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The Children’s Health Council:
A Community Foundation/State Government Partnership

Increased EPSDT participation in Connecticut is one result of this unique partnership.

by Christopher H. Hall, Mary Alice Lee, and Judith Solomon

The Children’s Health Council, created in 1995 by the Connecticut General Assembly, is charged with monitoring the impact of Medicaid managed care on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and implementing outreach efforts to ensure uniform statewide access to children’s health services. Under a unique partnership agreement between the Connecticut Department of Social Services (DSS) and the Hartford Foundation for Public Giving, lessons learned in a community-based, foundation-funded pilot project have been applied at the state level to bring about accountability and improvements in the EPSDT program.

Background

EPSDT. Medicaid’s EPSDT program is the largest comprehensive child health program in the United States, serving more than one in five children in 1996. Children eligible for EPSDT are entitled to a broad package of health care benefits, including periodic well-child medical, dental, vision, and hearing assessments; immunizations; laboratory tests; health education; and anticipatory guidance. In consultation with professional groups such as the American Academy of Pediatrics, states develop schedules for screening examinations that are performed at regular intervals until a child reaches age twenty-one. Federal goals for EPSDT participation require states to assure that at least 80 percent of all eligible children receive timely well-child screening. Most states have yet to achieve this goal.

As Medicaid managed care enrollment has increased, child health advocates have become increasingly concerned that cost containment efforts and changes in accountability will make the participation goal more difficult to achieve. Unfortunately, the results of a recent government evaluation of EPSDT services under Medicaid managed care offered little reassurance. In ten states fewer than one in three eligible children received complete and timely EPSDT screening while enrolled in Medicaid managed care plans; six in ten children in these states did not receive any EPSDT services at all. The results also showed that EPSDT participation is much better in states that track EPSDT services and monitor health plans’ performance.

Medicaid covers one in five Connecticut children, and more than 90 percent of them are enrolled in Medicaid managed care. As in other states, EPSDT participation has been low. In federal fiscal year (FFY) 1994, the last year of fee-for-service Medicaid in Connecticut, the EPSDT participation was 41 percent, far below the federal goal.

The Hartford Foundation’s involvement in
EPSDT is consistent with an extensive history of funding projects that aim to improve the quality of life in the greater Hartford area. Since it was founded in 1925, the foundation has become one of the largest community foundations in the nation, with assets now topping $450 million. In 1991 the foundation launched a ten-year, $10 million early childhood initiative designed to improve the school readiness of Hartford children. This project was based upon the premise that carefully crafted early intervention programs can make long-term improvements in the lives of low-income children.

HARTFORD HEALTHTRACK. Hartford HealthTrack aimed to improve children’s health, an important component of school readiness. Since Hartford’s most disadvantaged children are entitled to the comprehensive health services covered under EPSDT, the foundation approached the state Medicaid agency with an idea for a pilot project to improve the use of EPSDT health services. Hartford HealthTrack was developed and implemented in 1993 with an unprecedented two-year, $750,000 grant from the foundation to Connecticut’s DSS. The grant was structured to leverage Medicaid matching funds, bringing the total budget for the project to $1.5 million over two years. The grant was conditional upon the DSS’s commitment to expanding Hartford HealthTrack statewide after the first two years if results from the pilot project showed improved EPSDT participation in Hartford.

Hartford HealthTrack had three main components: an automated tracking system using Medicaid eligibility and claims data to determine which children needed EPSDT screening examinations; partnerships with community-based organizations that conducted outreach to ensure that even the most difficult-to-reach children received timely well-child exams and follow-up; and a plan for provider recruitment, education, and support, intended to expand the network of Medicaid providers and facilitate compliance with EPSDT screening recommendations. Collaborative, coordinated efforts on these three fronts proved to be effective. In the first eighteen months of Hartford HealthTrack operations, there was a remarkable 30 percent increase in the number of Hartford children who received EPSDT screening examinations.

In early 1995, near the end of Hartford HealthTrack, the DSS began planning for mandatory enrollment of Aid to Families with Dependent Children (AFDC) recipients and low-income children and pregnant women into a statewide Medicaid managed care program. Nearly 75 percent of the 220,000 enrollees would be children. The DSS proposed that the participating health plans assume full responsibility for the EPSDT program, obviating the need for a special statewide project modeled after Hartford HealthTrack. The foundation and others were seriously concerned, however, that the most effective, community-based aspects of Hartford HealthTrack could not be replicated by commercial health plans that were largely unfamiliar with the scope of EPSDT benefits and the needs of families on Medicaid.

