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Testimony Regarding
S.B.No. 139 An Act Concerning Independent Monitoring of the HUSKY Program

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Human Services Committee
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Senator Doyle, Representative Walker, and distinguished Members of the Human Services Committee:

I am here to testify on behalf of Connecticut Voices for Children, a non-profit organization that conducts research and policy analysis to advance public policies and programs that benefit the children, youth and families in Connecticut.

Connecticut Voices for Children supports this legislative proposal to put independent performance monitoring into statute. Since 1995, state-funded independent performance monitoring in the HUSKY Program has provided state policy makers, health program planners and advocates with information about how well the program and participating health plans serve children and families. Independent performance monitoring is valuable for tracking enrollment trends, evaluating the success of outreach efforts, describing utilization patterns, identifying access problems, informing policy development and program improvements, and evaluating the results. Independent performance monitoring fosters accountability and helps to ensure that taxpayer dollars for health care are wisely spent.

In recent years, the General Assembly's support for independent performance monitoring can be found in the budget for the Department of Social Services in a line item labeled "Children's Health Council" ($218,317 each year in FY10-11). (The history of independent performance monitoring is described in the testimony that follows.) However, in FY10, the Rell administration has chosen to ignore this direction from the legislature and has failed to contract for independent performance monitoring. Absent direction from the General Assembly, there is no compelling reason for the Department of Social Services to make any of its data available to any entity besides its own contractors. We recommend that the General Assembly clarify the intended purpose for this funding and its ongoing commitment to independent performance monitoring in the HUSKY Program.

We also recommend the following minor changes to the bill as it was proposed:

- **Delete "Each…" in Sec. 1(a)**: Unless the appropriation for this function is significantly increased, it makes little sense to split the appropriation (currently $218,317 each year) between several monitoring entities, as is implied with the use of the word "each" in this sentence notwithstanding the use of "a" in other references to the non-profit organization with which the state would contract.

- **Reword "…shall collaborate with…" in Sec. 1(b):** Assuming that the legislative intent is to support independent performance monitoring in the HUSKY Program, we suggest substituting the following: "…shall contract with the Department of Social Services Medical Care Administration Division to obtain data used to monitor the HUSKY Plan and report…." This wording makes it clear that the non-profit organization, not the Department of Social Services, monitors the HUSKY Program and that there shall be a contractual basis for exchange of the data needed for the monitoring.

Finally, we are supporting ongoing independent performance monitoring and would welcome an opportunity to vie for this role in ensuring accountability the HUSKY Program.

The testimony that follows describes the history of independent performance monitoring in the HUSKY Program and explains why it is important to have access to data that help to ensure accountability in the program, whether it is a managed care or fee-for-service program in the future.

Background on Independent Monitoring in the HUSKY Program

In 1995, when the Medicaid program for children and families changed from traditional fee-for-service to statewide managed care with mandatory enrollment, the Connecticut General Assembly established a system of oversight and provided for independent tracking of health services and monitoring of program and health plan performance. This work built on lessons learned from Hartford HealthTrack (1993-1995), a community-based public-private partnership between the Department of Social Services and the Hartford Foundation for Public Giving that effectively increased access to care for Hartford children in Medicaid.[1] For past 15 years, the Hartford Foundation for Public Giving has been the legislature's trusted partner in this effort, beginning with its sponsorship of the Children's Health Council (1995-2003) and most recently as the fiscal administrator for independent performance monitoring, under a contract with the Department of Social Services and a grant to Connecticut Voices for Children (2004-2009).

HUSKY Program performance monitoring is based mainly on analyses of administrative data. Under the performance monitoring contract that is negotiated with the Department of Social Services, Connecticut Voices obtains HUSKY A enrollment and encounter (claims) data and HUSKY B enrollment data from the Department of Social Services and uses the data to study enrollment and utilization trends.[2, 3] Connecticut Voices reports annually on well-child care and developmental screening, dental care and sealants, emergency care, and asthma prevalence and the quality of asthma care for children in HUSKY A. In addition, Connecticut Voices obtains birth data from the Department of Public Health and links these data to HUSKY enrollment data to identify and report on births to mothers with public coverage. In recent years, Connecticut Voices has issued special reports on infant health and health care, interpregnancy interval and other aspects of

maternal health, racial/ethnic health care disparities, and adult health care in the HUSKY Program. Last year, Connecticut Voices reported on trends in new enrollment and health care for new enrollees in the HUSKY Program, based on analyses of a longitudinal enrollment database created especially for performance monitoring. Results are reported regularly to the Department and the Medicaid Managed Care Council, disseminated via electronic listserv to over 2,500 interested individuals and organizations, and posted on Connecticut Voices' web site (www.ctkidslink.org).

