to disrupt access to care for 325,000 children, parents and pregnant women who were enrolled that month.

Cancellation of Risk-based Contracts for Managed Care

On November 19, 2007, Governor M. Jodi Rell announced that effective December 1, the state would cancel risk-based contracts with the four managed care organizations that were participating in the HUSKY Program (Anthem Blue Cross and Blue Shield; Community Health Network of Connecticut; HealthNet, Inc.; and WellCare Health Plans, Inc.).[1] The Governor took this action as a result of the managed care plans' unwillingness to enter into new contracts requiring compliance with Freedom of Information requests about their business practices. One plan (Community Health Network) agreed to the contract amendment the week before the Governor cancelled the contracts. Two other plans, however, claimed that the information was proprietary and that reporting would harm their commercial lines of business. Rather than comply, these two plans said they might leave the program with as little as 15 days' notice, a threat the Governor characterized as "utterly deplorable." The Governor preempted the health plans by terminating contract negotiations with all four plans. Never before had a state experienced such a sudden and sweeping change to its entire Medicaid managed care program.[2]

Freedom of Information

The question about transparency and accountability in the HUSKY Program arose two years earlier when a request for information about provider reimbursement rates was rebuffed by the managed care plans. In December 2005, the Freedom of Information (FOI) Commission ruled in favor of a complainant who was seeking information about provider rates and alleging that reimbursement rates were so low as to thwart the state's efforts to provide access to care for low-income individuals in the HUSKY Program.[3] Anthem, Community Health Network of Connecticut (CHNCT), and HealthNet appealed to the Superior Court. The state's Attorney General agreed with the FOI Commission, saying that "The vital principle of open and accountable government is at stake: the public must retain the right to know how tax dollars are spent, regardless of who provides a government service…. Disclosure is vital because of questions about whether [managed care organizations] are delivering the coverage they have been contracted to provide. These concerns cannot be resolved without release of reimbursement information."[4] The FOI Commission's ruling was subsequently upheld by the state Superior Court.[5]

Managed Care Plan Changes

The four HUSKY managed care plans agreed to act temporarily as prepaid inpatient health plans (PIHPs), defined under federal law as managed care entities that provide medical services, including inpatient hospital services, to enrollees under contracts with the state that are not comprehensive risk contracts.[6] The Centers for Medicare and Medicaid Services approved this change to the state's managed care waiver. Effective December 1, 2007, the plans were no longer authorized to deny, terminate, or reduce care without Department review. The Department of Social Services agreed to pay the PIHPs $18.18 per member per

month for administrative services (member services, provider enrollment, claims processing, case management, outreach, and member education). The Department assumed responsibility for rate setting (at or above the Medicaid fee schedule), setting provider enrollment criteria, and authorization reviews, as well as support services for those in traditional Medicaid (EPSDT, case management, prior authorization of services). The Department contacted providers in the managed care networks and urged them to enroll as Medicaid providers so they could continue serving their patients. Beginning April 1, after WellCare and HealthNet left the program, new HUSKY A members and all others were given the option to enroll in one of the remaining PIHPs or in traditional fee-for-service Medicaid. HUSKY B members were required to enroll with one of the two remaining PIHPs (Anthem or CHNCT), as there was no fee-for-service option in HUSKY B.

HUSKY Program Re-Procurement

In January 2008, the Department issued a Request for Proposals (RFP), inviting health plans to bid on the HUSKY Program and the Charter Oak plan, a new program for uninsured adults.[7] Under new contracts expected to take effect July 1, the HUSKY Program would to return to a risk-based model where managed care plans would make decisions about whether services were medically necessary and would bear the financial risk in a statewide program with mandatory enrollment in managed care (no fee-for-service option). Bidders were required to agree to contracts with FOI provisions. Further, health plans that were interested in the HUSKY Program were required to bid on Charter Oak as well, since the state tied participation in HUSKY to participation in Charter Oak.

Changing Coverage Options and Enrollment

Over the course of the year, managed care options for HUSKY enrollees and providers changed significantly and often. Two PIHPs (HealthNet and WellCare) with a combined enrollment of over 116,000 individuals left the program, effective March 31. The other two PIHPs (Anthem and CHNCT) agreed to FOI provisions in their contracts for participation through June 30 (subsequently extended to January 31, 2009). Enrollment in CHNCT grew from 57,000 in November 2007 to over 200,000 when managed care resumed 14 months later. Over 50,000 HUSKY members chose or were defaulted into traditional Medicaid. [8] CHNCT and two new managed care plans were successful bidders for the HUSKY/Charter Oak contracts.[9]

Shortly after Connecticut's enrollment broker began accepting applications for the Charter Oak plan in July 2008, the backlog of applications and renewals for HUSKY B increased to three to five times the monthly average in the previous year; enrollment in HUSKY B declined to the lowest level in six years. Once the enrollment broker reduced the backlog, enrollment in HUSKY B increased to near pre-Charter Oak levels.

