

IMPROVING THE HEALTH OF CONNECTICUT'S CHILDREN

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KEY FINDINGS

- **Connecticut's uninsured rate for children ranks 12th in the nation**, tied with Alabama, California, Iowa and Louisiana, and lagging behind Massachusetts, Rhode Island and New York.¹ More than 24,000 children in Connecticut have no source of health coverage.
- **More than half of Connecticut's uninsured children are likely eligible for HUSKY Health**, the state's Medicaid and Children's Health Insurance Program (CHIP).²
- **Between 2013 and 2015 the percentage of children enrolled in HUSKY for the entire year dropped from 86.5% to 76.6%.**^{3,4} Because children who lose coverage due to temporary changes in family circumstances often become eligible again soon after, Connecticut could reduce the uninsured rate among children by adopting a 12-month continuous eligibility policy—something 24 other states use in Medicaid.
- **HUSKY Health outperforms its counterparts in most states on key quality indicators, but the data may be not telling a complete story.** Unless children are continuously enrolled for at least 12 months, their health outcomes are not captured in most performance data. Additionally, aggregated data can mask disparities that are known to exist for children of color.
- **Connecticut could simplify HUSKY by aligning benefits across the three groups within the program that serve children**—HUSKY A, B, and Plus. This could also potentially eliminate duplicative administrative costs and confusion for providers and families.
- **There are stark disparities in the rates of infant mortality and low birth weight between white infants and black and Hispanic babies.** Connecticut can improve coverage for pregnant women to ensure safe full-term deliveries and healthy newborns.

AS THE LARGEST SINGLE SOURCE OF CHILDREN'S HEALTH COVERAGE, HUSKY HEALTH IS WELL POSITIONED TO DRIVE QUALITY IMPROVEMENTS THAT ARE PROVEN TO SUPPORT A CHILD'S HEALTHY DEVELOPMENT AND SUCCESS IN SCHOOL AND BEYOND.

Children's access to health care is critical to society, for reasons that stretch beyond children's immediate health and well-being. Whether or not children can access high-quality health care has implications for their ability to perform in school, to participate in the workforce as adults, and for the prevalence of high-cost chronic conditions among adults in the future.

HUSKY Health, Connecticut's name for Medicaid and the Children's Health Insurance Program (CHIP), provides access to health care for more than 330,000 vulnerable and disadvantaged children. The impact of this critical health coverage for children is clear. Medicaid and CHIP improve health from prenatal development to adolescence to adulthood, and are linked to improvements in educational outcomes at the elementary, high school, and college levels. These gains produce economic benefits in adulthood, including increased employment, higher tax payments, and returns on public investment in Medicaid.⁵

HUSKY Health outperforms its counterparts in many states on key indicators of health care quality. Yet Connecticut lags behind neighboring states in the rate of uninsured children, and there are opportunities to make Medicaid and CHIP more efficient and effective to improve children's outcomes. As the largest single source of children's health coverage, HUSKY Health is well positioned to drive quality improvements that are proven to support a child's healthy development and success in school and beyond.

This brief assesses how Connecticut compares to other state Medicaid and CHIP programs and identifies four top goals with nine recommendations for ways to improve HUSKY Health and reduce Connecticut's rate of uninsured children.



CONNECTICUT'S MEDICAID AND CHIP PROGRAMS FOR CHILDREN

HUSKY Health is the primary source of health coverage for one in three Connecticut children and represents a critical safety net for low-income families. HUSKY covers:

- 82 percent of children living in or near poverty.⁶ Few families in this income range have access to employer insurance and purchasing insurance on their own would be unaffordable.
- 37 percent of children under age six—the early formative years that are critical to healthy development.⁷
- 37 percent of children with special health care needs.⁸
- 100 percent of children in foster care, whose health care needs are often more extensive due to the neglect or abuse they have experienced.

The vast majority of children covered by HUSKY Health—95 percent—are part of HUSKY A,⁹ a portion of the Medicaid program that covers children with incomes up to 201 percent of the federal poverty level—the equivalent of \$41,768 for a family of three.

The state also offers coverage for children whose families earn too much for Medicaid but below 323 percent of the federal poverty level—the equivalent of \$67,119 for a family of three.^a This coverage is known as HUSKY B and is part of CHIP. Children covered by HUSKY B receive less-comprehensive benefits than those in Medicaid and their families are responsible for \$5 or \$10 copayments for non-preventive doctor visits and prescription drugs. Some are also charged monthly premiums (\$30 per child or \$50 for families with more than one child).

Separately, Connecticut offers HUSKY Plus for children eligible for HUSKY B who have specific health conditions. They can receive enhanced benefits without cost-sharing.