The legislature was also concerned. When the biennial budget for state fiscal years 1995–1997 passed, appropriations for the DSS included $5.2 million for a two-year children’s health initiative. The budget language specified that funds were to be provided to the Hartford Foundation to establish an entity called the Children’s Health Council. The legislature clearly expected the DSS to honor its commitment to the foundation to expand Hartford HealthTrack statewide.

The Children’s Health Council

Under a contract with the DSS, the Hartford Foundation developed the Children’s Health Council and provides ongoing fiscal and administrative support, contract oversight, and leadership. Membership on the council was determined by the DSS and the foundation, to reflect the public/private nature of the state’s health care delivery system and to have broad representation from the geographically and racially/ethnically diverse constituencies involved. Members include one legislator from each political party and representatives from state health and social services agencies, the DSS, Medicaid managed care organizations, health care providers, community-based organizations, and local and regional health planning councils.

The Children’s Health Council supports collaborative efforts among public and private entities to improve the health and well-being of low-income children. The council has thematic workgroups focused on topics such as dental health, mental health, and obesity, and it has taken on other initiatives, including declaring “December 10, 1997” as the first statewide “AIDS Awareness Day.” The Children’s Health Council has also established an ongoing partnership with the Connecticut Association of School Boards in support of school health programs.

In the context of this growing partnership, the Children’s Health Council has continued to play a role in the state’s health care delivery system. It has been involved in initiatives such as the development of a state-wide health information network and the implementation of the Children’s Health Information and Access System. The Children’s Health Council also serves as a platform for the exchange of information and the development of strategies to improve the health and well-being of low-income children.
welfare agencies, community and professional organizations, health plans, and child health advocacy groups. The foundation’s executive director, who now serves as council chairperson, convenes council meetings eight to ten times a year. The council evaluates access to EPSDT services and recommends policy solutions to problems that are identified.

In August 1995 the foundation issued a request for proposals for the operational aspects of the council’s work. The successful bidder, MAXIMUS, Inc., of McLean, Virginia, developed the Connecticut Children’s Health Project, the statewide successor to Hartford HealthTrack. At the direction of the council, the project conducts EPSDT tracking and performance monitoring; provides information, referrals, and care coordination to families with children enrolled in Medicaid managed care; offers community education about and training on EPSDT and Medicaid managed care; and conducts enrollment outreach.

**Tracking and Performance Monitoring.** Using Medicaid managed care enrollment and encounter data, the Connecticut Children’s Health Project tracks well-child care by identifying children due or overdue for screens, according to the EPSDT periodicity schedule, and notifies their respective health plans. This project can track children and services across health plans, a valuable service, since families enrolled in Medicaid managed care may change health plans as often as every thirty days. Monitoring of EPSDT participation is based on a measure of utilization that also takes into account the timeliness of screening exams (EPSDT on-time visit rate). EPSDT participation by children in state custody is reported separately. Special studies of children’s health services—some in collaboration with other organizations—have focused on well-baby care, access to preventive dental services and treatment, use of ambulatory care services by adolescents, and blood lead screening rates in Medicaid managed care.

**Education and Training.** Education and training efforts focus on the information that community-based service providers and others need to help families to obtain Medicaid managed care coverage or navigate its complexities. Special training sessions have been offered for community service organizations, child-welfare caseworkers, and foster parents. Participating health plans have hosted training sessions for their member services and utilization management staffs on the scope of EPSDT benefits. To promote collaborative outreach efforts, the project has convened representatives of health plans and community-based service organizations to discuss effective strategies for reaching the hardest-to-reach families.

**Information and Care Coordination.** The project also operates the Children’s Health Infoline. Information, referrals, and care coordination services are available by toll-free telephone in several languages to families enrolled in Medicaid managed care. When a family member calls, care coordinators can get access to a child’s case files electronically, enter information about the nature of the call and follow-up, and check on EPSDT screening status to make sure that the child is up-to-date with screenings. Since 1 July 1996 the Infoline has received more than 18,000 calls and has placed more than 30,000 outgoing calls. Care coordinators meet monthly with council and DSS staffs to review challenging cases, discuss strategies for resolving individual problems, and identify programwide issues.

**Enrollment Outreach.** The Children’s Health Council also is concerned about access to health care for uninsured children in Connecticut. In 1997, when it became evident that many of Connecticut’s uninsured children were eligible for but not enrolled in...
Medicaid, the Connecticut Children’s Health Project conducted a statewide, school-based campaign to reach low-income families with uninsured children. More than 1,500 families called the Children’s Health Infoline for assistance in obtaining coverage; these calls revealed significant information needs and enrollment barriers. This information was invaluable in later work with the DSS to simplify application procedures and design outreach efforts for Connecticut’s State Children’s Health Insurance Program (CHIP), the HUSKY Plan. In 1998 the Children’s Health Council assembled a coalition of state agencies and community-based organizations and successfully bid for an enrollment outreach grant under the Robert Wood Johnson Foundation’s Covering Kids initiative.