Concern about the adequacy of provider networks, especially in the two new plans, resulted in delay of program implementation. Voluntary enrollment in the three managed care plans began on a county-by-county basis September 1. Meanwhile, Anthem agreed to continue in the program as a PIHP until January 31, 2009, when statewide mandatory enrollment in the new managed care plans was finally implemented.

In the last month of the transition period, the Department and its enrollment broker processed managed care enrollment for nearly 38,000 individuals who were still in traditional Medicaid and over 100,000 who were still enrolled in Anthem. To support HUSKY Program members who were trying to navigate these changes, the Department contracted for additional help from United Way 2-1-1 HUSKY Infoline, its contractor for providing information and assistance by telephone.

Other Program Initiatives

Meanwhile, other major program changes were underway. In chronological order:

- As a result of $100 million appropriated by the Connecticut General Assembly in June 2007, the Department increased provider reimbursement under the Medicaid fee schedule to about an average of 57 percent of Medicare reimbursement, up from 45 percent.[10] The fee increases that were announced in early 2008 were retroactive to July 1, 2007 (providers) and October 1, 2007 (hospitals). In the RFP for the new HUSKY managed care program, the Department stipulated that provider reimbursement under new contracts would have to be at or above rates set in the new Medicaid fee schedule.

- Medicaid was expanded to cover pregnant women with income up to 250 percent of the federal poverty level, effective January 1, 2008.[11]

- Effective January 1, 2008, newborns who would have otherwise been uninsured were enrolled in the HUSKY Program, with the state paying the first four months' premiums for those whose families would have needed to pay for coverage in HUSKY B.[12]

- Effective January 1, 2008, pediatric care providers who performed developmental screening or testing could bill for and expect to be reimbursed for screening performed on the same day as a well-child visit or other service.[13] However, the policy bulletin informing providers of this change was not issued until October 2008.

- Pharmacy services were "carved-out" of managed care effective February 1, 2008, and turned over to the Department's contractor to administer using the Department's Preferred Drug List. Procedures for obtaining prescription medications changed.

- Under the terms of the settlement of a long-standing lawsuit against the Department, children's dental services were enhanced.[14] Beginning April 1, 2008, reimbursement for children's dental care under the Medicaid fee schedule increased significantly. All dental services for the HUSKY Program were "carved-out" of managed care in September 2008.

- Design of a primary care case management option continued throughout 2008. Effective February 1, 2009, primary care case management was finally offered in two communities (Willimantic, Waterbury) as an alternative to enrollment with a HUSKY managed care plan.

Program Oversight and Support

The HUSKY Program is supported by a strong network of policy makers and health advocates who are dedicated to ensuring that children, parents, and pregnant women in low-income families have access to the care they need. These entities advised the Department and disseminated information about program changes throughout the transition period.

- The Medicaid Care Management Oversight Care Council is made up of legislators, providers, and advocates who meet monthly with the Department and health plan representatives.[15] The Council is well-informed about this complex program and engaged in improving the ways the program serves Connecticut families. Throughout 2008, the Council meetings provided advocates with opportunities for getting information, asking questions about program developments, and advising the Department.

- Under a contract with the Department of Social Services, the HUSKY Infoline, operated by United Way 2-1-1 of Connecticut, provides information and assistance to HUSKY members and those who are interested in applying for coverage. Calls from families experiencing difficulties with the program serve as an early warning of health plan-specific or program-wide problems. At various times in 2008, the Department enlisted HUSKY Infoline for help with contacting members who had not yet chosen the new enrollment options that were available to them.

- Covering Connecticut's Kids and Families coalition, convened by Connecticut Voices for Children and funded in part by the Connecticut Health Foundation, is a statewide network of community-based providers who meet quarterly to exchange information with the Department about how the HUSKY Program is serving the families they work with. Over 130 community-based service providers typically attend the quarterly meetings; nearly 1,200 receive periodic updates on program developments via list serve. On December 13, 2007, with support from the Connecticut Health Foundation, Covering Kids sponsored a statewide conference call with the state Medicaid Director who informed over 120 participants about the latest developments in the program.

- The Connecticut Health Policy Project is a non-profit non-partisan research and educational organization dedicated to improving access to affordable, quality health care for all Connecticut residents. Project staff has worked with legislators, providers, and other advocates on promoting primary care case management as an alternative to managed care for all HUSKY members statewide.

All these groups stayed up-to-date on program developments in 2008 and informed their respective constituents and coalitions about changes in the program.

PURPOSE

The purpose of this study is to describe enrollment trends and children's health services utilization in the HUSKY Program 2008.