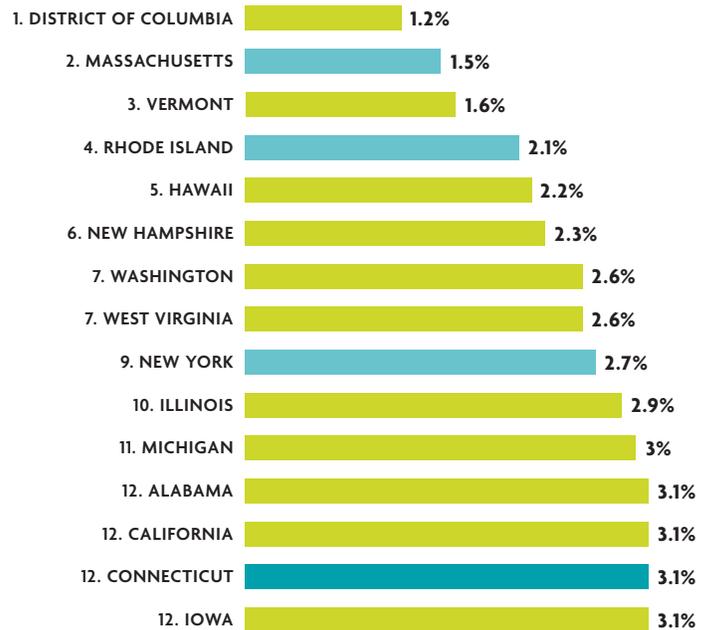
Medicaid also supports key programs for children in Connecticut such as Birth to Three home visiting, health-related special education services, and direct services through school-based health centers.

The federal government pays a significant share of Medicaid and CHIP costs, reimbursing Connecticut for 50 percent of its expenditures for HUSKY A. For CHIP, the federal government typically reimburses Connecticut 65 percent of what the state spends, but the reimbursement rate is currently higher because Congress raised the rate temporarily for 2016 through 2020.

UNINSURED RATE

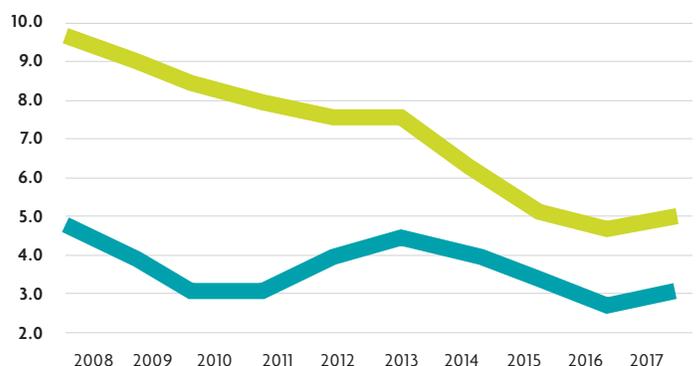
Although the percent of uninsured children in Connecticut—3.1 percent—is lower than the national average of 5 percent, the state ranks 12th in the nation in covering children¹⁰ and lags behind neighboring states of Massachusetts (1.5 percent), Rhode Island (2.1 percent) and New York (2.7 percent).

FIGURE 1: RANKING OF STATES WITH THE LOWEST RATE OF UNINSURED CHILDREN UNDER 19 (2017)



For more than a decade, the U.S. has experienced steady progress in covering uninsured children, although Connecticut's uninsured rate has been more variable (see Figure 2). However, in 2017, the rate of uninsured children in the U.S. increased from 4.7 percent to 5 percent,¹¹ and Connecticut's rate of uninsured children increased from 2.8 percent to 3.1 percent.^b The state's uptick in uninsured children might be associated with Connecticut's reduction in HUSKY income eligibility for parents—which led to parents losing coverage in 2015 and 2016—as research has shown a clear link between children's enrollment and parent eligibility.¹²

FIGURE 2: PERCENT OF UNINSURED CHILDREN IN THE U.S. AND CONNECTICUT



GOAL 1: GET AND KEEP ELIGIBLE CHILDREN COVERED	Track and address reasons children are denied coverage, and improve communications with families
	Smooth out transitions that occur on a child's first or eighteenth birthday
	Implement 12-month continuous eligibility
GOAL 2: MEASURE AND IMPROVE THE QUALITY OF CARE	Report all child core set measures to track performance of Medicaid and CHIP
	Disaggregate quality indicators to differentiate outcomes by race and ethnicity
	Address the high usage of emergency departments for non-emergency care
GOAL 3: MAXIMIZE PROGRAM EFFICIENCY AND EFFECTIVENESS	Simplify program administration by extending early and periodic screening, diagnostic, and treatment benefits in Medicaid to CHIP
	Transition CHIP into Medicaid to simplify program administration
GOAL 4: REDUCE ADVERSE BIRTH OUTCOMES	Expand eligibility for pregnant women



One key way to reduce the number of uninsured children is to eliminate gaps in coverage and smooth out transitions between eligibility groups.