Connecticut Voices staff also monitors HUSKY Program developments and gathers information that can be used to inform performance monitoring. Staff relies on the deliberations of various oversight councils, testimony at public hearings, and meetings with community-based outreach providers to get a picture of how policy affects program implementation. Regular meetings with HUSKY Infoline staff shed light on how the program actually serves families seeking care for their children. Requests for data and technical assistance from state and local health agencies, special commissions, foundations and advocates enables individuals and entities charged with health planning and results-based accountability to obtain the information they need.

Funding

The Connecticut General Assembly appropriates funding for independent performance monitoring in the budget for the Department of Social Services. In FY10-11, $218,317 per year was appropriated for this work (unchanged from FY07-9) in a line item labeled "Children's Health Council," a very specific reference to the historical contractual relationship between the Department of Social Services and the Hartford Foundation for Public Giving. [4] The Department of Social Services claims federal matching funds to reimburse the state for 62 cents of every dollar spent on independent performance monitoring. On occasion, private foundations have funded special projects that are approved by the Department and consistent with the use of Medicaid data for program administration. At the request of the Department of Social Services, the contract was expanded in FY09 to include reporting on health in early childhood for results-based accountability.

Independent performance monitoring in the HUSKY Program has been seriously disrupted during the current state budget crisis. In the absence of a budget agreement and in the face of the Governor's opposition to funding the work, the FY07-09 contract for performance monitoring lapsed June 30. Even though funding was included in the FY10-11 budget that passed August 31, the Rell administration has been unwilling to contract for independent performance monitoring in FY10. Recently however, the Governor apparently dropped her opposition to the function and spending in FY11 since the funding was included in her mid-term adjustments.

How Independent Performance Monitoring Informs Policy Development

The best policy development is data-driven, that is, informed by what is actually happening in a program or as a result of program or policy change. Over the years, independent performance monitoring has contributed to improved access to care for thousands of children and families. Regular reporting on preventive care (well-child and dental) and emergency care shed light on program trends and factors, such as health plan, age, gender, and race/ethnicity that are associated with primary care utilization and avoidable emergency care. Annual reporting on births to mothers in the HUSKY Program and Medicaid has drawn attention to the very significant role this program plays in improving maternal health and birth outcomes in Connecticut. Maternal smoking rates, for

example, are about five time higher for mothers with Medicaid coverage, indicating a need for treatment for tobacco dependence; however, Connecticut is one of just seven states that do not cover this essential service in its Medicaid program. Annual reporting on asthma prevalence in the HUSKY Program has been incorporated into the state's asthma surveillance report. Recently, analyses of asthma care data for children in the HUSKY Program revealed stark differences in emergency care management for children in New Haven, heretofore unreported by the Department of Public Health. Last year, the Early Childhood Education Cabinet relied on independent analyses of HUSKY Program data for development of a baseline against which to measure community-level improvements in health care for very young children (results-based accountability). Recent reports on enrollment dynamics have shown that while outreach is largely successful, keeping children and parents enrolled in the program is a significant and long-standing problem.