METHODS

Using a retrospective cohort design, we have described enrollment and children's health services utilization in the HUSKY Program in 2008. For investigation of trends, utilization in 2008 was compared to previous years (2007, 2006). The impact of the program changes on state expenditures in 2008 have been described elsewhere.[16]

This report on enrollment and children's health services utilization builds on many years of state-funded independent performance monitoring in the HUSKY Program.[17] Connecticut Voices for Children obtains HUSKY Program data directly from the Department of Social Services.[18] Annual reports on enrollment, preventive care (well-child and dental), emergency care, asthma prevalence and asthma care, and births to mothers with HUSKY Program or Medicaid coverage can be found at www.ctkidslink.org. After a recent one-year hiatus, independent performance monitoring has resumed.

Data and Analytic Approach

Using HUSKY A eligibility and enrollment data, children who were continuously enrolled in HUSKY A between January 1 and December 31, 2008 were identified.[19] For the analyses, children were grouped by whether they had been continuously enrolled in a participating PIHP (any PIHP) for the 12-month period or had switched between one or more PIHPs and traditional Medicaid. No analyses at the managed care plan level were conducted.[20]

Enrollment trends over the period November 2007 to February 2009 were described in terms of enrollment counts and growth by program type (HUSKY A and B) and age group (HUSKY A adults and children). The number and percentage of HUSKY A members who were enrolled in traditional Medicaid were determined. Data on the number and percentage of members who defaulted to traditional Medicaid (v. choosing that option) were not available from the Department or the HUSKY enrollment broker.

Health services data for those in HUSKY A (managed care and traditional Medicaid) were obtained from the Department of Social Services for utilization analyses. Encounter records for HUSKY A managed care services and claims data for those in traditional Medicaid and for services that were carved-out of managed care were searched for selected types of care, using procedure codes reported by providers to the health plans and the Medicaid program. The methods used to determine utilization rates in 2008 were the same as methods used in 2007 and 2006. [Note: Data for behavioral health services and data for services in HUSKY B were unavailable for analyses of utilization in 2008, 2007, or 2006.]

- **Well-child care:** HUSKY A claims and encounter data were searched for records corresponding to annual well-child visits for children 2 to 19 during the one-year period.[21, 22, 23] Similarly, HUSKY A claims and encounter data were searched for records corresponding to and developmental screening received by children under 6 in 2008.[24]

- **Dental care:** HUSKY A claims and encounter data were searched for records corresponding to dental care, including sealants, received by children 3 to 19 in 2008 in the following categories: any dental care, preventive dental care, and dental treatment.[25, 26, 27]

- **Emergency care**: HUSKY A claims and encounter data were searched for records corresponding to emergency department visits, including emergency visits for dental care, for children under 21 in 2008.[28, 29] The subset of visits for treatment of ambulatory care sensitive conditions was also identified.[30]

- **No care:** The percentage of children 2 to 19 who did not receive any care at all in the one-year period (no claims or encounter records for care in 2008) was also determined and compared to previous years.[31] [Note: Since claims for behavioral health services were not available for 2007 and 2006 analyses, these claims were not searched for the 2008 analyses. Thus it is possible that some children without any other services (office visits, prescriptions, dental care, etc.) had behavioral health services that could not be counted; these children would be included in the count of those without care in the one-year periods.]

Results are reported in terms of unadjusted utilization rates, calculated by comparing the numbers of children with care to the numbers who were continuously enrolled during the period. Differences between 2008 and utilization in 2007 and 2006 were determined by comparing utilization rates for services (rate ratios); differences that were significant at $p<.001$ are reported as either higher or lower than rates for previous years or program (continuously enrolled in PIHPs v. PIHP and traditional Medicaid). The differences that both statistically significant and meaningful in program terms are highlighted in the discussion section.

The findings are subject to certain limitations associated with secondary analysis of administrative data and the methods used for this study: The data were not audited for completeness or accuracy. It was not possible to determine which if any of the children had health services that were covered by third party payers or delivered by providers who did not submit claims. The experience of children who were continuously enrolled may not be representative of all children who were ever enrolled that year. Despite these limitations, the findings when taken as a whole provide agency staff and policy makers with information that can be useful for program and policy development.

RESULTS

Enrollment

During 2008, enrollment in HUSKY A grew steadily; enrollment in HUSKY B declined (Table 1). Between November 2007 and February 2009, enrollment in HUSKY A increased by over 21,000 overall, including over 9,600 children. The largest percentage increase (11.8%) was among adults 19 and over.

Meanwhile, enrollment in HUSKY B was stable through July, and then declined steadily until enrollment was just 83 percent of what it had been prior to the program transition. Enrollment in January 2009 was the lowest it had been since December 2002.