GOAL 1: GET AND KEEP ELIGIBLE CHILDREN COVERED

As of 2017, an estimated 24,000 children in Connecticut lacked health coverage. Studies have shown that as many as two-thirds of uninsured children are eligible but not enrolled in Medicaid/CHIP, with recent research estimating that 56.8 percent of uninsured children were eligible for Medicaid/CHIP in 2016.¹³ Historically, as many as one-third of uninsured children had been enrolled in Medicaid or CHIP the year before, indicating that one key way to reduce the number of uninsured children is to eliminate gaps in coverage and smooth out transitions between eligibility groups.¹⁴ Most children enrolled in public health insurance programs remain eligible for much of their childhood, although some move between programs or temporarily lose coverage.¹⁵

Experience across all states has demonstrated that sustained and targeted outreach to the uninsured, personalized consumer assistance and follow-up, improved communications, and simplified application and renewal processes that reduce administrative barriers are key factors in getting and keeping eligible children enrolled.¹⁶

STRATEGY: TRACK AND ADDRESS REASONS CHILDREN ARE DENIED COVERAGE, AND IMPROVE COMMUNICATIONS WITH FAMILIES

One strategy that can improve both enrollment and retention of eligible children is tracking the reasons children are denied coverage or disenrolled, and taking action to address procedural or paperwork barriers.¹⁷ For example, mailing notices using the postal service's "address service requested" provides the agency with the beneficiary's updated address and can avoid a child being disenrolled because the family did not receive the notice following a move. In addition, research from many states suggests that complicated notices can lead to confusion among families about what a parent needs to do to enroll or

renew their child's coverage. Simplifying notices to ensure information is not overly complicated—or even contradictory—can help.¹⁸

STRATEGY: SMOOTH OUT TRANSITIONS THAT OCCUR ON A CHILD'S FIRST OR EIGHTEENTH BIRTHDAY

In Connecticut, babies turning one and adolescents turning 18 were more likely than other children to have experienced gaps or loss of coverage in 2014 and 2015 when age triggered a review of eligibility.¹⁹ Special effort should be taken to identify actions to assure continued enrollment of eligible children in these age groups.

STRATEGY: IMPLEMENT 12-MONTH CONTINUOUS ELIGIBILITY

While the most common time that eligible children lose coverage is at the annual renewal, children or families can lose coverage at any time because of a modest increase in income or change in status that may temporarily impact their child's eligibility. For example, a child may become ineligible when a parent works overtime or takes on temporary seasonal employment to supplement the family income; the child would likely become eligible again soon after. Adopting 12-month continuous eligibility can help in these circumstances and reduce the number of children who become uninsured.

Twelve-month continuous eligibility is a long-standing federal policy option that allows children to stay enrolled until their annual renewal, regardless of changes in family circumstances, which are often modest or temporary. Currently, 24 states provide 12-month continuous eligibility for Medicaid, as do 26 of the 36 states that run separate CHIP programs.^c Connecticut does not.^{d,20}

In Connecticut, a 12-month continuous eligibility policy would mean that instead of having children's eligibility re-evaluated if there is a change in their families' income or other circumstances, they would remain eligible until one year after they gained or renewed coverage.



A DEEPER LOOK: WHAT CONTINUOUS ELIGIBILITY COULD MEAN FOR CONNECTICUT

A continuous-eligibility policy increases the continuity of children's enrollment in Medicaid and CHIP, and offers multiple advantages.²¹ Continuous eligibility could:

IMPROVE CHILD HEALTH OUTCOMES

Children who are not consistently covered are likely to miss out on timely preventive and routine care. Medical conditions or developmental delays may go undetected and untreated, which can result in poorer health outcomes. Gaps in health care coverage also make it harder to manage chronic diseases such as diabetes, asthma, and mental or behavioral disorders. In turn, poorer health status is a contributing factor in school absenteeism and performance, which impact graduation rates, college attendance, and workforce readiness.²²

AVOID INCREASED HEALTH CARE COSTS THAT OCCUR DURING OR AFTER COVERAGE GAPS

If low-income children lose coverage and their families are unable to afford doctor visits or to fill their prescriptions for even a month or two, they can become sicker and eventually require emergency room or hospital inpatient care. Already Connecticut experiences a rate of emergency room use that is among the highest in the country (discussed on page 7). The lack of 12-month continuous eligibility may contribute to this poor ranking. Prior analysis of emergency services comparing continuously covered children and those with gaps in coverage shows that children with coverage gaps have both more ER visits per month and higher ER payments per month of enrollment.²³

Studies have also shown a link between coverage gaps and an increase in avoidable hospitalizations.²⁴ One Ohio study revealed that hospitalizations increased particularly for eligible adolescents who experienced gaps in Medicaid coverage, with pregnancy-related complications and mental illness as the two main reasons for inpatient hospital stays in the first three months after a gap in coverage.²⁵

PROVIDE A MORE ACCURATE PICTURE OF THE QUALITY OF CARE FOR KIDS IN HUSKY

While continuity of coverage is important to ensure that children get care when they need it, the state is unable to fully measure the quality of health care without continuous coverage. A minimum of 12 months of continuous coverage is required to compute most health care performance indicators. This means that children who are enrolled for fewer than 12 months are excluded when performance measurement rates are calculated. Although Connecticut performs well on most measures of health care quality for HUSKY children, these rates may not reflect a complete picture of how well children are faring.