Policy development is a long and often complex process, so it is difficult to quantify "savings" that are directly attributable to independent performance monitoring. What is clear, however, is that independent performance monitoring fosters data-driven policy development and accountability by identifying program-wide and managed care plan-specific problems with access to care and utilization n the HUSKY Program. The following examples illustrate how independent HUSKY Program performance monitoring has produced data for policy development and program evaluation:

- **Evaluation of HUSKY Program outreach:** Connecticut Voices recently reported that HUSKY Program enrollment increased by about 11,000 children and adults between January 2006 and December 2007; however, in that same 24-month period, the number of new enrollees (those who had not been enrolled at any time in the previous 12 months) *exceeded 141,000*.[5] This finding shows that eligibility expansions and state-funded outreach have been very successful. It also indicates that outreach and administrative changes are urgently needed to *keep eligible children enrolled.*

- **Health care for children and adults newly enrolled in the HUSKY Program:** Connecticut Voices recently reported that over 60 percent of children and adults had an office visit within the first six months after enrolling in HUSKY A.[6] Children, especially young children under 2, were more likely than teens and adults to have had well-child care. School-aged children were more likely than younger children and adults to have had dental care. Nearly 30 percent had emergency care within the first six months after enrolling. The findings indicate that access to care in HUSKY A is better than that suggested by the results of the "mystery shopper" study, commissioned by the Department and conducted during the same time period.[7]

- **Effect of application simplification on HUSKY Program enrollment:** Connecticut Voices uses enrollment data to demonstrate the effects of policy changes on HUSKY Program enrollment.[8] Recently, Connecticut Voices studied the effect of application simplification on enrollment trends.[9] In an effort to reduce spending in the HUSKY Program, the Connecticut General Assembly changed the application requirements for children in the HUSKY Program, effective July 1, 2005, so that families would no longer be permitted to "self-declare" income as they had since 2001.[10] In HUSKY B, the effects of this single program change that year were evident in the enrollment trends: after continued enrollment growth from 1998 to 2005, HUSKY B enrollment declined steadily until self-declaration of income was restored one year later. However, after another year, enrollment was still about ten percent less than what it

would have been had the policy change not occurred. This finding is evidence that administrative changes can have profound effects on program uptake.

- **Dental care for Hartford children in HUSKY A:** Children in the HUSKY Program are entitled to preventive dental care (2 visits per year) and treatment when needed. In 2006, less than half of children 3 to 19 who had coverage for the entire year received any preventive dental care.[11] Since performance monitoring began, dental care utilization has improved very little. Each year, however, the data show that school-aged children 5 to 12 in Hartford are far more likely than other children in HUSKY A to receive preventive care and treatment. This finding is solid evidence of the effectiveness of providing services through school-based dental clinics in the elementary and middle schools in Hartford.

- **Emergency care for non-emergency conditions:** Connecticut Voices reports annually on emergency care for children in HUSKY A. In 2006, 38 percent of children had emergency care. [12] One in four emergency visits was for treatment of a condition that might have been prevented or treated in a primary care setting. The leading reason for these visits was for treatment of severe ear, nose and throat infections (60%), followed by treatment for asthma (13%). Very young children were most likely to have had emergency care. Contrary to expectations, those who had well-child care were more likely than children without well-child care to have had emergency care. These findings have led to lively discussion among members of the Medicaid Managed Care Council and have prompted examination of managed care plan practices for ensuring communication between emergency departments and primary care providers.

- **Developmental screening for children in HUSKY A:** Connecticut Voices reports annually on well-child care for children in HUSKY A.[13] Recently, that reporting has been expanded to include data on developmental screening that was performed and billed by pediatric care providers. In 2006, just two percent of children under 6 who were enrolled for the entire year had an encounter record for developmental testing (limited or extended). This finding is important information for the design, implementation and evaluation of pay-for-performance and other efforts to improve the quality of health care for young children.

- **Care for children with asthma:** Connecticut Voices uses HUSKY A encounter data to identify children who received care for a diagnosis of asthma and to describe patterns of care.[14] In 2006, about 20 percent of children received care or a prescription for medication used to treat asthma. About 10 percent of the children with asthma had emergency visits and about two percent were hospitalized. Fewer than one in four who had emergency care for asthma had a follow-up visit within the next two weeks. Just over half of children who were hospitalized for asthma had a follow-up visit within two weeks of discharge. The follow-up rates varied by managed care plan. Use of preferred medications for treatment of persistent asthma also varied by managed care plan. The results led at least one plan to invest more resources into managing asthma care. Each year since 2002, the Department of Public Health has included these data on children in HUSKY A as part of its statewide surveillance reporting.[15] Recently, Connecticut Voices reported that among children with asthma, those living in New Haven are far more likely to have had emergency care (28.7%, compared with 15.1% overall) and far more likely to be hospitalized (9.6%, compared to 2.6% overall).