Beginning April 1, 2008, traditional Medicaid was offered as an alternative to PIHP enrollment for new enrollees and for those whose health plans left the HUSKY Program. Traditional Medicaid was also the default option for those who failed to select a PIHP. At the peak in October, over 50,000 adults and children were enrolled in traditional Medicaid. Compared to children enrolled in managed care (PIHPs) all year, children with traditional Medicaid coverage were disproportionately non-Hispanic Black (30.2% v. 23.2%) and residents of Bridgeport (17.7% v. 7.9%). The number in traditional Medicaid declined as enrollment in new managed care entities was rolled out county-by-county beginning in September; however, nearly 38,000 HUSKY enrollees remained in traditional Medicaid in the last month before mandatory managed care enrollment resumed statewide. Data on the number and percentage of

Table 1. HUSKY Program Enrollment in Transition, 2008

	Nov 1, 2007	Jan 1, 2008	Apr 1, 2008	Jul 1, 2008	Oct 1, 2008	Jan 1, 2009	Feb 1, 2009
Enrollment options	**Managed care**	**Prepaid Inpatient Health Plans (PIHP)[a]**	**PIHPs and traditional Medicaid[b]**	**PIHPs and traditional Medicaid**	**PIHPs, traditional Medicaid, and managed care (voluntary)[c]**	**PIHPs, traditional Medicaid, and managed care (voluntary)**	**Managed care (mandatory)[d]**
HUSKY A							
Total	308,817	312,675	317,769	322,173	330,381	331,519	329,889
Adults 19 and over	96,545	98,464	101,038	103,484	107,088	108,076	107,974
Children under 19	212,272	214,211	216,731	218,689	223,293	223,443	221,915
Traditional Medicaid	Not an option	Not an option	44,154	37,708	51,152	37,762	Not an option
HUSKY B							
Children under 19	16,713	16,132	16,344	16,224	14,660	13,654	13,828

[a] PIHP: Prepaid inpatient heath plans, a type of managed care that does not involve a comprehensive risk contract between the state and the managed care entities.

[b] Traditional Medicaid (fee-for-service, with care and claims management by the Department of Social Services) enrollment is part of the total HUSKY A enrollment and was offered as an alternative to prepaid inpatient health plans, beginning April 1, 2008. The percent of HUSKY enrollees in traditional Medicaid ranged from 11% to over 15% of the total enrollment, with increasing numbers of enrollees defaulted to traditional Medicaid as the year progressed.

[c] Voluntary enrollment in managed care resumed September 1 and was phased in by county.

[d] Mandatory statewide enrollment in managed care resumed February 1, 2009, when about 62,000 individuals were defaulted into one of the two new managed care plans. The option to enroll in Primary Care Case Management was also offered to HUSKY enrollees in selected parts of the state, beginning February 1; 104 enrolled, mainly in Waterbury.

HUSKY members who were defaulted into traditional Medicaid were unavailable from the Department for this study.

In 2008, the percentage of ever enrolled children under 21 who were continuously enrolled in HUSKY A was higher than in 2007 or 2006 (Table 2). Among those who were continuously enrolled, the percentage of children who changed between managed care enrollment in PIHPs and traditional Medicaid was over 12 percent, far higher than the rate of plan change observed in previous years. Compared to those who were continuously enrolled in managed care (any PIHP), HUSKY enrollees who were in traditional Medicaid at any point during the year were disproportionately non-Hispanic Black children and disproportionately residents of Bridgeport.

Table 2. Continuous Enrollment in HUSKY A, 2008

	2008	2007	2006
Children under 21 who were:			
Ever enrolled	**276,028**	267,204	268,327
Continuously enrolled	**172,267**	160,227	157,178
Percent continuously enrolled	**62.4%*†**	60.0%	58.6%
Among continuously enrolled children:			
Changed between PIHP and traditional Medicaid	**12.5%**	NA	NA
Changed health plans	**NA**	5.0%	5.9%

*****Rate in 2008 is significantly greater than the rate in 2007 ($p<.001$).
†Rate in 2008 is significantly greater than the rate in 2006 ($p<.001$).

Health Services Utilization

Children's health services utilization in 2008 was unchanged or improved for some measures and worse for others, compared to the two previous years (Table 3). For most types of services, children who were continuously enrolled in managed care (prepaid inpatient health plans or managed care plans) were more likely to have had care than those who switched between managed care (PIHPs) and traditional Medicaid (Table 4).

Well-child care: In 2008, 57 percent of children 2 to 19 had at least one annual well-child exam. The rate was up from the previous year (54.4%) when data problems may have affected the rate, but was still significantly lower than the rate observed in 2006 (65.3%). Those who were in managed care for the entire year were more likely to have had well-child care than were those children who switched between managed care and traditional Medicaid during the year (RR=1.07; 95% CI: 1.06, 1.09).
In 2008, the percentage of children under six with claims or encounter records for developmental screening more than doubled, to 5.3 percent of young children.

Dental care: In 2008, the percentages of children 3 to 19 who had any dental care (56.3%), preventive care (48.4%), or treatment (24.3%) were essentially unchanged from the previous year; however the rates were significantly higher than 2006 rates. The percentage of children who had sealants placed (17.6%) was increased over previous years. Those who were in managed care for the entire year were significantly more likely to have had dental care than children who switched between managed care and traditional Medicaid (any dental care: RR=1.28, 95% CI: 1.26, 1.30; preventive dental care: RR=1.33, 95% CI: 1.31, 1.36; treatment: RR=1.37, 95% CI: 1.32, 1.41).

