CONNECTICUT VOICES FOR CHILDREN

Coverage Continuity in the HUSKY Program Increases Children's Preventive Medical and Dental Care Utilization

Mary Alice Lee, PhD, Kenneth Feder, and Sharon Langer, M.Ed., J.D.

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Key Findings

Health insurance is key for access to affordable, timely preventive care. Continuous health insurance coverage is important for building relationships between families and children's health care providers. This report examines how the length of time children are enrolled in Connecticut's HUSKY health insurance program affects access to preventive medical and dental care. Children who lose coverage for part of the year may have less opportunity to access preventive care than their peers enrolled a full twelve months. We find that as the number of months a child is enrolled in HUSKY increases, so does the likelihood that he or she will receive at least one medically recommended annual check-up (known as a "well-child" visit). A similar effect is seen for preventive dental care. In fact, children enrolled for 11 to 12 months are **more than 10 times more likely** to have well-child care or preventive dental care than children enrolled less than three months.

We recommend that the Department of Social Services and policy makers take the following steps to ensure ongoing coverage for eligible children:

- Adopt a policy guaranteeing all children who enroll in the HUSKY program at least 12 months of "continuous eligibility" in the HUSKY program, regardless of changes in family circumstances.
- Conduct "passive renewal" when re-determining eligibility for persons for whom there is no reason to believe eligibility status has changed.
- When estimating costs associated with continuous eligibility and passive renewal, take into account the additional administrative costs for reprocessing applications for eligible children who lose coverage and return to the Medicaid program.
- Commission a qualitative study of the health insurance status of persons who experience gaps in HUSKY coverage.

INTRODUCTION

Health insurance is key for access to affordable, timely preventive care. Continuous health insurance coverage is important for ongoing care and for building relationships between families and children's health care providers. This report examines the effect of coverage continuity in Connecticut's HUSKY A health insurance program (Medicaid for children and families) on children's utilization of recommended preventive physical and oral health care. In 2012, the HUSKY Program provided health insurance coverage to over 300,000 children, a number that has been steadily increasing since 1998 when the HUSKY Program began. For these children, HUSKY offers critical

access to preventive physical and oral healthcare. Unfortunately, children often "churn" in and out of the HUSKY program over the course of a year; in 2012, among children enrolled on January 1st, nearly one out of every seven (13.5%) lost or experienced a gap in coverage before the end of the year.[1] These gaps may jeopardize children's access to recommended preventive care.

METHODS

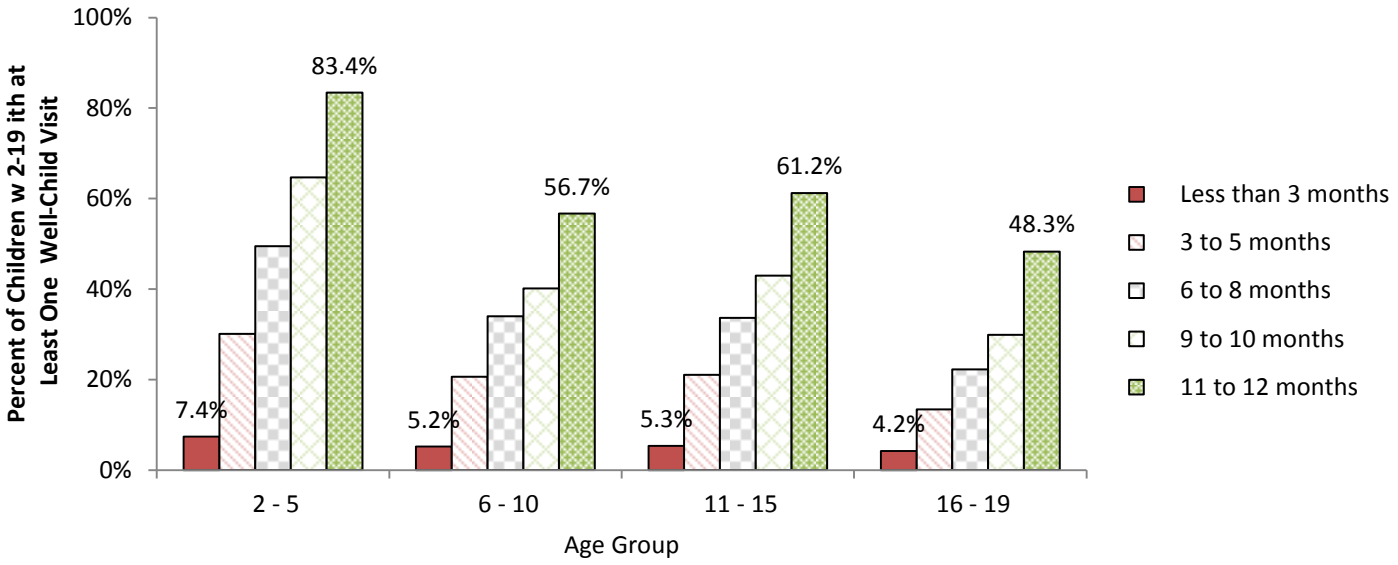
Using a retrospective cohort design, we described enrollment and children's utilization of well-child care and preventive dental care in the HUSKY Program in 2012.[2] The focus of this report is in on HUSKY A (Medicaid for children and families) because this part of the program serves the majority of children in the HUSKY Program (95% of all children who were enrolled on January 1, 2012).

