

# Impact on Children's Health Care of HUSKY Program Change from Risk-Based Managed Care to Administered Fee-for-Service

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Presentation for  
Council on Medical Assistance Program Oversight  
October 9, 2015



# Overview of Program Changes

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- **1995-2011, Connecticut’s Medicaid program for children, parents and pregnant women was risk-based managed care**
  - Up to 11 managed care companies participated
  - MCOs paid per member per month for all health services
- **Some services were “carved out” of managed care to address concerns about access to care:**
  - Behavioral health services (2006)
  - Dental services (2008)
- **In 2012, HUSKY program was converted to an administered fee-for-service program for all Medicaid enrollees, including low income adults, elderly, and disabled beneficiaries**

# Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

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- Under federal Medicaid law, children are entitled to timely, comprehensive preventive care and all medically necessary services to detect, treat and address acute and chronic health conditions
- **Monitoring children's health services:**
  - DSS submits annual report to Centers for Medicare and Medicaid Services on preventive health care by age
  - Connecticut Voices monitors children's health services over time by age and other factors that affect access to care and utilization, e.g., gender, race/ethnicity, and major program/policy changes

# Purpose and Design of This Study

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- To describe the impact of program change on medical services for children by comparing utilization under administered fee-for-service (2012-2013) to utilization under risk-based managed care (2007-2011)
- To identify areas for continued monitoring and improvement

# Methods

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- **Identified continuously enrolled children in each one-year period (2007 – 2013)**
- **Searched for encounter records and claims corresponding to selected care:**
  - **Primary care** (well-child care, episodic visits)
  - **Emergency care** (all visits, visits for treatment of ambulatory care-sensitive conditions)

# Procedure Codes

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**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.

**Episodic primary care:** Encounter records with CPT-4 codes (99201-5, 99201-99205, 99211 - 99215, 99432-3), clinic codes (510, 514, 515, 516, 519, 3000Y), or UB-92 revenue codes (450, 456, 459), clinic codes (510, 514, 515, 516, 519, 3000Y, T1015), or UB-92 revenue codes (450, 456, 459) with any diagnosis other than well-child care.

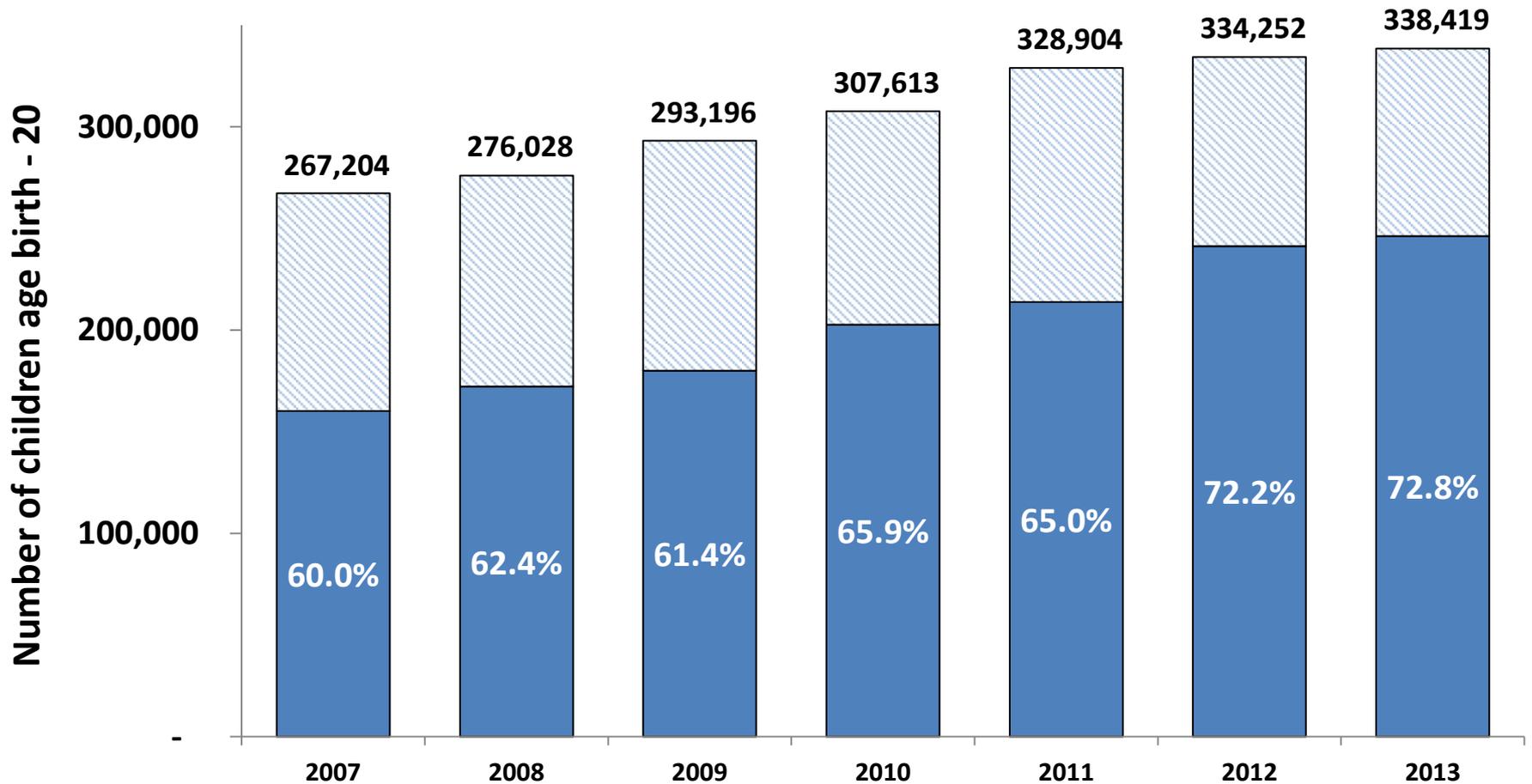
**Emergency care:** CPT-4 codes (99281, 99282, 00283, 99284, 99285), and IB-92 revenue codes (450, 456, 459).