Table 3. Children's Health Services in HUSKY A, 2008 and previous years

	Age Group	Children with Care[a] 2008	2007 [b]	2006
Primary Care:				
Well child care	2 to 19	**57.0% *†**	54.4%	65.3%
Developmental screening	Under 6	**5.3% *†**	2.0%	2.1%
Dental care:				
Any dental care	3 to 19	**56.3% †**	55.7%	51.9%
Preventive dental care	3 to 19	**48.4% †**	48.7%	45.3%
Dental treatment	3 to 19	**24.3% †**	24.6%	23.4%
Sealants[c]	3 to 19	**17.6% *†**	16.3%	16.1%
Emergency care:				
Any emergency care	Under 21	**37.2% ***	34.4%	37.8%
Emergency care for ACSC[d]	Under 21	**36.0% ***	34.8%	35.7%
Children with no care[e]	2 to 19	**13.7% *†**	10.9%	9.1%

[a] Percent of children who were continuously enrolled for 12 months (any managed care plan and/or traditional Medicaid in 2008) who had at least one service or visit.
[b] Encounter records for 2007 were incomplete for HUSKY members in BlueCare Family Plan.
[c] Percent of those with any dental care who had sealants placed.
[d] Percent of those with any care who had emergency care for ambulatory care sensitive conditions (ACSC).
[e] Percent of children who did not have even one claim or encounter record for outpatient, inpatient, dental, or pharmacy services in the 12-month period. Note: Some of these children may have had behavioral health services, but those claims were not available for these analyses.
*****Rate in 2008 is significantly different than the rate in 2007 ($p<.001$).
†Rate in 2008 is significantly different than the rate in 2006 ($p<.001$).

Emergency care: Compared with 2007, more children under 21 had emergency care (37.2%) and more children had emergency care for conditions that might have been treated or averted with primary care in a non-emergency setting (36.0%). However, the rates observed in 2008 were not higher than rates reported in 2006. Children who were in managed care for the entire year were less likely to have had emergency care than those children who switched between managed care and traditional Medicaid (RR=0.96; 95% CI: 0.94, 0.98).

No care: In 2008, about 15,600 children 2 to 19 did not have claims or encounter records for care while enrolled for 12 months in the HUSKY Program.[32] The percentage with no care (13.7%) was up significantly over 2007 (10.9%) and 2006 (9.1%). Those children who were in managed care for the entire year were less likely to have gone without care than those children who switched between managed care and traditional Medicaid (RR=0.79; 95% CI: 0.77, 0.82).

Table 4. Children's Health Services in HUSKY A, 2008

		Children with Care in 2008 [a]	
	Age Group	In managed care	In managed care and traditional Medicaid [b]
Primary Care:			
Well child care	2 to 19	57.5%*	53.6%
Developmental screening	Under 6	5.2%*	6.1%
Dental care:			
Any dental care	3 to 19	57.4%*	45.1%
Preventive dental care	3 to 19	49.9%*	37.4%
Dental treatment	3 to 19	25.2%*	18.4%
Sealants[b]	3 to 19	17.6%	18.0%
Emergency care:			
Any emergency care	Under 21	37.0%*	38.5%
Emergency care for ACSC[c]	Under 21	36.1%	35.7%
Children with no care[d]	2 to 19	13.2%*	16.7%

[a] Children who were continuously enrolled in HUSKY A for 12 months in 2008.
[b] Children who switched at least once between managed care and traditional Medicaid in 2008.
[b] Percent of those with any dental care who had sealants placed.
[c] Percent of those with any care who had emergency care for ambulatory care sensitive conditions (ACSC).
[d] Percent of children who did not have even one claim or encounter record for outpatient, inpatient, dental, or pharmacy services in the 12-month period. Note: Some of these children may have had behavioral health services, but those claims were not available for these analyses.
*Rate for those in managed care (PIHPs) the entire year is significantly different than the rate for those who switched between managed care and traditional Medicaid.

DISCUSSION

This report on children's health services in the HUSKY Program is based on utilization data from 2008, a transition year in the managed care program. The timing of this report coincides with the Department's recently released report on the financial impact of program changes that year.[33] Despite the fact that both these two reports describe expenditures and utilization that occurred three years ago, under different administrative and financial arrangements than exist today, the information is important for understanding the impact of significant program changes. Lessons learned in 2008 will be useful for planning and implementing major program changes in the upcoming year.