- **Births to mothers with HUSKY Program and Medicaid coverage:** The Medicaid program is vitally important for ensuring access to care for mothers and infants in Connecticut.[16] In 2006, one of every three babies in Connecticut was born to a mother with HUSKY Program or fee-for-service Medicaid coverage, up from 27 percent in 2000.[17] In Hartford, 76 percent of all births were covered by these public programs. Mothers with HUSKY Program and Medicaid coverage are more likely than other mothers to be teens, especially Hispanic teens, and more likely to be at risk for pregnancy complications such as anemia.

    - **Births to immigrant women:** Medicaid fee-for-service coverage includes emergency Medicaid for labor and delivery for women who would otherwise be income eligible for Medicaid but did not apply during pregnancy. Connecticut Voices reported that the percentage of mothers who were foreign-born (68% in 2006) is disproportionately high among those with Medicaid fee-for-service coverage, compared with mothers in the HUSKY Program (15%) and other mothers (23%).[18] This group includes an estimated 1,800 foreign-born women, many of whom are probably undocumented immigrants.
    - **Smoking during pregnancy:** Since monitoring by coverage type began in 2000, the smoking grate among mothers with HUSKY Program coverage has declined steadily, as it has statewide and nationwide. However, the rate remains *five to six times higher* than the rate for other mothers in Connecticut. Babies born to HUSKY Program mothers who smoked were more likely than babies born to non-smokers to be preterm or low birthweight. Connecticut one of just seven states that does not cover treatment for tobacco dependence in its Medicaid program. As a result of Connecticut Voices' reporting, legislation calling for coverage was enacted in 2003 but never funded.[19] Over time and as a result of the reporting, all four HUSKY managed care plans voluntarily covered treatment for tobacco dependence. In addition, the Tobacco Settlement Board cited data from Connecticut Voices when it set aside funding for smoking cessation efforts by community health centers.
    - **WIC and low birthweight:** Using 2000 birth-HUSKY A/Medicaid data linked by the Children's Health Council, the Department of Public Health reported that just 67 percent of women enrolled in Medicaid were also enrolled in WIC, the supplemental food program for women, infants and children.[20] The risk of giving birth to a low birthweight baby was significantly reduced for mothers in HUSKY A who were enrolled in WIC at least 12 weeks prior to the birth. The availability of linked birth-HUSKY A data permitted the Department of Public Health to demonstrate the effectiveness of an important program for improving maternal and infant health.

How Independent Performance Monitoring Differs from HEDIS Measurement

Independent performance monitoring in the HUSKY Program provides data about how the program and its contractors actually serve children and families, not just how managed care plans are performing relative to each other. Performance measures developed by the National Committee on Quality Assurance for its Healthcare Effectiveness and Data Information Set (HEDIS) and adopted for use by the Department of Social Services are designed to monitor managed care plans and do not provide the kind of public health information that legislators and policy makers need. For example, HEDIS measures are not reported by race/ethnicity or by residence so it is not possible to determine whether the program is differentially effective in some communities. HEDIS measures

would not have identified New Haven as a state-funded Easy Breathing community with high rates of emergency care and hospitalization for children with asthma. HEDIS measures for maternal health and birth outcomes do not include data on the entire pregnancy but only prenatal care that occurs after enrollment in managed care; do not include reporting on maternal risk factors for poor birth outcomes; do not include on cesarean delivery rates; and do not include on smoking during pregnancy. HEDIS measures do not include an estimate of or count of the percentage of enrollees who do not get any care at all, about 10% of children each year for whom Connecticut pays 12 months of capitation payments to the managed care plans charged with their care.

Independent performance monitoring provides a more public health approach to reporting and increasing our understanding of how the program actually serves families. Going forward, even if the managed care program is dismantled, it is important to maintain the reporting and accountability that has become a part of the managed care program.