**Ambulatory-care sensitive conditions:** 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).

# Results

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# Enrollment Increased Steadily

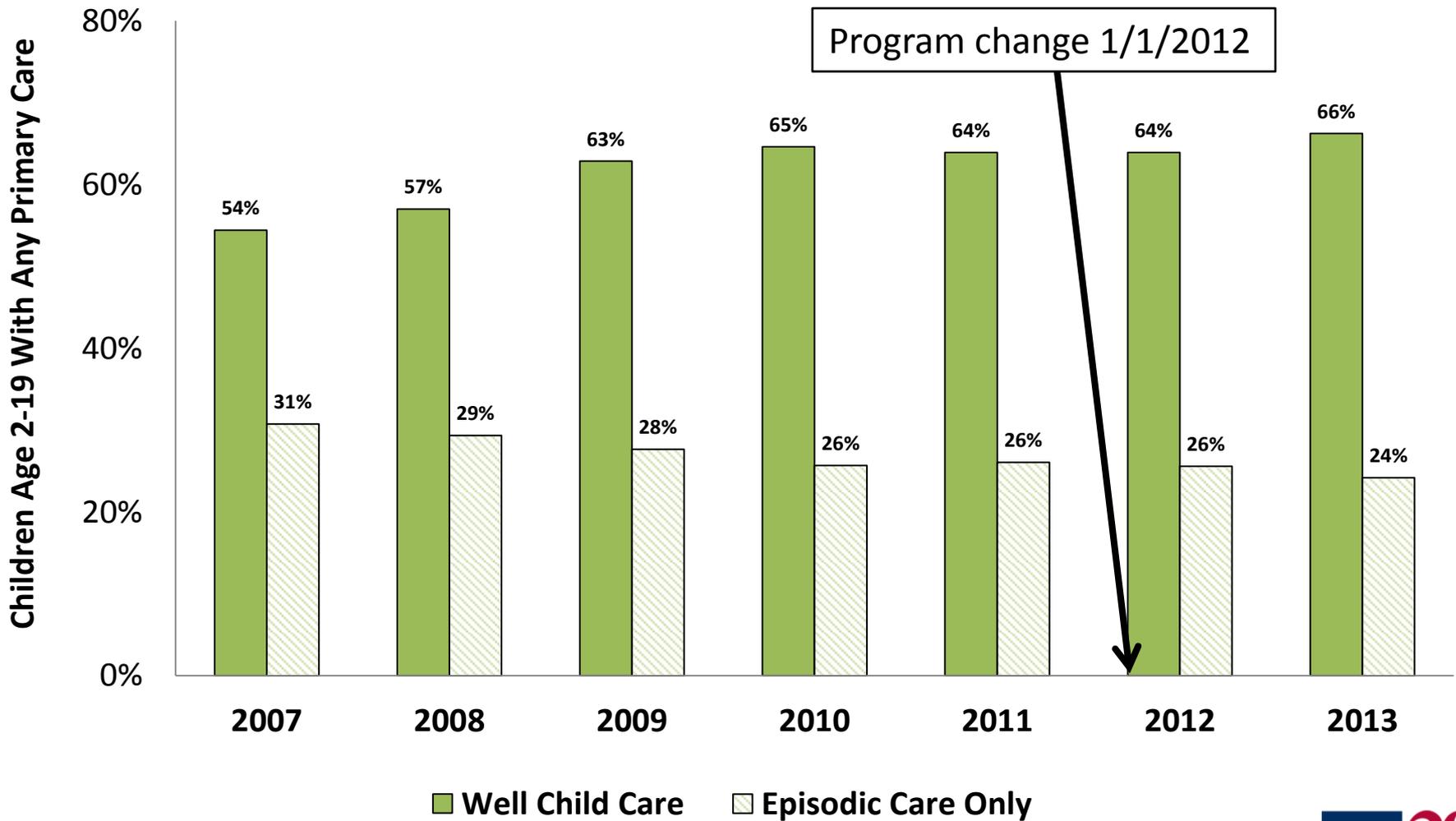


