



How is the HUSKY Program Performing?

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The public health implications of the HUSKY program's performance in providing health care are wide reaching, since HUSKY is responsible for providing health care for about 236,000 Connecticut children and youth (one in four), as well as approximately 108,000 parents and pregnant women.¹

The implications for fiscal accountability are also important. In HUSKY's managed care system, the state pays HUSKY health plans a monthly fee for each enrolled member and requires the plans to provide services required by federal law, including regular preventive care. The state makes these payments whether or not the member receives any services; when required care is not provided, the plans are not required to reimburse the state.

To help ensure that tax dollars are being spent wisely and to help meet accountability standards, Connecticut Voices for Children monitors the health care services that children enrolled in HUSKY A (Medicaid managed care) are receiving. Under a state appropriation and a contract with the Hartford Foundation for Public Giving, this annual performance monitoring project examines encounter data for children and youth who are continuously enrolled in HUSKY A for a year. (Health care utilization data for children in HUSKY B are not available.) This brief highlights several of the most recent findings from 2006 and 2007. More detailed reports are available on the Connecticut Voices Web site at www.ctkidslink.org.²

Well-child care

All children need high quality care to support healthy growth and optimal development, to identify health problems early, and to reduce the need for emergency care or more costly health care services later on. Pediatric care guidelines established for Medicaid

under federal law call for regular preventive well-child exams.³ In 2007:

- Just 54 percent of children ages 2 to 19 received well-child care, down from 65% the previous year. Young children 2-5 were most likely to have had care. Problems with data quality may account for at least part of the decrease.
- Nearly 16,000 children (11% of those enrolled for an entire year) *did not get any health care at all*. Children without care were more likely to be older adolescents, male, or African-American.

Emergency care

Research suggests that publicly insured children are more likely to use emergency care services than uninsured or privately insured children. In 2007:

- Over one-third of children (34%) were seen for emergency care, down from 38% the previous year. However, problems with data quality may account for at least part of the decrease, as the rate for three managed care plans without data problems was 38%. Children under 6 and Hispanic children were most at risk for emergency care.
- The leading reasons for emergency visits were respiratory conditions for children under 6 and injuries for older children and youth.
- More than one in four emergency visits was for treatment of a condition that can often be managed or avoided with primary care.
- Overall, just over 3% of children had emergency care for dental conditions.

Dental care

Tooth decay is the most common chronic disease of childhood. Low-income children have more dental problems and are more likely to go untreated. In 2007:

- Just 49% of children ages 3 to 19 had preventive dental care, an increase from the previous year. Children who were school-aged (6 to 11), Hispanic children, or residents of Hartford were most likely to have had care.

Asthma and related care

Asthma is among the most common childhood illnesses and disproportionately affects children in low-income families. For children who need emergency or hospital care, follow-up outpatient care is important in reducing the likelihood of future hospital visits. In 2006:

- Fewer than one in four children who had emergency care for asthma received follow-up care within two weeks of the visit, as recommended in treatment guidelines. Just 52% of those who were hospitalized for treatment of asthma had timely follow-up care.

Prenatal care

The importance of the Medicaid program for improving maternal and infant health outcomes cannot be overstated. In 2006:

- One in three Connecticut babies (33%) were born to mothers covered by the HUSKY Program (HUSKY A or B) and Medicaid fee-for-service (FFS).
- Fewer women with HUSKY Program coverage began prenatal care in the first trimester (75% v. 90% of other mothers).
- Mothers in the HUSKY Program were less likely to have adequate care (i.e., care that began early, followed by at least 80% of recommended visits) than other mothers (73% vs. 83% of other mothers).

Low birthweight and preterm births

Babies born at a low birthweight or preterm (“premature”) are more likely to suffer illness, developmental problems, or death. In 2006:

- Babies born to mothers with HUSKY Program coverage were significantly more likely to be low birthweight (9.4% vs. 7.4% for babies born to other mothers) or preterm (10.5% vs. 9.3% for babies born to other mothers).

Smoking during pregnancy

In addition to all the other health risks, women who smoke during pregnancy are at risk for pregnancy

complications, preterm birth, low birthweight infants, stillbirth, and infant death. In 2006:

- Fourteen percent of mothers with HUSKY coverage smoked during pregnancy, compared with just over 2% of other mothers who gave birth. The percentage of HUSKY A mothers who smoked has declined from 19% in 2000, when this monitoring began.
- Among mothers in the HUSKY Program, the low birthweight rate for mothers who smoked (13.7%) was over one-third higher than the rate for non-smoking mothers (8.7%). The preterm birth rate for HUSKY mothers who smoked (13.5%) was also higher than the rate for non-smokers in HUSKY A (10.0%).
- In 2006, Medicaid programs in 41 states and the District of Columbia covered at least some smoking cessation services (e.g., counseling, medications) for all Medicaid recipients. *Connecticut does not.*

Conclusion

Preventive care guidelines established under federal Medicaid law and codified in Connecticut are specially designed to meet the needs of children in low-income families who are disproportionately at risk for common chronic conditions and special health care needs. Unfortunately, the health care actually provided to children enrolled in HUSKY falls short of these goals. These findings are troubling.

In the past two years, Connecticut has “carved-out” dental care, behavioral health care, and pharmacy benefits from the managed care program. It is time to do the same for medical care and ancillary services. Despite the disruption it might cause for many families, Connecticut would be wise to consider eliminating the role of the current HUSKY managed care plans and instead applying the lessons learned in working with administrative services organizations that do not bear financial risk when helping Connecticut families get the care they need. Ongoing performance monitoring is critically important for assessing the impact of program and policy changes.

¹ HUSKY A and B enrollment as of February 1, 2009

² Performance monitoring reports are available from Connecticut Voices for Children at www.ctkidslink.org/pub_issue_12.html.

³ Under Medicaid’s Early Periodic Screening Diagnostic & Treatment (EPSDT) program, states must provide children with timely comprehensive physical and oral health care and needed health services.