During this time period, enrollment in HUSKY A grew at an unprecedented rate. However, enrollment in HUSKY B declined. Several factors could have contributed to this decline. First, as health plans left the program, there was no default fee-for-service option for continuing coverage of children in HUSKY B when their families failed to select new managed care plans (PIHPs); however, the enrollment drop-off did not coincide with plans leaving the HUSKY program in April. Second, and perhaps most significantly, the number of HUSKY B applications that were pending, i.e., awaiting processing, grew month to month in the latter half of the year as the enrollment broker began to take in applications for the new Charter Oak Program.[34] HUSKY B enrollment fell steadily to the lowest level in six years. Within a few months after mandatory managed care enrollment was completed, the enrollment broker reduced the backlog of applications and HUSKY B enrollment rose to near 2007 levels. This experience suggests that the

Department needs to consider ramping up its agreements with contractors in anticipation of significant change in the HUSKY Program *and* when changes in other programs have a direct effect on HUSKY operations.

Trends in children's health services utilization were mixed. Even the rate differences that were statistically significant were not large, suggesting that the same utilization patterns seen in previous years persisted, *despite* the program changes. For example, the well-child visit rate increased over the previous year, but was still not back to the level observed in 2006. In fact, more than four in ten children did not have a well-child exam in 2008. The rate of developmental screening increased considerably, but is still far from optimal. Moreover, it is difficult to attribute the increase in developmental screening to a change in Medicaid policy since providers were not notified of the change until October 2008.[35] Dental care utilization was unchanged from 2007, suggesting that program enhancements aimed at increasing access to care (increased provider reimbursement, service carve-out) had not yet had a measurable effect on utilization. More than one in three children had emergency care, a rate that is still far too high for a program that seeks to improve access to primary care. One in seven had no care at all, despite being enrolled for the entire year. The program has a long way to go toward ensuring that all children receive timely well-child and preventive dental care and that all young children are screened for developmental delays. Emergency care rates remain unacceptably high. These findings suggest that when the program is revamped in the upcoming year, there should be special attention paid to incentivizing administrative performance aimed increasing well-child care and reducing emergency care.

Indeed, the greatest impact of the 2008 program changes may have been for those who spent any time, by choice or default, in the unmanaged traditional Medicaid program. It is possible that there were some who, when given the choice, preferred coverage in Medicaid to enrollment in managed care. However, they may not have received the kinds of assistance with appointment scheduling and transportation, for example, that managed care plans were obligated to provide. It is also possible that many or most of those in traditional Medicaid were defaulted into this type of coverage, either because of not receiving the notices about plan selection or because they were confused or not inclined to take the steps required to remain in the managed part of the program. Another possible explanation is that those were covered in traditional Medicaid might not have used services anyway. Some of their providers may not have been enrolled as Medicaid providers. The fact that over 38,000 HUSKY enrollees remained in traditional Medicaid up until the very last month before enrollment in managed care was mandatory suggests that many of these families are not easily reachable by the usual means (mail, telephone) and may not be actively engaged with the health care system. This experience in 2008 suggests that the Department, its contractors, and all those groups that serve HUSKY families need to develop and employ alternative strategies for informing and assisting families when significant program change threatens their ability to obtain needed care.

Why did such significant program change have relatively little effect on utilization? Overall, it is possible that what appeared to policy makers and advocates to be considerable administrative turmoil in the HUSKY Program was just that—administrative—and not felt as acutely by HUSKY families. Indeed, enrollment in HUSKY A increased steadily throughout the program transition year, no doubt because it coincided with increased need for coverage during an economic downturn. For children in HUSKY A, coverage continued uninterrupted, whether in managed care (PIHPs) or traditional Medicaid. It is also likely that access to care was uninterrupted for most families, as providers that traditionally serve the Medicaid population, such as community health centers and hospital outpatient departments, continued delivering services to children in the HUSKY Program. Even some private providers continued delivering care, despite being understandably anxious about payment. The Department took steps to identify providers in the managed care networks and to enroll them as Medicaid providers. This experience in 2008 suggests that provider relations—recruiting and cultivating the Medicaid provider network, while ensuring that providers are well-informed about program changes—is a key component of ensuring that program change does not

disrupt access to care. The vitally important role of safety net providers should not be overlooked or taken for granted.

During the transition period, the Department took steps to ensure continuous coverage and as little disruption in services as possible. The Department's ongoing contractual relationship with Anthem and CHNCT, acting as PIHPs during the transition year, probably helped to make program changes largely invisible for many HUSKY enrollees. Further, the federal Centers for Medicare and Medicaid Services and the Medicaid Care Management Oversight Council used their respective oversight roles to ensure compliance with federal requirements and with legislative intent to provide coverage and access to care for eligible children and their families. The Department implemented other, very significant program changes that year with more time to plan and varying degrees of disruption post-implementation. Lessons learned in 2008 should be applied in the upcoming year to ensuring transparency, ample oversight, collaboration with contracted and community-based partners, and real-time monitoring of the effects of transition on access to care.

CONCLUSIONS

- Overall, utilization rates in 2008 remained at or near the low utilization rates observed in recent years.

- Unmanaged care and/or problems with reaching those who ended up in traditional Medicaid had a detrimental effect on access to care and utilization.

- Implementation of a new program had a detrimental effect on an existing one.