Using HUSKY A enrollment data obtained from the Connecticut Department of Social Services, we identified the children who were ever enrolled in the HUSKY program between January 1 and December 31, 2012. We described enrollment in terms of number of months ever enrolled in that year (0 to 3 months, 4 to 5, 6 to 8, 9 to 10, and 11 to 12 months). These months may or may not have been consecutive. Using HUSKY A claims data compiled by the Connecticut Department of Social Services, we searched for records corresponding to preventive care for children in 2012. Claims were searched for selected procedure codes corresponding to health services indicative of a routine well-child visit and preventive dental care visits received by program participants.[3] Health services utilization was described by age group and by total number of months enrolled in 2012.[4] The results are reported in terms of unadjusted utilization rates, calculated by comparing the numbers of children with care to the numbers who were ever enrolled during the year 2012. Utilization rates are reported for well-child care and preventive dental care.[5]

RESULTS

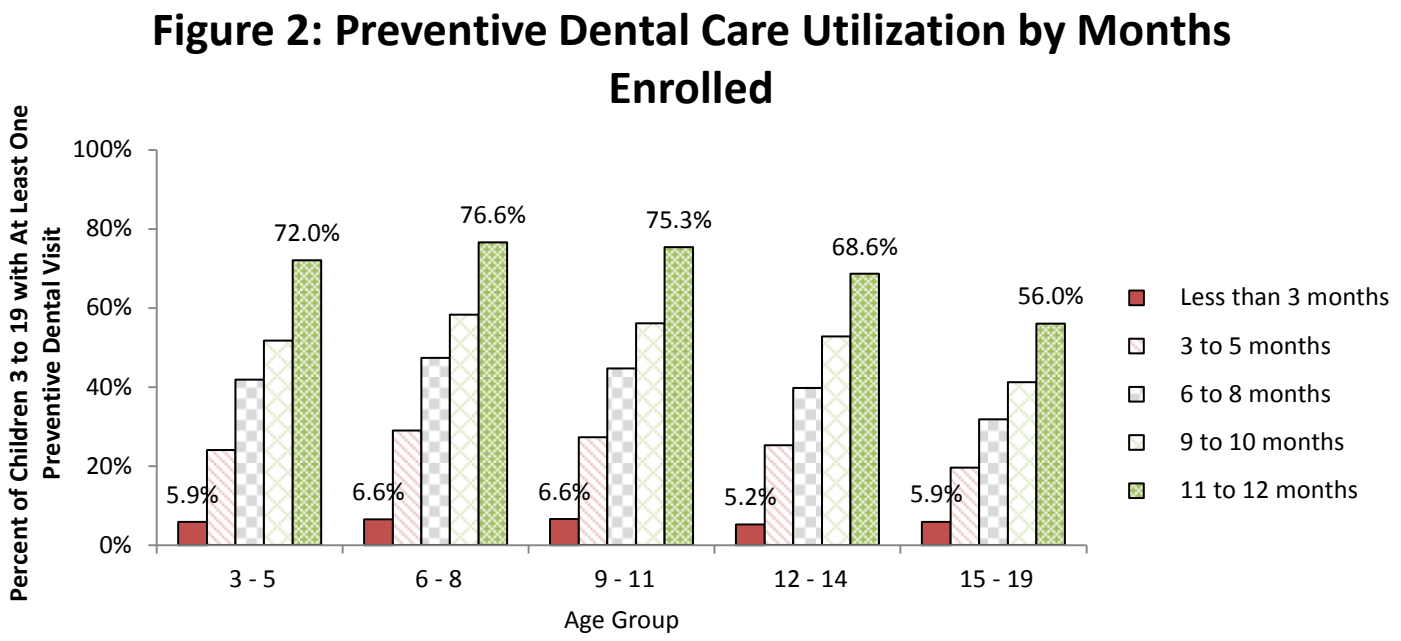
The longer children were enrolled, the greater the likelihood that they received at least one well-child visit. A child who was enrolled for 11 to 12 months was ***more than 10 times more likely*** to have a well-child visit than a child who was enrolled for 3 months or less (Figure 1).