HOW MUCH WOULD CONTINUOUS ELIGIBILITY COST?

Providing specific estimates on the cost of implementing 12-month continuous eligibility is difficult because of the lack of current, publicly available information in Connecticut on average length of enrollment, reasons for disenrollment, and monthly per-child health care expenditures. However, research has shown that average monthly Medicaid costs for children steadily decline over time; in 2010, by a child's 10th month of coverage, costs were down 27 percent compared to the first month of coverage.²⁶ The cost calculation for Connecticut will differ from most other states, which pay a set monthly fee to managed care organizations to cover members' medical costs and would therefore incur these costs for each month a child is covered regardless of actual medical costs. In Connecticut, the state pays only the medical costs of Medicaid clients, so as children's health care costs decline the longer they are covered, the state's costs would drop as well. One of the most recent studies estimated that the cost of providing 12-month continuous eligibility in Medicaid increases annual expenditures for children's benefits over a fiscal year by a modest 2.2 percent.²⁷ Even with 12-month continuous coverage, not every child will be enrolled for 12 months; some will move out of state, gain other coverage, or age out. Fiscal analysis should take into consideration these factors, as well as the historical evidence.

The immediate cost to Medicaid should not be the only determining factor in promoting continuity of coverage; analyses should take into account the longer-term and cross-sector return on investment. Services that support a child's health and development can improve school readiness and graduation rates, reduce special education costs, and address other social problems such as poverty and crime.²⁸ Access to health care and early learning from birth produces a 13 percent return on investment.²⁹ There is also evidence that providing coverage during critical periods of child development reduces the need for costly care in the future, even years later.³⁰

Older studies have shown the potential for administrative savings associated with continuous eligibility at between 2 and 12 percent.³¹ However, almost all states, including Connecticut, have implemented new data-driven eligibility systems that have reduced the cost of processing paperwork and mailings to applicants and beneficiaries. While it is fair to expect that administrative savings would be more limited in today's high technology environment, some savings could accrue by minimizing disenrollments and re-enrollments, as well as responding to inquiries from beneficiaries and providers when children lose coverage unexpectedly.

GOAL 2: MEASURE AND IMPROVE THE QUALITY OF CARE

Measuring quality is the critical first step to assuring access to and improving health care services, enhancing the patient’s experience, and reducing unnecessary costs or waste in health care delivery. Collecting and reporting data is not enough; data must be analyzed, compared, and trended over time to identify opportunities for improvement, to measure progress, and to meet specific performance targets.³²

In 2009, the federal Centers for Medicare & Medicaid Services launched an ambitious children’s health care quality initiative, which included the adoption of the Child Core Set of Health Quality Measures in Medicaid and CHIP. The core set is the best source of data to compare the performance of Medicaid and CHIP across states.

In 2017, Connecticut’s performance on the reported child care measures was above the median reported by states on all but one measure—use of emergency department services for non-emergency care (see Appendix B). In fact, the state ranked in the top quartile on 17 of 25 measures in 2017, up from 15 of 25 measures in 2016 (see Figure 3). The state outperforms almost all states for well child care, childhood and adolescent immunizations, and primary care access.

FIGURE 3: CONNECTICUT’S RANKING ON REPORTED CHILD HEALTH QUALITY MEASURES IN MEDICAID AND CHIP



Although Connecticut performed better than average on nearly all measures, there is room for improvement on several key measures (detailed in Appendix A). These measures call attention to areas where the state could focus its quality improvement efforts.

While these indicators report on the experience of children enrolled in HUSKY, they may also reflect issues within the broader health care system. For example, a lack of access to primary or urgent care after work hours can drive up a child or adolescent’s usage of emergency rooms for non-emergency conditions, regardless of coverage source.



STRATEGY: REPORT ALL CHILD CORE SET MEASURES TO TRACK PERFORMANCE OF MEDICAID AND CHIP

Reporting on the core measures is not currently a federal requirement, and detailed state-level data is only available if at least 25 states report a measure. Connecticut voluntarily reported 19 of 26 core measures in 2016 and 19 of 27 core measures in 2017.^e Beginning in 2024, states will be required to report all child core measures. Connecticut should work toward reporting all measures as quickly as possible.

STRATEGY: DISAGGREGATE QUALITY INDICATORS TO DIFFERENTIATE OUTCOMES BY RACE AND ETHNICITY

Reporting on quality indicators at an aggregate level can mask health care disparities that exist for children of color.³³ It is important for the state to work toward the collection of data needed to effectively disaggregate health care quality data based on race and ethnicity; doing so can help to pinpoint problems that might otherwise be missed and focus health improvement efforts on children with the greatest need. For example, if a certain group of children has lower rates of well child care or immunizations, outreach and parent education can be directed to those families to improve health outcomes.