- Ongoing performance monitoring is important for ensuring that data are used to assess the impact of policy and program changes.

RECOMMENDATIONS

In anticipation of significant program change in the upcoming year, Department staff and contractors, policy makers and advocates should use the 2008 experience to develop more effective ways to work together to achieve the program's aims. This process should involve open communication, deliberative planning, dedicated resources, innovative ideas, and respectful collaboration between all parties. Specific recommendations:

- Ramp up operations (staffing, functions) with program contractors (enrollment broker, HUSKY Infoline) in anticipation of increased call volume and administrative functions.
- Work with HUSKY Infoline and community-based organizations like Healthy Start and community health centers, and with coalitions like the Covering Connecticut's Kids and Families to disseminate information about program changes and to gather real-time information about the impact of changes on access to care.
- Work with community-based organizations to design and implement additional ways to reach hard-to-reach families.
- Attend to the information needs and administrative burdens for providers are key to ensuring access to care during the program transition.
- Improve notices about program changes and communication with families.

ACKNOWLEDGEMENTS

This report was prepared by Connecticut Voices for Children under a contract between the Department of Social Services and the Hartford Foundation for Public Giving, with a grant from the Hartford Foundation to Connecticut Voices for Children. This report was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow, with assistance from Sharon Langer, J.D., Senior Policy Fellow. Amanda Learned of MAXIMUS, Inc. conducted the data analyses. The following individuals and groups provided useful feedback: Robert Zavoski, M.D., Medical Director for the Department of Social Services Medical Care Administration; Patricia O'Hagan, HUSKY Program data liaison; and members of the Medicaid Care Management Oversight Council's subcommittees on Quality Assurance and Consumer Access. This publication does not express the views of the Department of Social Services or the State of Connecticut. The views and opinions expressed are those of the authors.

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[1] "Governor Rell Orders Termination of HUSKY Contractors' Managed Care Role over Failure to Accept Public Oversight." Press release, November 19, 2007. Available at: www.cslib.org.

[2] Personal communication with Robert Hurley, Ph.D., December 18, 2007.

[3] *Hartwig v. Commissioner of DSS,* Freedom of Information Commission, Docket No. FIC 2005-025 (December 14, 2005).

[4] "Attorney General, Comptroller, Healthcare Advocate Join Court Fight to Open MCO Medicaid Records." Press release issued by the Connecticut Office of the Healthcare Advocate, March 17, 2006.

[5] *Health Net of Connecticut v. FOI, et al.,* 2006 WL 3691796, 42 Conn. L. Rptr. 441 (Conn. Super., November 29, 2006) (Levine, J.).

[6] 42 CFR 438.2.

[7] The Charter Oak Plan is a health insurance program for uninsured adults that was first proposed by Governor Rell in December 2006. Joint procurement was seen as a way to interest managed care plans in this new untested option that some feared might be subject to adverse selection. Premiums are set at a state-negotiated group rate that was partially state-subsidized for low-income members until July 2009. Out-of-pocket costs were capped; however, the program had annual and lifetime limits to coverage.

[8] Data on the number and percentage of HUSKY members who were defaulted into fee-for-service Medicaid, as opposed to selecting this option, were not available from the Department or the HUSKY Program enrollment broker for this report.

[9] Aetna Better Health is operated by Schaller Anderson, an Aetna company. AmeriChoice is operated by United Healthcare. These two plans and Community Health Network of Connecticut are Medicaid-only plans, i.e., they do not have commercial lines of business.

[10] Appropriation for Medicaid fee increases in SFY 2008: $27 million for physician services, $10 million for clinic services, $20 million for dental care, $1 million for vision care, and $46 million for hospital services. See also: Hero J, Lee MA. Medicaid provider reimbursement: recent changes to pediatric, obstetric, and other selected fees. New Haven, CT: Connecticut Voices for Children, April 2008. Available at: www.ctkidslink.org/pub_detail416.html.

[11] The income eligibility level was raised from 185% FPL to 250% FPL ($44,000 for family of 3 in 2008; for the purpose of determining eligibility, a pregnant woman is counted as 2 persons).

[12] Coverage in HUSKY A is free for families with income under 185% of the federal poverty level (FPL). Families with income between 185% and 235% FPL do not pay a premium for coverage in HUSKY B. Families with income between 235% and 300% FPL pay a monthly premium for coverage (in 2008, $30 per month per child; $50 maximum per family); these are the families that could qualify under the newborn initiative for state payment of four months' premiums. Families with income over 300% FPL continued to be responsible for the entire cost of the premium at a state-negotiated group rate.

[13] Connecticut Department of Social Services. Policy Transmittal 2008-52. October 2008.

[14] *Carr v. Wilson-Coker*, No. 3; 00CV1050(D.Conn., Aug. 26, 2008)

[15] The Medicaid Care Management Oversight Council, formerly known as the Managed Care Council, is the oversight body created by the Connecticut General Assembly to advise the Department on HUSKY Program policy and operations. Notes and minutes from monthly meetings throughout the time period in question provided much of the information about program changes included in this report. For more information about the Medicaid Care Management Oversight Council, see www.cga.ct.gov/ph/medicaid.