Figure 1: Well-Child Care Utilization by Months Enrolled



Source: Connecticut Voices for Children's analysis of data from the Connecticut Department of Social Services.

A nearly identical effect was seen for preventive dental care: longer periods of enrollment corresponded to dramatically higher rates of preventive dental utilization (Figure 2).



Source: Connecticut Voices for Children's analysis of data from the Connecticut Department of Social Services.

Recommendations

National research shows that a lack of health insurance coverage can create barriers to primary medical care and preventive dental care for children.[6] The findings presented here show that the longer children are on HUSKY A, the more likely they are to receive recommended well-child and dental care from the HUSKY program. Gaps in or loss of coverage reduce access to preventive care. In order to ensure that children have optimal access to preventive medical and dental care, we recommend that:

Connecticut should adopt a policy guaranteeing that all children who enroll in the HUSKY program at least 12 months of "continuous eligibility" in the HUSKY program, regardless of changes in family circumstances that might otherwise make them ineligible for the balance of the year. One promising approach to stabilizing Medicaid and CHIP enrollment is adoption of a policy called "continuous eligibility:" granting 12 months' coverage to eligible individuals, even if they would otherwise lose eligibility due to changes in personal circumstances (e.g., income, family size).[7] Connecticut had continuous eligibility for children until the policy was eliminated for state budget reasons in May 2003. Any cost estimate for adoption of this policy change should take into account the administrative costs for re-processing applications for eligible children who temporarily lose coverage and return to the program.

Connecticut should conduct "passive renewal" when re-determining eligibility for persons for whom there is no reason to believe eligibility status has changed. Currently, DSS conducts an eligibility redetermination every 12 months. Families must sign and submit a renewal form indicating that there have been no changes to income or household status, and that they or their children are still eligible for Medicaid. Using passive renewal, DSS can automatically reenroll children without requiring paperwork from families, thus minimizing the risk that eligible children will lose coverage simply because of cumbersome administrative procedures and requirements.

Connecticut should take into account the additional administrative costs to the state for reprocessing applications for eligible children who lose coverage and return to the Medicaid program. Data from

neighboring states like Massachusetts show that administrative costs of enrollment can run as high as $200 per child.[8] Connecticut should determine if the churning of children on and off of Medicaid generates unnecessary administrative costs for the State and strains DSS staffing and call centers.

Connecticut's Department of Social Services (DSS) should commission a qualitative study of the health insurance status of persons who experience gaps in HUSKY coverage. It is possible that children who leave Medicaid mid-year are enrolling in other private or public health insurance coverage; however, many are likely going uninsured, especially if the family is unaware that coverage lapsed. In fact, a 2006 study found that a third of all uninsured children were enrolled in Medicaid the previous year,[9] and a 2003 study found that the majority of people who leave Medicaid immediately join the ranks of the uninsured.[10] This finding suggests that many of the children who were enrolled in HUSKY for very few months and did not receive medical or dental services *also* did not receive these services when they were not enrolled in HUSKY, and instead simply went without recommended preventive care. By interviewing children and families who exit and reenter the HUSKY program during the course of the year, DSS can determine the reasons these children left and reentered the HUSKY program, whether they were insured during the time they were not enrolled in HUSKY, and whether they utilized any care.

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[1] Mary Alice Lee & Amanda Learned, "Fewer Children Experience Gaps or Loss of Coverage in the HUSKY Program," Connecticut Voices for Children. January 2014. Available at http://www.ctvoices.org/sites/default/files/h14huskycoveragegaps20102012.pdf.