STRATEGY: ADDRESS THE HIGH USAGE OF EMERGENCY DEPARTMENTS FOR NON-EMERGENCY CARE

Connecticut ranked in the bottom quartile among reporting states in the use of emergency departments for ambulatory conditions in both 2016 and 2017—a striking contrast to the state’s overall high ranking on the other measures. Ambulatory conditions are illnesses that can be managed effectively in a primary care or urgent care setting at considerably lower cost, such as treatment for the flu. In 2017 in Connecticut, there were 53.1 visits to the emergency department for ambulatory conditions per 1,000 enrollees, compared to the lowest state rate of 4.8 visits per 1,000 in Idaho. Connecticut’s rate was the highest in the Northeast.

As a starting point to address the high rate of potentially unnecessary emergency department visits, officials could examine the top diagnoses involved in these visits to identify opportunities for intervention. In addition, Connecticut’s State Innovation Model initiative, which already has a goal of reducing emergency department use for asthma, could broaden the goal to address other reasons for visits as well.

GOAL 3: MAXIMIZE PROGRAM EFFICIENCY AND EFFECTIVENESS

The benefits provided under HUSKY A (Medicaid) offer children a comprehensive set of services, known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT is structured to focus on prevention, early detection of physical concerns or developmental delays, and treatment to correct or ameliorate physical and mental illnesses and conditions. In other words, EPSDT ensures that children receive a broad range of services to support healthy development, which in turn impacts school readiness and performance.

States may provide EPSDT-level benefits to children enrolled in CHIP, but have the flexibility to cover fewer services—an option Connecticut has chosen for HUSKY B. However, Connecticut has taken an additional step to provide a small subset of children eligible for HUSKY B with enhanced benefits under HUSKY Plus if they meet specific guidelines. In doing so, Connecticut must administer three different benefit packages to HUSKY children based on their eligibility group, even though only approximately 5 percent of children covered by HUSKY are enrolled in either HUSKY B or HUSKY Plus.^f

STRATEGY: SIMPLIFY BENEFIT PROGRAM ADMINISTRATION BY EXTENDING EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT BENEFITS IN MEDICAID TO CHIP

A more streamlined approach to benefit administration would be to extend EPSDT benefits to all children enrolled in HUSKY. This would reduce confusion for parents and providers when children transition between HUSKY A, B, or Plus.

STRATEGY: TRANSITION CHIP INTO MEDICAID TO STREAMLINE PROGRAM ADMINISTRATION

The state could go one step further by transitioning its separate CHIP program into Medicaid while still receiving the higher federal reimbursement that CHIP receives. Doing so could result in significant program efficiencies and reduce duplicative administrative costs associated with operating HUSKY A, B, and Plus with different eligibility, benefits, and cost-sharing. Between 2010 and 2013, four states—California, Michigan, New Hampshire and South Carolina—transitioned their separate CHIP programs into Medicaid, bringing the total number of states that administer CHIP through their Medicaid program to 15. While Connecticut would still need to identify children eligible for Medicaid versus CHIP for federal funding purposes, some administrative tasks would no longer be necessary, such as verifying health status to determine eligibility in HUSKY Plus. Additionally, the state's administrative services organization would not have to administer three different benefit packages.

GOAL 4: REDUCE ADVERSE BIRTH OUTCOMES

Although Connecticut's infant mortality rate of 4.8 per 1,000 births is lower than the national average of 5.9, the overall rate masks the dramatically disparate outcomes based on race and ethnicity. The infant mortality rate of non-Hispanic black children is 11.7 per 1,000 births, almost four times that of non-Hispanic white children (2.9) and three times higher than that of Hispanic children (3.7).³⁴ While Connecticut's rate of low-weight births at 7.8 is slightly lower than the national average of 8.2, other states have achieved much lower rates, including Alaska's rate of 5.9.³⁵

STRATEGY: EXPAND ELIGIBILITY FOR PREGNANT WOMEN

HUSKY covers pregnant women with incomes up to 263 percent of the federal poverty level—the equivalent of \$54,652 for a family of three—through 60 days postpartum. The state has taken advantage of federal flexibility in Medicaid to waive the five-year waiting period before lawfully residing pregnant women can be covered.

Connecticut could benefit from two CHIP options to expand coverage to more pregnant women. One option is to raise the income eligibility limit to the current eligibility level for children. Additionally, HUSKY could cover pregnant women regardless of immigration status to ensure safe deliveries and healthy newborns, many of whom will be eligible for HUSKY. With regular prenatal care, fewer pregnancies would result in premature births and low birth weight, which are costly to treat and can impact a child's trajectory in life. Both options would qualify for the higher CHIP federal matching rate, where 65 percent of costs would be covered by the federal government.⁸ The cost of expanding eligibility for pregnant women could be partially offset by reducing expensive neonatal intensive care treatment. Additional savings in the education sector could accrue given that low birth weight children are almost 50 percent more likely to require special education.³⁶





CONCLUSION

Connecticut can take pride in its commitment to providing health coverage and ensuring access to health care services for children. The state's Medicaid and CHIP programs are strong and are delivering results for the state. However, Connecticut can and should do better to improve the quality of care and reduce the number of uninsured children. There are clear opportunities for the state to make strides in assuring that all children can access health care, in improving care quality, and creating a more efficient coverage program.