■ Enrolled 12 Months ■ Enrolled Less Than 12 Months

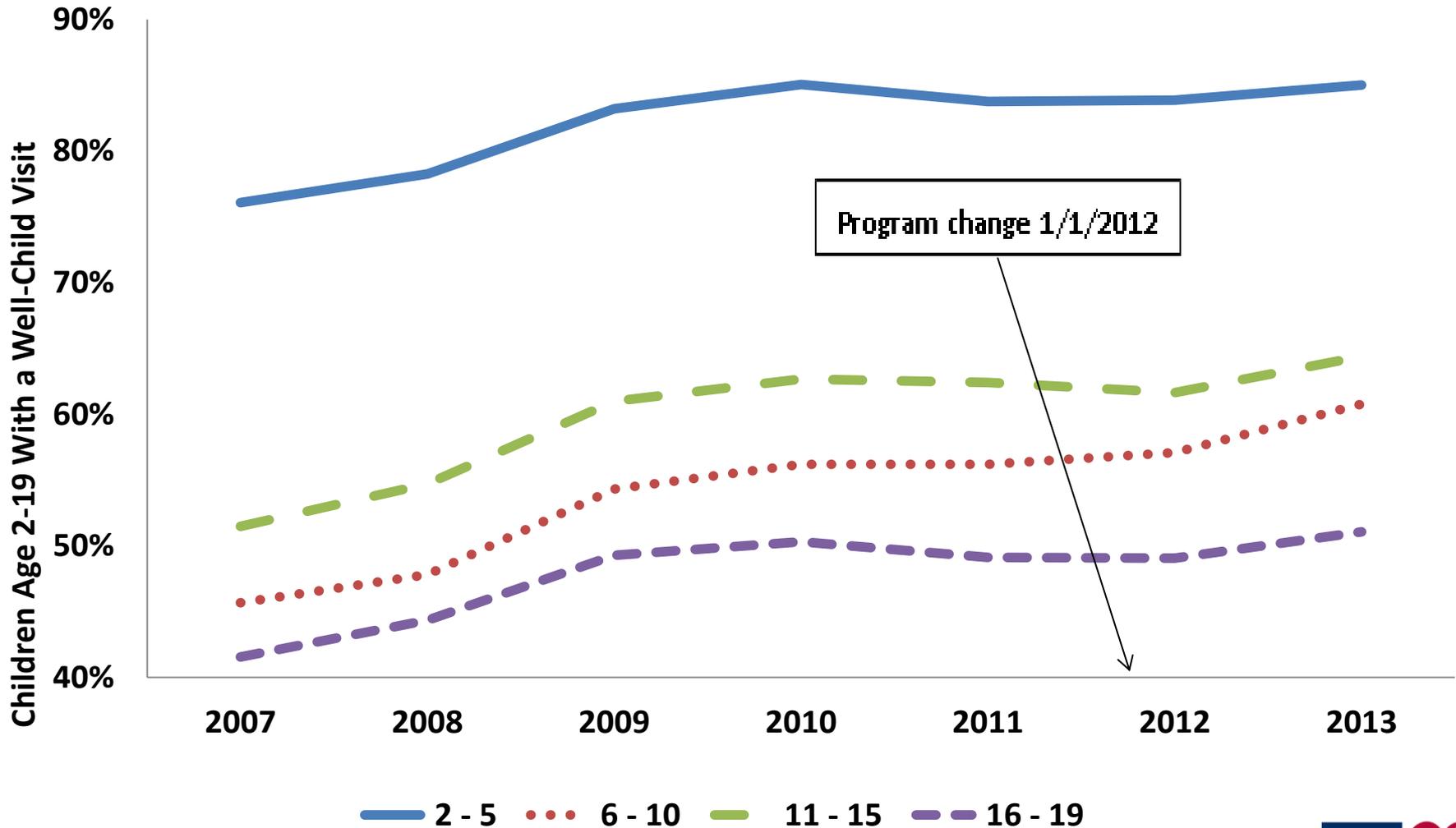
# Primary Care

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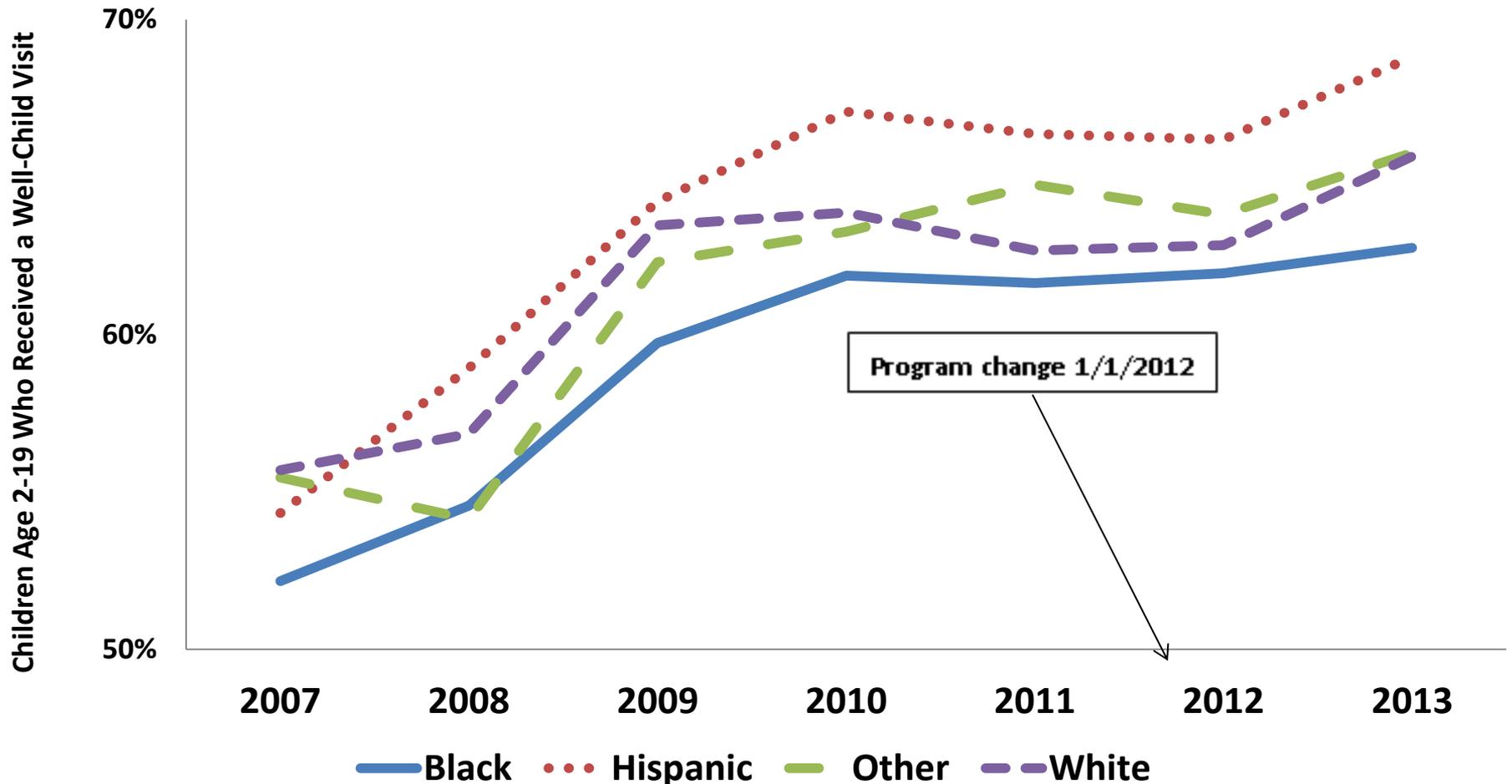
# Well-Child Care Increased Before the Program Change