[2] As part of a larger state-funded project for independent performance monitoring, Connecticut Voices for Children obtains client-level data on children, parents, and pregnant women who are enrolled in Connecticut's HUSKY Program. These data are analyzed for reporting on key indicators of program performance, including enrollment trends, utilization of preventive care (well-child visits, developmental screening, dental care) and emergency care, and births to mothers with Medicaid coverage. Independent performance monitoring in the HUSKY Program has been state-funded since 1995 under a contract between the Department of Social Services and the Hartford Foundation for Public Giving acting as fiscal intermediary (contract #064HFP-HUO-04/13DSS1001ME for 7/1/13-6/30/15). With a grant from the Hartford Foundation, Connecticut Voices for Children monitors access to care and children's health service utilization. Under an agreement with Connecticut Voices, MAXIMUS, Inc. conducts data management and analyses. 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.

[3]Well-child care (EPSDT screening exams): Encounter records with CT-4 codes for preventive care (99381-5, 9938R, 9938T, 99382, 99391-5 ,9939R, 9939T, 99431, 9943R, 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 a well-child diagnosis (v20 series, v70, v70.0, v70.3-v70.90). For this study, an annual well-baby visit 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 and 2 weeks, then 2, 4, 6, 9, 12, 15, and 18 months of life. Preventive dental care: Encounter records with a HCFA Common Procedure Coding (HCPC) system code ranging from D1000 through D1999 or ADA codes 01000 – 01999.

[4] Consistent with other Connecticut Voices for Children reports, age groups for well-child care are 2-5, 6-10, 11-15, and 16-19. These groupings reflect the fact that before age 2, the number of recommended medical visits per year exceeds one, so the percentage of children with at least one preventive visit is not an appropriate measure of service utilization. Age groups for dental care are 3-5, 6-8, 9-11, 12-14, 15-19. These groupings reflect that utilization rates for children under age 3 are very low.

[5]The findings are subject to certain limitations associated with secondary analysis of administrative data and availability of data for this study: The encounter and claims datasets are checked systematically against historical data for total record volume and records per enrollee; however, we did not conduct any other more formal audit for completeness or accuracy. To the extent that the counts and rates reported herein might differ from counts and rates in other reports, the differences may be due to methods (i.e., continuously enrolled v. ever enrolled, calendar year v. federal fiscal year) and/or when or how the datasets were created by the Department for the respective analyses. It was not possible to determine which if any of the HUSKY enrollees in our sample had medical services that were covered by third party payers or delivered by providers who did not submit claims. Despite these limitations, the findings can provide state agency staff and

contractors, policy makers, providers, foundations, and health advocates with data for assessing the role of coverage continuity on children's utilization of medical and dental services in the HUSKY program.

[6]Newacheck et al., "Health Insurance and Access to Primary Care for Children," N Engl J Med 1998; 338:513-519. Available http://www.nejm.org/doi/full/10.1056/NEJM199802193380806.Susan Fisher-Owens et al., "An examination of racial ethnic disparities in children's oral health in the United States," *Journal of Public Health Dentistry*. 2013 Spring; 73(2):166-74. Abstract available at http://www.ncbi.nlm.nih.gov/pubmed/22970900. See also Carol Cristina Guarnizo-Herreno& George Wehby, "Explaining Racial/Ethnic Disparities in Children's Dental Health: A Decomposition Analysis," *American Journal of Public Health*. 2012 May; 102(5):859-66. Abstract available at http://www.ncbi.nlm.nih.gov/pubmed/22420801.

[7] See, Mary Alice Lee, Sharon Langer, and Dorothy Chen, "Continuous Eligibility: A Proven Strategy for Stabilizing Children's Coverage in the HUSKY Program," *Connecticut Voices for Children*. February 2014. Available at http://www.ctvoices.org/publications/continuous-eligibility-proven-strategy-stabilizing-childrens-coverage-husky-program.

[8] See, Robert Seifert, Garrett Kirk, and Margaret Oakes, "Enrollment and Disenrollment in MassHealth and Commonwealth Care," *Massachusetts Medicaid Policy Institute*. April 2010.

[9] See, Benjamin D. Sommers, "Why Millions of Children Eligible for Medicaid and SCHIP are Uninsured: Poor Retention vs. Poor Take-Up." *Health Affairs*, 26, no.5 (2007):w560-w567. Available at http://content.healthaffairs.org/content/26/5/w560.full.html?related-urls=yes&legid=healthaff;26/5/w560.

[10] Pamela Farley Short et al., "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem." *The Commonwealth Fund Task Force on the Future of Health Insurance*. November 2003. Available at http://www.allhealth.org/briefingmaterials/688Shortchurnchurnchurnhowinstabilityofhltinsuranceissuebrief-320.pdf.