- To ensure that eligible children get and stay covered, Connecticut can track and address reasons children lose or are denied coverage; ensure that babies and 18-year-olds do not lose coverage because of administrative glitches; and implement a 12-month continuous eligibility policy.
- To improve care quality and ensure it can be adequately measured, the state can report all child core set measures, disaggregate quality indicators by race and ethnicity, and address the high usage of emergency departments for non-emergency care.
- To ensure Medicaid and CHIP are as efficient and effective as possible, the state can extend critical EPSDT benefits to CHIP and transition CHIP into Medicaid.
- To reduce adverse birth outcomes, Connecticut can expand HUSKY eligibility for pregnant women.

Too often, the attention on health care quality improvement is focused on bending the cost curve, leaving children out because they incur notably lower average health care costs than adults, seniors, or people with disabilities. In doing so, we neglect to recognize cross-sector and longer-term benefits of improving children's health outcomes.

From reducing the rising cost of caring for adults with chronic health conditions that start in childhood to improving educational outcomes that have significant economic and social benefits, it is imperative that programs like HUSKY that serve the most vulnerable and disadvantaged children strive to take advantage of all opportunities to invest in our children's futures.



There are clear opportunities for the state to make strides in assuring that all children can access health care, in improving care quality, and creating a more efficient coverage program.

APPENDIX A

Opportunities to Improve the Quality of Health Care for Children in HUSKY Health

The Child Core Set of Health Care Quality Measures in Medicaid and CHIP is a standardized set of child health care quality measures used to assess the quality of care for children in Medicaid and CHIP. It was adopted in 2010 in an effort to provide states with a way to determine the gap between current and best performance, mobilize improvement efforts, and incorporate performance and quality into reimbursement methodologies for plans and providers.

The core set is reviewed annually by a broad group of stakeholders convened by the Centers for Medicare & Medicaid Services (CMS) and the National Quality Forum. Over time, measures may evolve as the science of quality measurement and improvement advances. CMS reports state-level data if at least 25 states report a measure. While specific rates are disclosed, CMS also categorizes states into quartiles based on performance. However, it is insufficient to simply consider the quartile ranking. The range of reported rates is also important to examine, as there may be significant opportunity for improvement even if a measure ranks in the top or second-highest quartile. Connecticut's quartile ranking and reported rate are included in the tables that follow this discussion.

As noted in the body of this report, Connecticut compares favorably to most states, with two-thirds of its reported measures ranking in the highest-performing quartile. However, as mentioned in the report, the state ranks in the bottom quartile on the use of the emergency room for non-emergency care. The following are other areas where there is opportunity to ensure that HUSKY children are getting the right care at the right time in Connecticut.

- **Developmental Screenings** – In the first three years of life, developmental screenings are critical to ensure that developmental concerns or delays are detected early and treated. This measure assesses whether children are screened for developmental, behavioral, or social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthdays. In 2017, Connecticut reported a screening rate of 46.8 percent. While this is above the median, there is considerable room for improvement. The highest rate of 81.1 percent was reported by Vermont.
- **HPV Vaccinations** – The Human Papillomavirus (HPV) is the most common sexually transmitted infection and some types can lead to certain cancers and diseases later in life for both males and females. Three doses of the vaccine are recommended before age 13. The measure assesses whether adolescents who turned age 13 during the measurement years received all three recommended doses. On this measure, Connecticut reported a vaccination rate of 20.9 percent, well below the highest rate of 57 percent in Oregon.
- **Body Mass Index** – Overweight and obesity among children that persists into adulthood is a primary driver of chronic disease. This measure assesses the percentage of children ages 3 to 17 who had an outpatient visit with a primary care provider and whose weight was classified based on the body mass index (BMI) for age and gender. In 2017, only 67.9 percent of Connecticut children,

compared to Rhode Island's best rate of 89.6 percent, were assessed for their BMI, which is the first step in identifying children who should receive counseling for nutrition and physical activity.