# Well-Child Care Rate for Young School-Aged Children Increased



# Well-Child Care Rates for White and Hispanic Children Increased

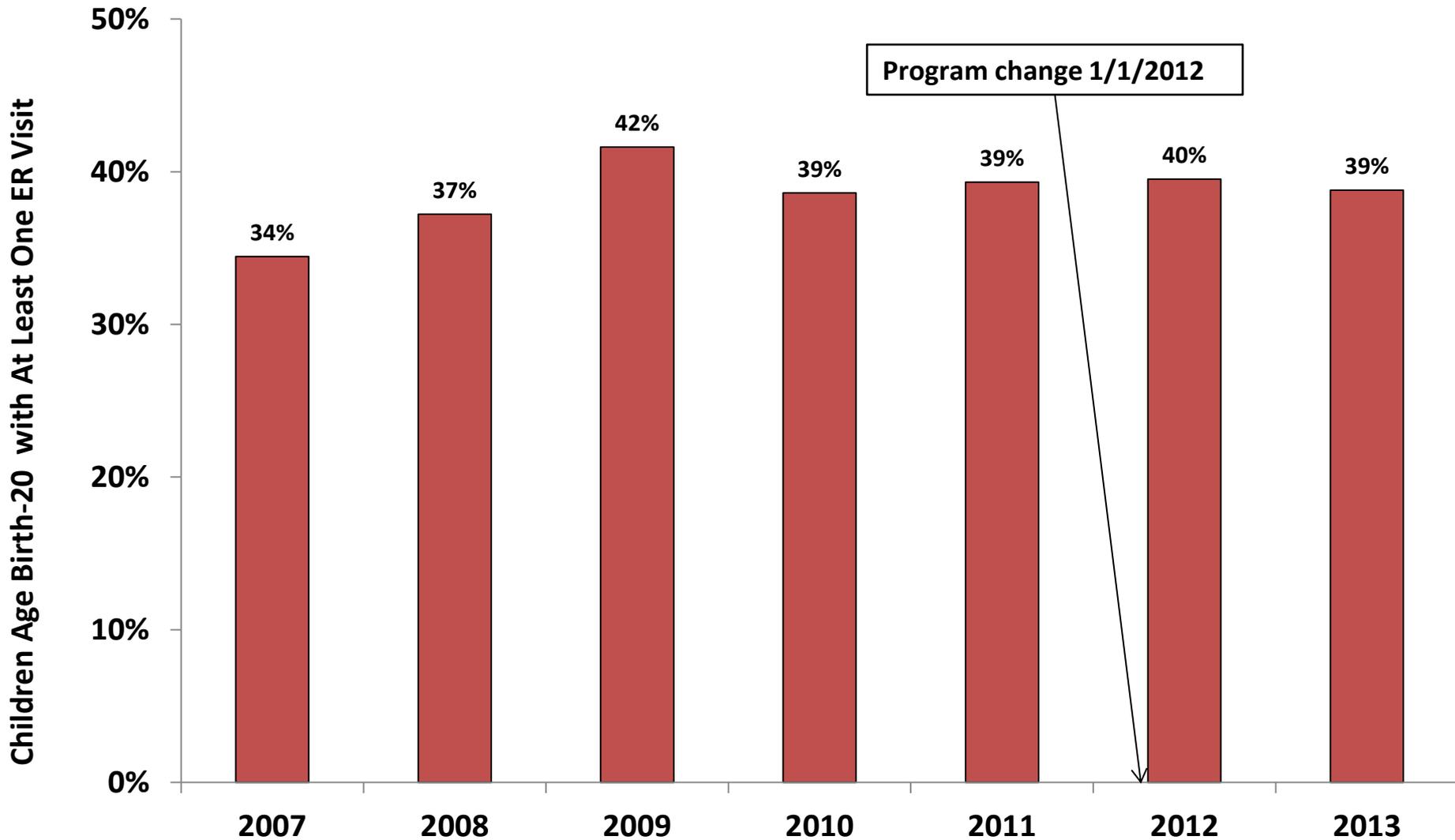