Why Independent Performance Monitoring is Valuable to Policy Makers

The HUSKY Program is Connecticut's major policy tool for ensuring access to care for children and their families. One out of every four children in Connecticut depends on this coverage for access to care. One out of every three babies is born to Connecticut mothers with HUSKY Program or Medicaid coverage.

Health care coverage in the HUSKY Program costs about $800 million. Connecticut shares this cost with the federal government, which currently reimburses the state 62 cents for every dollar spent on HUSKY A and 65 cents for every dollar spent on HUSKY B.

Independent performance monitoring in the HUSKY Program supports data-driven decision-making and policy development that is based on understanding just how the program serves the health care needs of children and families. Independent performance monitoring in Connecticut by an organization without other ties to state government is practically unique nationwide. Very few other states permit any access to client level data even for the state health department or state university partners. Medicaid/CHIP state agencies typically focus their limited resources on tasks that are strictly necessary for program administration (contract management, provider oversight, rate setting, regulatory compliance, federal reporting requirements, etc.). Policy makers need more information than the Department might be include or able to generate given their responsibility for the financial and operational aspects of the program. In the absence of independent performance monitoring, the information available to policy makers will be limited to self-reports by the Department or its contractors (managed care plans, enrollment broker, external quality reviewer, actuaries).

Legislators and other policy makers also need information about how recent significant program changes have affected access to care and utilization. Ongoing performance monitoring is critically important for determining the impact of these major program changes on access to care and utilization. In the past two years, the HUSKY Program has undergone tremendous change, including:

- Effective January 1, 2008, managed care plans were no longer at risk for care; two of the four (Health Net and Wellcare/Preferred One) left the program several months later. Anthem and

Community Health Network of Connecticut (CHNCT) continued to administer program benefits for their enrollees. Some HUSKY Program enrollees opted for coverage in traditional fee-for-service Medicaid.

- Effective February 1, 2008, pharmacy benefits were "carved-out' of managed care and are now administered by the Department with new procedures for obtaining prescription medications.
- Provider fees increased for some medical services, as of January 1, 2008, and for children's dental care, effective April 1, 2008.
- Enrollment in the Charter Oak Health Insurance plan began August 1, 2008, providing coverage for adults who are not otherwise eligible for Medicaid, including uninsured parents of children in HUSKY B.
- Two new managed care plans (Aetna Better Health, AmeriChoice) began providing services July 1, 2008, joining CHNCT. Mandatory enrollment in managed care began in February 2009 once provider networks were determined to be adequate by the Department of Social Services.
- Dental care was "carved-out" of managed care, effective September 1, 2008, and is now paid on a non-risk basis and administered by an administrative services organization under contract with the Department of Social Services. Provider participation has increased significantly.
- Primary Care Case Management (PCCM), a managed care option that relies on and pays health care providers to coordinate care, is now available on a limited basis to HUSKY Program members who see pediatric and adult care providers in Willimantic, Waterbury, Hartford, and New Haven that have chosen to participate.
- State funding for HUSKY outreach effectively ended in May 2009.

Thanks to continuous support of independent performance monitoring since 1995, the Connecticut General Assembly has a multi-year managed care "baseline" against which to measure the effect of these many program changes. With continued funding, independent performance monitoring will continue to provide valuable information and data about HUSKY Program and managed care plan performance that can be used for policy development. During this time of tremendous change in the HUSKY Program, independent performance monitoring can help to promote program accountability, identify access problems, examine enrollment and utilization trends, and ensure data-driven policy development going forward.

The Bottom Line

Independent performance monitoring in the HUSKY Program supports data-driven decision-making and policy development that is based on understanding just how the program serves the health care needs of children and families. Now that the Governor herself as proposed continuing this funding in FY11, we urge the Connecticut General Assembly to take this additional step to ensure the ongoing availability of these data on how the HUSKY Program serves children and families whose health care is publicly financed.

[1] Hall CH, Lee MA, Solomon J. The Children's Health Council: a community foundation/state government partnership. Health Affairs 1999; 18(4): 167-171.

[2] Under contracts that were in effect until December 31, 2007, the Department of Social Services did not require participating managed care plans to submit HUSKY B encounter (claims) data.