- **Percent of Pregnant Women Receiving More than 80 percent of Expected Prenatal Visits** – Early and ongoing prenatal care is important for both the health of the pregnant woman and her child. Connecticut ranks in the top quartile among states in pregnant women accessing care in their first trimester or within 42 days of enrolling in Medicaid (87.4 percent compared to the highest reported rate of 92.6 percent). However, the state falls into the third quartile with respect to pregnant women receiving at least 80 percent of recommended prenatal visits. In 2017, 66.3 percent of pregnant women received the expected number of prenatal visits, compared to the highest state rate of 82 percent in Illinois.
- **Asthma Medication Management** – Asthma is the most common childhood chronic illness and the leading cause of chronic disease-related school absenteeism. It can be managed through routine care and the use of prescribed medications, although environmental issues may also impact its prevalence and severity.³⁷ Connecticut has shown progress on this measure, moving from the third quartile in 2016 to the top quartile in 2017. However, the state's rate for children ages 5 – 20 who remained on their medications for at least 75 percent of the treatment period was 38.7 percent in 2017 compared to the highest state rate of 71.9 percent in West Virginia.
- **Follow-up Care for Children Prescribed ADHD Medication** – Once a child is diagnosed with attention deficit hyperactivity disorder (ADHD), it is important that there be routine follow-up care to ensure that prescribed medications are working as expected. Clinical guidelines call for follow-up visits to occur within the first 30 days and again within 10 months. Although Connecticut ranks in the top quartile on both measures, there is room for improvement, particularly in follow-up within 10 months, when 70.1 percent of children in Connecticut received the recommended follow-up, compared to the highest reported rate of 98.1 percent in Alabama.
- **Chlamydia Screenings** – Chlamydia is an often undetected sexually transmitted infection that may have few symptoms but can cause health problems later on, including preventing women from getting pregnant or endangering their pregnancies. Thus, it is important to screen for this disease in sexually active young women. Connecticut ranks in the top quartile but its screening rate of 59.5 percent of at-risk populations is well below the highest reported rate of 80.4 percent in the District of Columbia.

Quality improvement takes time and resources. While this analysis reflects several areas that could be improved, states generally focus on a small number of improvement projects at any given time due to resource limitations. It is also important to recognize the difficulty providers face in meeting the demands of numerous improvement projects. There is also the choice of focusing on where the need is greatest or where there is already momentum to achieve faster results.

APPENDIX B

CONNECTICUT REPORTING ON CHILD HEALTH QUALITY MEASURES IN MEDICAID AND CHIP (2016–2017)

	2016	2017
Primary Care Access and Preventive Care		
Access to Primary Care Practitioners, Ages 12 – 24 months	★★★★	★★★★
Access to Primary Care Practitioners, Ages 25 months – 6 years	★★★★	★★★★
Access to Primary Care Practitioners, Ages 7 – 11	★★★★	★★★★
Access to Primary Care Practitioners, Ages 12 – 19	★★★★	★★★★
Well-Child Visits in the First 15 Months of Life	★★★★	★★★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	★★★★	★★★★
Adolescent Well-Care Visits	★★★★	★★★★
Childhood Immunizations	★★★★	★★★★
Immunizations for Adolescents—Combination	★★★★	★★★★
Immunizations for Adolescents—3 Doses HPV Vaccine by Age 13	★★★	★★★
Developmental Screening in the First Three Years of Life	★★★	★★★
Chlamydia Screening Women Ages 16 – 20	★★★★	★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Index	★★	★★
Maternal and Perinatal Health		
Timeliness of Prenatal Care	★★★★	★★★★
Frequency of Ongoing Prenatal Care	★★★	★★★
Care of Acute and Chronic Conditions		
Ambulatory Care: Emergency Department Visits	★	★
Medication Management for People with Asthma, Ages 5 – 20	★★★	★★★★
Medication Management for People with Asthma, Ages 5 – 11	★★★	★★★★
Medication Management for People with Asthma, Ages 12 – 18	★★★	★★★★
Behavioral Health Care		
Follow-up Care for Children Prescribed ADHD Medication (within 30 day initiation phase)	★★★★	★★★★
Follow-up Care for Children Prescribed ADHD Medication (during 10 month continuation and maintenance phase)	★★★★	★★★★
Follow-up Care After Hospitalization for Mental Illness, Ages 6 – 20 (within 7 days)	★★★★	★★★
Follow-up Care After Hospitalization for Mental Illness, Ages 6 – 20 (within 30 days)	★★★	★★★
Use of Multiple Concurrent Antipsychotics	★★	★★★
Dental and Oral Health Services		
Percentage of Eligibles Who Received Preventive Dental Services	★★★★	★★★★

- ★★★★ Ranks in top quartile at or above the 75th percentile
- ★★★ Ranks at or above the median but below the 75th percentile
- ★★ Ranks at or above 25th percentile but below the median
- ★ Ranks in the bottom quartile below the 25th percentile

CONNECTICUT REPORTING ON CHILD HEALTH QUALITY MEASURES IN MEDICAID AND CHIP (2017)