Note: Scale enlarged for viewing rate differences

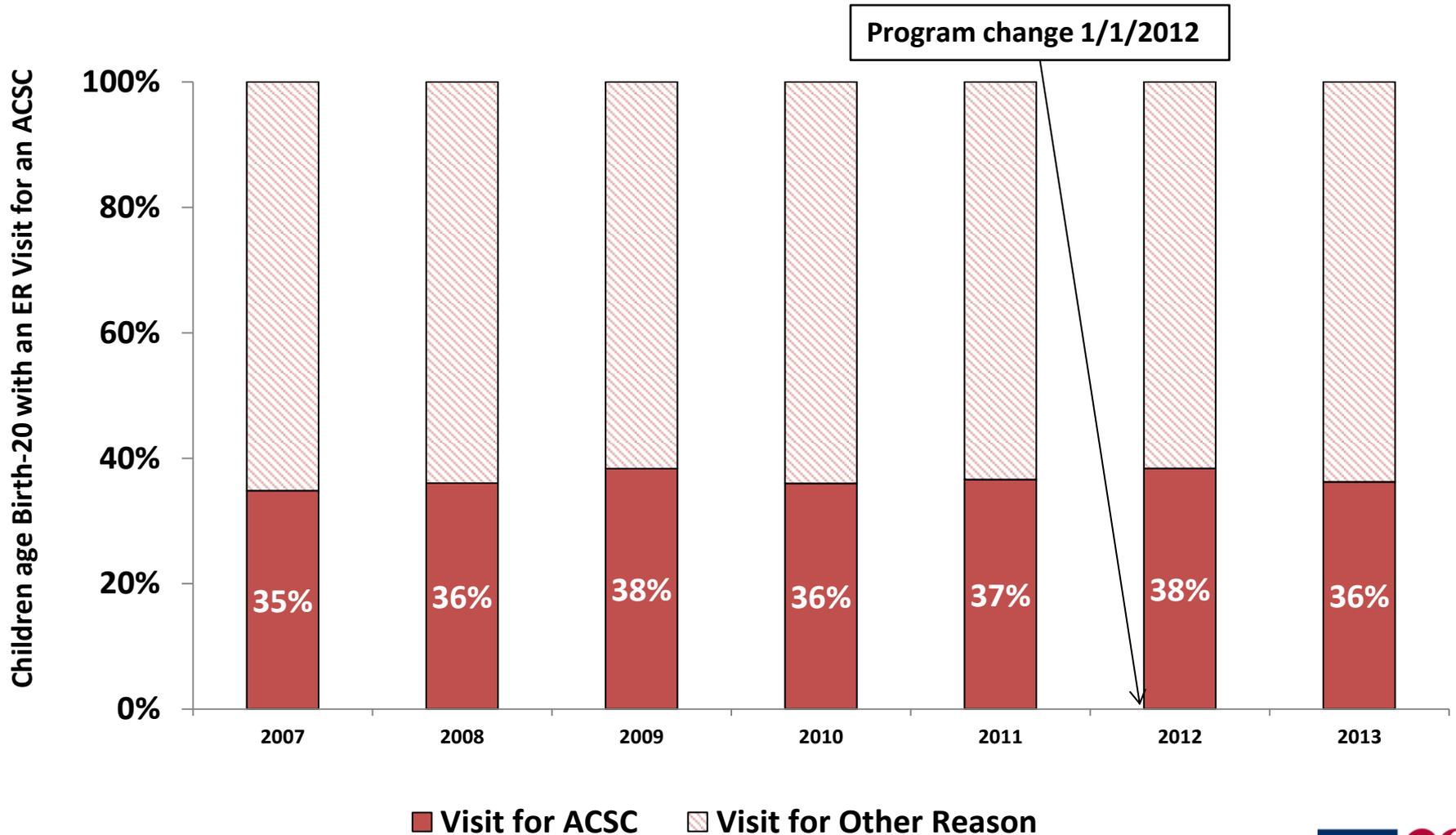
# Emergency Care

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# Emergency Care Rates Remained High