[3] In 1998, the Connecticut General Assembly expanded children's health insurance coverage by creating the **H**ealthcare for **U**nin**S**ured **K**ids and **Y**outh (HUSKY) Program after enactment of the federal State Children's Health Insurance Program (CHIP) in 1997. **HUSKY A** is Medicaid managed care for children and parent or relative caregivers with family income less than 185 percent of the federal poverty level (FPL). Pregnant women with family income less than 250 percent FPL are eligible for HUSKY A coverage. The federal government reimburses Connecticut for 62 cents of every dollar spent on coverage in HUSKY A. There are currently over 364,000 children and parents enrolled in HUSKY A, including over 241,000 children and 123,000 adults. **HUSKY B** is a separate CHIP of managed care program for uninsured children under age 19 in families with income between 185 percent FPL and 300 percent FPL (subsidized coverage) and higher for children whose families pay the full cost of coverage. The federal government reimburses Connecticut 65 cents for every dollar spent on coverage in HUSKY B. There are currently over 15,500 children in HUSKY B.

[4] In previous years, the funding has appeared under "enhanced community services" or "HUSKY data and outreach." In past years, both the Hartford Foundation for Public Giving and Connecticut Voices have been named in back-of-the-budget language as responsible for HUSKY Program performance monitoring.

[5] Connecticut Voices for Children. Trends in new enrollment in the HUSKY Program: 2006-2007. New Haven, CT: Connecticut Voices, July 2008. Available at: www.ctkidslink.org.

[6] Connecticut Voices for Children. Health care for children and adults newly enrolled in HUSKY A. New Haven, CT: Connecticut Voices, August 2008. Available at: www.ctkidslink.org.

[7] Jeannero N, McGuire K. Mystery shopper project. Hartford, CT: Connecticut Department of Social Services, November 2006.

[8] Connecticut Voices for Children. Covering Connecticut's Children: how policy changes affect HUSKY Program enrollment. New Haven, CT: Connecticut Voices, November 2006. Available at www.ctkidslink.org.

[9] Unpublished data, available from Mary Alice Lee, PhD, Connecticut Voices for Children.

[10] The Department of Social Services verified income electronically or by following up with the family as needed.

[11] Connecticut Voices for Children. Preventive care for children in HUSKY A: 2006. New Haven, CT: Connecticut Voices, November 2007. Available at: www.ctkidslink.org.

[12] Connecticut Voices for Children. Emergency care for children in HUSKY A: 2006. New Haven, CT: Connecticut Voices, February 2008. Available at: www.ctkidslink.org.

[13] Connecticut Voices for Children. Preventive care for children in HUSKY A: 2006. New Haven, CT: Connecticut Voices, November 2007. Available at: www.ctkidslink.org.

[14] Connecticut Voices for Children. Asthma and asthma-related health care for children enrolled in HUSKY A: 2006. New Haven, CT: Connecticut Voices, April 2008. Available at: www.ctkidslink.org.

[15] Connecticut Department of Public Health. Asthma in Connecticut 2008: a surveillance report. Hartford, CT: Department of Public Health, August 2008. Available at: www.ct.gov/dph.

[16] Effective January 1, 2008, the income eligibility level for pregnant women was raised from 185% FPL to 250% FPL ($45,775 for a family of 3). For the purpose of determining eligibility, a pregnant woman is counted as two persons.

[17] Connecticut Voices for Children. Births to mothers with HUSKY Program and Medicaid coverage: 2006. New Haven, CT: Connecticut Voices, September 2008. Available at: www.ctkidslink.org.

[18] Connecticut Voices for Children. Ensuring health care coverage for all pregnant women and their babies. New Haven, CT: Connecticut Voices, February 2007. Available at: www.ctkidslink.org.

[19] Connecticut Voices for Children. Smoking cessation treatment needed for HUSKY members. New Haven, CT: Connecticut Voices, February 2008. Available at: www.ctkidslink.org.

[20] Stone CL. WIC participation and improved birth weight outcomes: Connecticut, 2000. Hartford, CT: Connecticut Department of Public Health, Hartford, CT, 2007. Available at: http://www.ct.gov/dph/lib/dph/family_health/wic_brief_final.pdf