	CT Rate	Best State Rate	Median	Worst State Rate
Primary Care Access and Preventive Care				
Access to Primary Care Practitioners, Ages 12 – 24 months	99.0	99.4	95.2	82.9
Access to Primary Care Practitioners, Ages 25 months – 6 years	95.0*	95.0*	87.4	69.9
Access to Primary Care Practitioners, Ages 7 – 11	97.0	97.5	90.8	48.3
Access to Primary Care Practitioners, Ages 12 – 19	96.7*	96.7*	90.1	65.5
Well-Child Visits in the First 15 Months of Life	88.9*	88.9*	59.3	20.5
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	86.5*	86.5*	66.9	26.9
Adolescent Well-Care Visits	69.7	69.8	44.7	12.0
Childhood Immunizations	78.2	83.2	67.9	0.0
Immunizations for Adolescents—Combination 1	88.1	90.9	73.2	20.1
Immunizations for Adolescents—3 Doses HPV Vaccine by Age 13	20.9	57.0	20.8	5.4
Developmental Screening in the First Three Years of Life	46.8	81.1	39.8	3.7
Chlamydia Screening Women Ages 16 – 20	59.5	80.4	49.4	4.2
Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Index	67.9	89.6	61.1	0.3
Maternal and Perinatal Health				
Timeliness of Prenatal Care	87.4	92.6	81.6	23.0
Frequency of Ongoing Prenatal Care	66.3	82.0	61.7	1.8
Care of Acute and Chronic Conditions				
Ambulatory Care: Emergency Department Visits per 1,000 Enrollees (<i>lower rate is better</i>)	53.1	4.8	42.3	99.6
Medication Management for People with Asthma, Ages 5 – 20	38.7	71.9	27.3	16.7
Medication Management for People with Asthma, Ages 5 – 11	39.4	81.8	27.9	16.9
Medication Management for People with Asthma, Ages 12 – 18	37.6	60.6	26.9	10.3
Behavioral Health Care				
Follow-up Care for Children Prescribed ADHD Medication (within 30 day initiation phase)	60.8	66.7	50.0	9.6
Follow-up Care for Children Prescribed ADHD Medication (during 10 month continuation and maintenance phase)	70.1	98.1	61.5	24.2
Follow-up Care After Hospitalization for Mental Illness, Ages 6 – 20 (within 7 days)	61.9	88.8	47.8	11.7
Follow-up Care After Hospitalization for Mental Illness, Ages 6 – 20 (within 30 days)	77.0	92.9	69.2	29.7
Use of Multiple Concurrent Antipsychotics (<i>lower rate is better</i>)	2.5	0.0	2.7	8.9
Dental and Oral Health Services				
Percentage of Eligibles Who Received Preventive Dental Services	62.6	67.5	48.2	27.3
Measures Reported by Connecticut But Data Not Released by CMS				
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Consumer Assessment of Health Providers and Systems Survey				
Measures Not Reported By Connecticut				
Audiological Evaluation in First 3 Months				
Percentage of Low Weight Live Births (< 2500 grams)				
Cesarean Sections				
Behavioral Risk Assessment for Pregnant Women				
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment				
Dental Sealants for 6 – 8 Year Old Children at Elevated Caries Risk				

* NUMBERS REFLECT WHEN CONNECTICUT'S RATE IS THE BEST RATE REPORTED BY STATES.



Children's access to health care has implications for their ability to perform in school, to participate in the workforce as adults, and for the prevalence of high-cost chronic conditions among adults in the future.

NOTES

- a. Connecticut is one of 19 states that provides insurance coverage to children in families with income at or above 300 percent of the federal poverty level. Brooks, T., et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey," Kaiser Family Foundation, January 2018. <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/>
- b. The increase in Connecticut is not considered statistically significant but aligns with troubling trends at the national level where for the first time in a decade, there has been an increase in the uninsured rate among children.
- c. States have three options in how they design their CHIP programs to cover children in families with incomes above the Medicaid limit: expand Medicaid, create a separate CHIP program, or a combination of these approaches. In a Medicaid expansion, all Medicaid rules apply, with the exception that children eligible for CHIP funding must be uninsured. In separate CHIP programs, there are different rules in regard to benefits, eligibility and other criteria. Fifteen states operate CHIP-funded Medicaid expansions, while 34 states have combination programs. Connecticut and Washington are the only two states with completely separate Medicaid and CHIP programs.
- d. Nearby states New York and New Jersey have adopted 12-month continuous eligibility in their Medicaid and CHIP programs.
- e. Several of the core measures are disaggregated based on age or other factors so in total Connecticut reported on a total of 25 performance indicators where there is comparable state data in the each of the past two cycles.
- f. The higher federal CHIP reimbursement rate supports coverage for approximately 34,000 children enrolled in HUSKY Health; half of whom are enrolled in HUSKY A. This is due to a special provision that provides CHIP matching funds to cover children enrolled in Medicaid with income above 150 percent of the federal poverty levels in states that had expanded Medicaid eligibility above that level before CHIP was enacted.
- g. Connecticut receives 50 percent in federal matching funds for Medicaid expenditures. The standard federal CHIP match is 30 percent higher or 65 percent for the state. However, between 2016 and 2019, Congress boosted the federal CHIP match by additional 23 percentage point, which phases down by half in 2020 and reverts to the standard federal CHIP match in 2021.

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