[16] Connecticut Department of Social Services. Prepaid inpatient health plan reconciliation process (handout distributed for information and discussion at the January 14, 2011 meeting of the Medicaid Care Management Oversight Council). See also: Connecticut Department of Social Services. Capitation Expenditures November 2007 and PIHP Expenditures May 2008 (handout distributed for information and discussion at the October 10, 2008 meeting of the Medicaid Managed Care Council). Both reports are available at: www.cga.ct.gov/ph/medicaid.

[17] Independent performance monitoring is state-funded in the line item "Children's Health Council" in the Department of Social Services budget. This label is a clear reference to the state-funded, Hartford Foundation-sponsored oversight council that monitored program performance from 1995 to 2003. In 2004, state-funding and independent performance monitoring resumed under a new contract between the Department of Social Services and the Hartford Foundation, with a grant to Connecticut Voices for Children for conduct of the performance monitoring.

[18] Contract #064HFP-HUO-03 / 10DSS1001ME between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving (in effect April 1, 2010 to June 30, 2011). With a grant from the Hartford Foundation, Connecticut Voices for Children conducts the performance monitoring described in this contract.

[19] 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 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.

[20] Detailed information about the sociodemographic characteristics of continuously enrolled children (distribution by age group, gender, racial/ethnic group, primary language, and residence can be found in the data tables posted at www.ctkidslink.org/publications.

[21] 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).

[22] 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.

[23] 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 well-baby visits that should occur at 2-4 days and 2 weeks, then 2, 4, 6, 9, 12, 15 and 18 months of life. In its CMS-416 report to the federal Centers for Medicare and Medicaid Services, the Department of Social Services reported that about 95% of infants and young children 1 to 2 received well-child screening exams in FFY08.

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

[25] 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 and T1015 codes for clinic visits.

[26] Dental sealants: Encounter records with ADA code 01351 or state codes D1351 or 1351D (sealant-per tooth).

[27] 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. According to the CMS-416 report submitted to the Center for Medicare and Medicaid Services, 7.5% of infants and young children 1 to 2 received any dental care in FFY08.

[28] Emergency care: CPT-4 codes (99281, 99282, 99283, 99284, 99285), and UB-92 revenue codes (450, 456, 459).

[29] Emergency dental care: ED visits (UB-92 revenue codes 450, 456, 459) for diagnoses 521.0, 522.x, 525.1 (digestive system); 873.6, 873.7 (dental injury).

[30] Ambulatory-care sensitive conditions were defined based on a review of the literature, including reports such as: Gadomski A, Jenkins P, Nichols M. 1998, Impact of a Medicaid primary care provider and preventive care on pediatric hospitalization. Pediatrics 101(3): E1. For the purposes of this report, conditions counted as ambulatory care sensitive included: ICD-9-CM code 090 (congenital syphilis); 033, 037 (immunization preventable conditions); 345, 780.3 (grand mal status and other epileptic convulsions); 493 (asthma); 382, 462, 463, 465, 472.1, 20.01 (severe ear, nose, and throat infections); 481, 482.2, 482.3, 482.9, 483, 485, 486 (bacterial pneumonia); 011-018 (tuberculosis); 250.0-250.3, 250.8, 250.9 (diabetes A, B, and C); 251.2 (hypoglycemia); 681-683, 686 (cellulitis); 558.9 (gastroenteritis); 590, 599.0, 599.9 (kidney or urinary infection); 276.5 (dehydration); 280.1, 280.8, 280.9 (iron deficiency anemia); 260-262, 268.0, 268.1 (nutritional deficiencies); and 783.4 (failure to thrive).

[31] This rate was compared with numbers and rates from 2007 and 2006. This rate would undoubtedly be lower if children under 2 were included because they are far more likely than older children to receive care.

[32] Claims for behavioral health services were not available for this analysis or for previous utilization analyses in 2007 and 2006. Thus it is possible that some of these children actually had behavioral health services even though they did not have even one office visit, dental visit, prescription, emergency visit or hospital admission in the 12-month period.

[33] Connecticut Department of Social Services. Prepaid inpatient heath plan reconciliation process: State of Connecticut (handout distributed and discussed by the Medicaid Care Management Oversight Council, January 14, 2011). Available at: www.cga.ct.gov/ph/medicaid.

[34]ACS, Inc. HUSKY Program Update. Report to Medicaid Managed Care Council on enrollment and application processing, January 9, 2009. Available at: www.cga.ct.gov/ph/medicaid.

[35] The increase may be due almost entirely to billing for children in fee-for-service Medicaid where claims for same-day services had been denied. According to Department staff, the managed care plans and PIHPs had been accepting and paying on claims for developmental screening that occurred on the same day as a well-child visit.