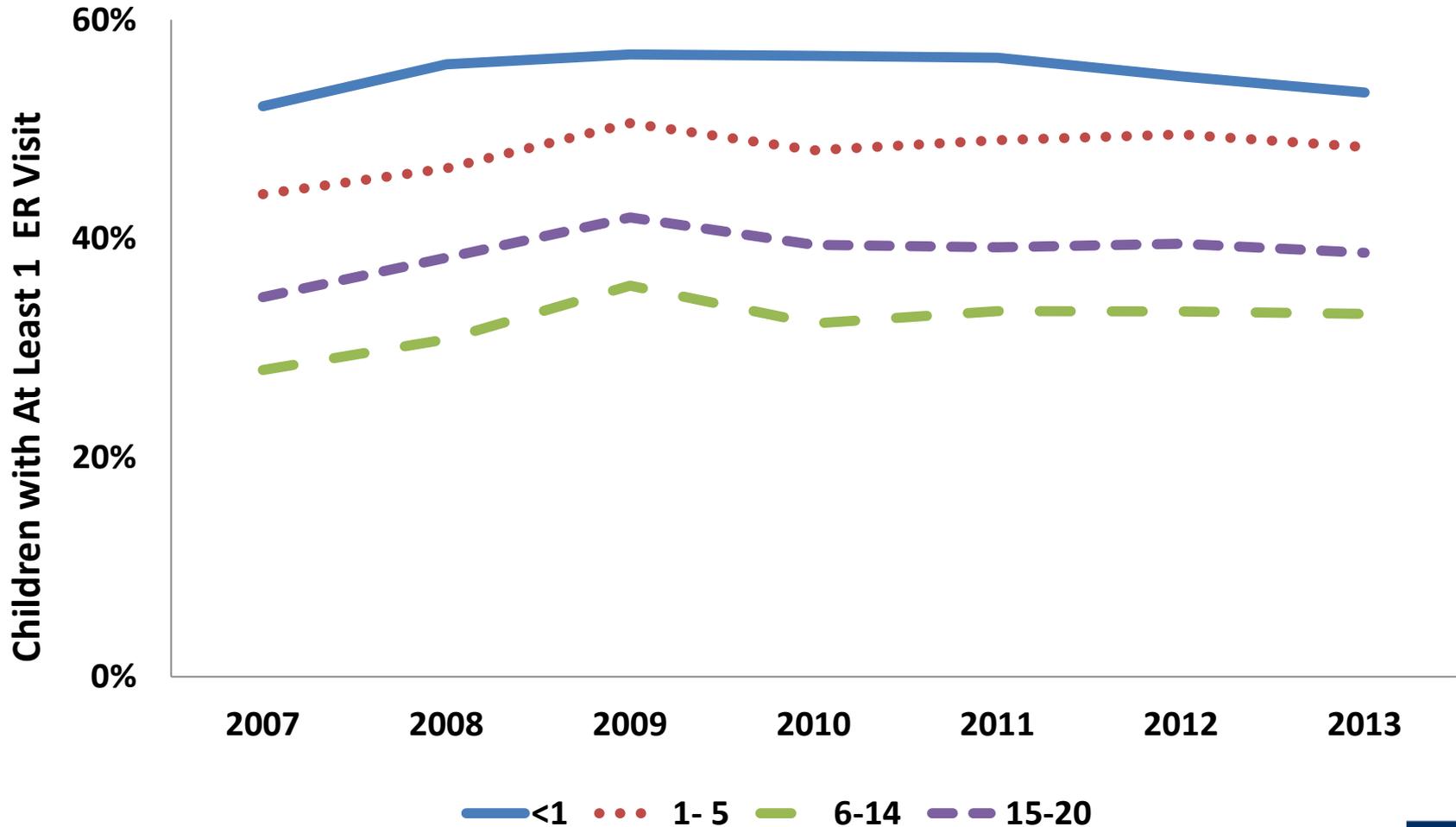


# Emergency Care Rate for ACSC\* Remained High

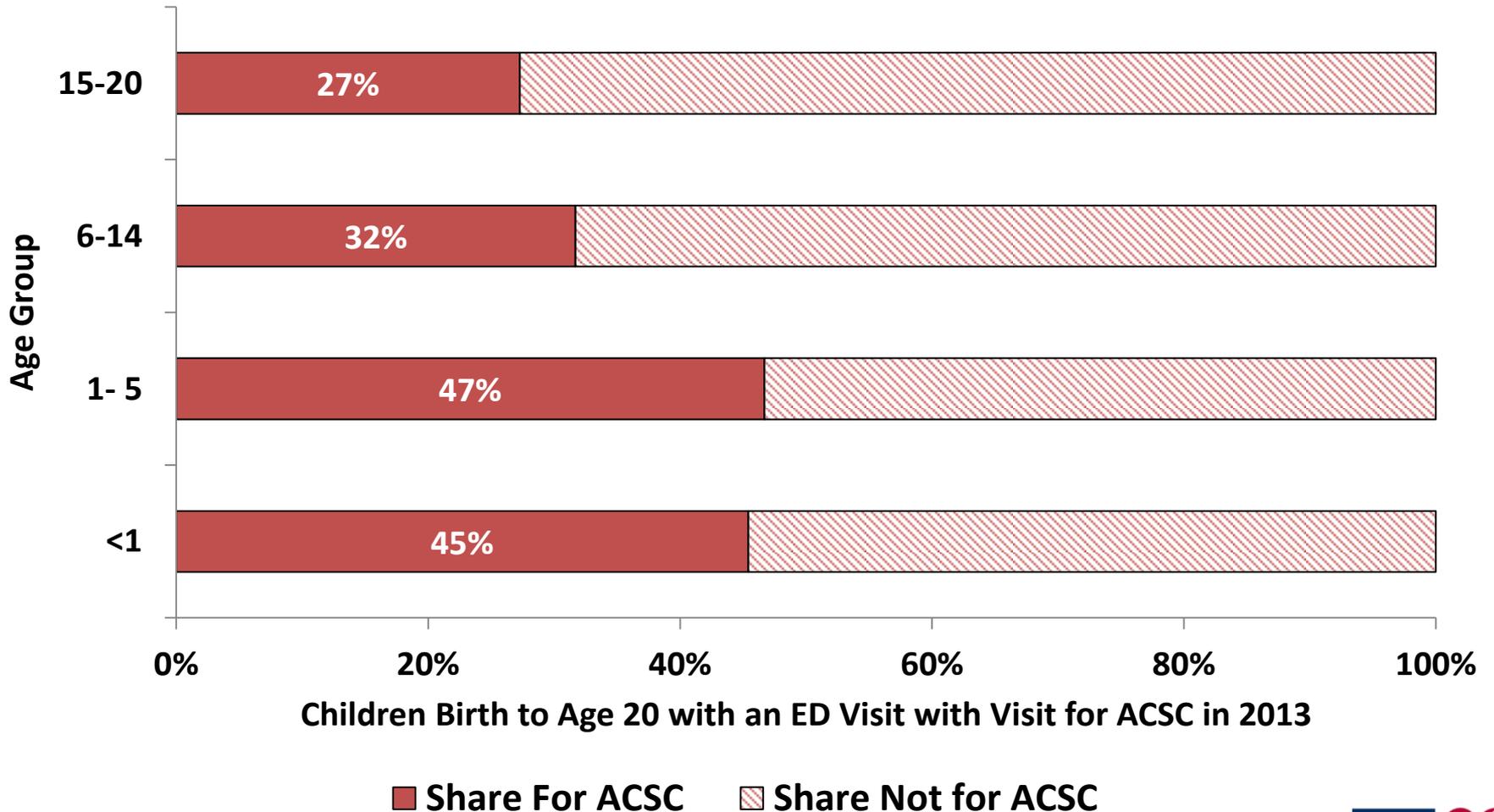


\*ACSC: ambulatory care-sensitive conditions

# Youngest Children Were Most Likely to Receive Emergency Care

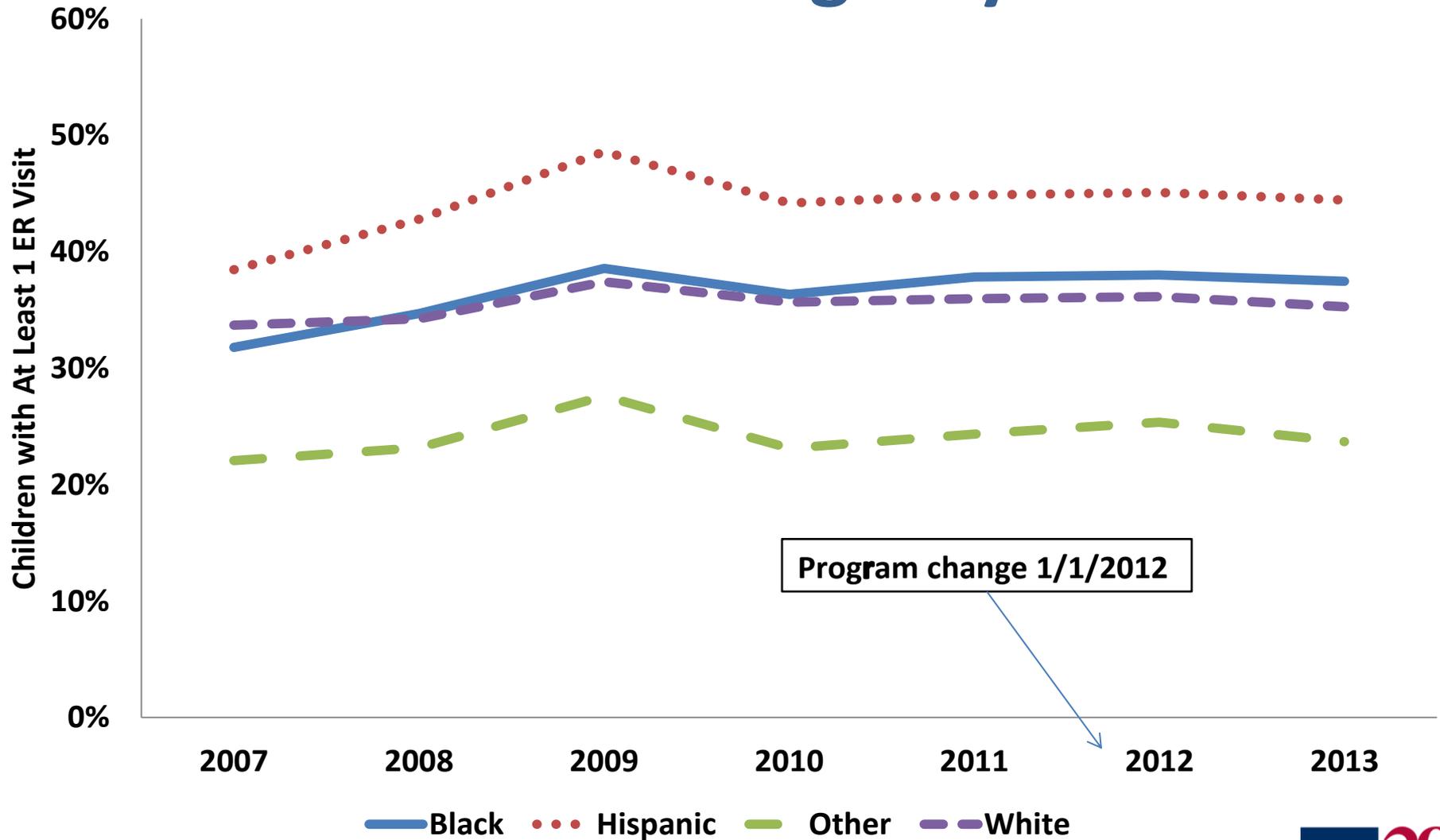


# Youngest Children Were Most Likely to Receive Emergency Care for ACSC\*

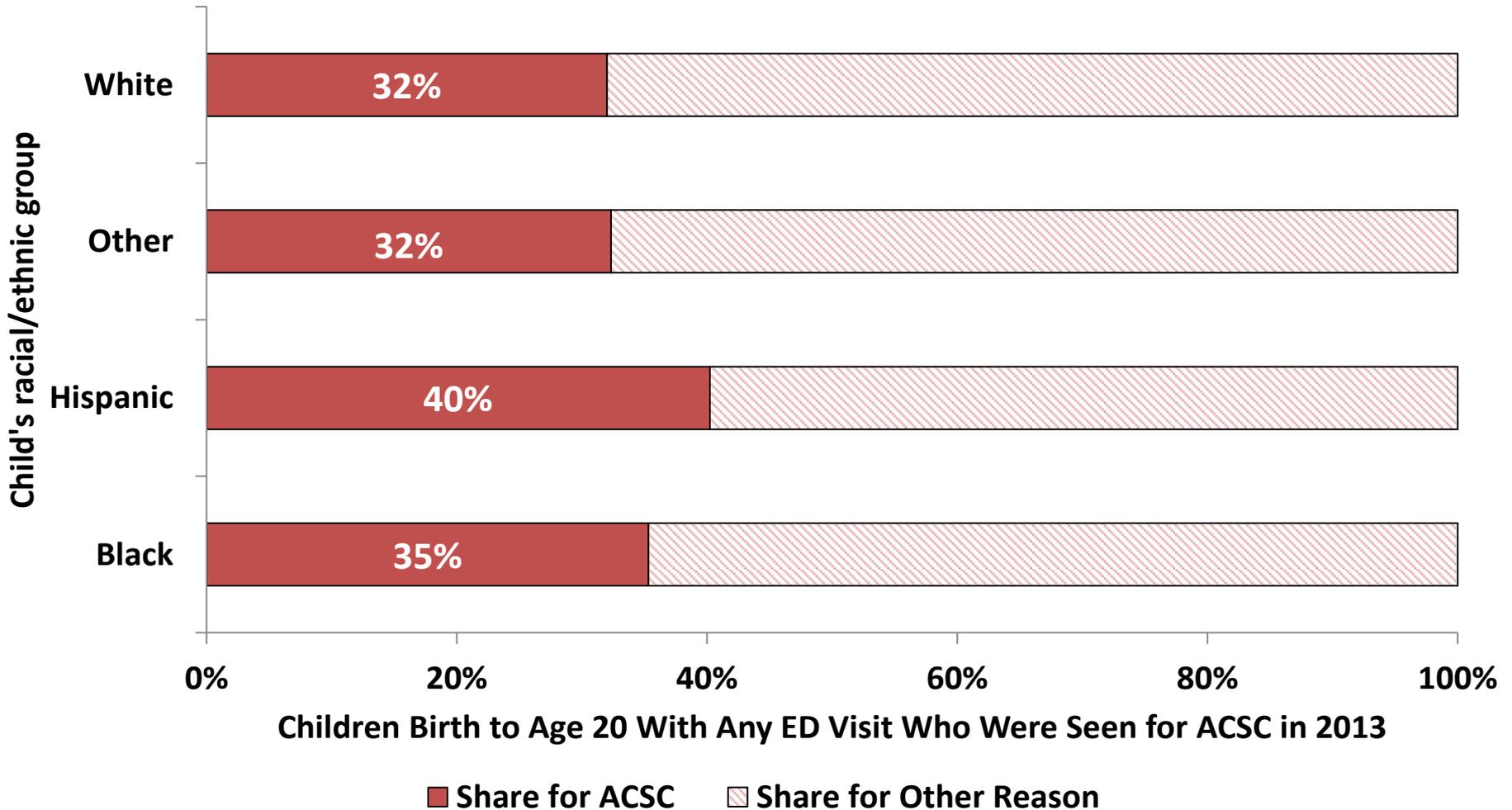


\*ACSC: ambulatory care-sensitive conditions

# Hispanic Children Were Most Likely to Receive Emergency Care



# Hispanic Children Were Most Likely to Receive Emergency Care for ACSC\*



\*ACSC: ambulatory care-sensitive conditions

# Increasing Access to Primary Care and Reducing Emergency Care

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# CHNCT Initiatives (2013 and later)

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- **Linking members with Primary Care Providers** based on claims data review v. default assignment
- **Encouraging timely use of preventive care** with reminder calls, age-appropriate text reminders for well-child care, immunizations, screening exams
- **Supporting Primary Care Providers** with follow-up to patients who miss appointments, support for Primary Care Medical Home with financial incentives, and performance reporting

# CHNCT Initiatives (2013 and later)

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- **Reducing use of emergency care** by providing:
  - 24/7 nurse advice line and marketing
  - Follow-up with members who were advised to go to the ED
  - Follow-up with members without assigned PCPs
  - Offers of care management and information on self-management
  - Intensive care management for members and families
  - Timely follow-up after hospital discharge

# Conclusions

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- Program changes and enhancements have the potential for improving access to primary care and reducing emergency care, but have not yet turned the curve or affected age- and racial/ethnic-related differences in utilization
- Continued high emergency care rates, especially for young children and Hispanic children, should be targeted for improvement
- Continued monitoring may reveal the impact of program changes as time goes on

# Acknowledgement

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# For further information ...

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**A detailed report is available at: [www.ctvoices.org](http://www.ctvoices.org)**