POLICY DEVELOPMENT. The Children’s Health Council focuses on the development of policy. Quantitative and qualitative data gathered through performance monitoring, care coordination activities, enrollment outreach, and interactions with community-based providers are continually examined by council staff for evidence of problems at both the program and health plan levels that require policy solutions. The council researches a problem, solicits input from key individuals and organizations, identifies strategies for addressing the problem, recommends policy changes, disseminates its recommendations, and works with the DSS, the health plans, and others to implement solutions. For instance, in 1997, at the request of the DSS, the council conducted an evaluation of access to care in Connecticut’s Medicaid managed care program (the Health Care Financing Administration required an evaluation). Programwide problems were identified, and most of the council’s recommendations for improvements in program design, contract provisions, and policy development were adopted in new contracts with participating health plans.

The Hartford Foundation’s Role

Because of its nonpartisan reputation and respected work, the Hartford Foundation has been an effective advocate for children’s health issues through the Children’s Health Council. The foundation’s collegiate relationships with legislators and policymakers in the governor’s office were critical when funding was threatened one year into the initiative. Overall, communication between the council and the DSS has become increasingly less adversarial and more effective, sometimes as a direct result of intervention by foundation staff. A number of difficult Medicaid policy issues have been researched and resolved quickly and effectively, before they could escalate into public confrontations. Sponsorship of the council also has created opportunities for the foundation to contribute to developments in children’s health policy in Hartford and throughout the state.

Lessons Learned

By all indications, children’s access to well-child screening examinations and some other EPSDT services has improved in Connecticut. EPSDT participation reported by the DSS nearly doubled over fee-for-service levels, to 60 percent in FFY 1998. A similar trend is evident in the EPSDT on-time visit rate, which increased from 24 percent to 40 percent. The council’s tracking and performance monitoring activities have contributed greatly to this improvement, as has been demonstrated in other states with EPSDT tracking systems. The DSS has addressed some of the other access problems identified by the council with policy changes or contractual provisions that clarify the health plans’ responsibilities under EPSDT. The council has been able to maintain high visibility for children’s health issues, adding to incentives to improve access to care.

For the Hartford Foundation, Hartford HealthTrack and the Children’s Health Council were ventures into uncharted waters. Initially, the foundation’s board members and staff had reservations about the implications of providing funds for a public program, as well as the dangers of becoming too involved in state government issues and program politics. The foundation also was concerned about the shift in focus from funding to actually operating a program. The foundation’s experiences have led to several insights: (1)
Through selective, strategic participation in public/private partnerships, a community foundation can be an effective advocate for constructive changes in public expenditures and policies. (2) When a community foundation funds a government program, the foundation may be criticized for making a risky investment and inappropriately substituting private funds for taxpayer dollars, when, in fact, substantial financial and public policy benefits for the community can accrue from investment in a program that is consistent with the community foundation’s mission and other projects.

(3) Community foundation funding for a government program must be contingent upon contractual provisions that clearly delineate the government agency’s responsibility for financial contributions and continuation of program support after the grant period. (4) In work with government agencies, community foundations must strive for a balance between building mutual trust and preserving the ability to effectively confront undesirable government policies and practices. (5) When community foundation participation in a government program involves tracking and performance monitoring, government agency staff are likely to regard that involvement as threatening and adversarial. (6) Community foundation funding of governmental programs may strengthen institutional- and staff-level relationships that will benefit other foundation-funded activities.

The children’s health council is a useful model for other states to consider when designing systems of accountability to monitor health care reform or expansion of children’s health coverage. This unique and effective partnership between a community foundation and a state agency has contributed to measurable improvements in Connecticut’s Medicaid managed care program.

NOTES
7. Ibid., FFY 1994, 1995 (Hartford: DSS, 1995, 1996). The EPSDT participant ratio is equal to the number of children who received EPSDT screening examinations divided by the number of children eligible for them, adjusted for the frequency of recommended exams and the average period of eligibility.
8. State of Connecticut General Assembly, Connecticut State Budget 1993–97: A Summary of Revenue Appropriations and Bonds Authorized by the General Assembly (Hartford: Office of Fiscal Analysis, 1995), 501. This appropriation was reduced to $2.4 million per year when the newly elected governor recommended adjustments to the biennial budget.
9. The DSS deemed that recruitment, education, and support of providers and EPSDT outreach activities are the health plans’ responsibility.
10. The EPSDT on-time visit rate is a measure developed by the Children’s Health Council and the Connecticut Children’s Health Project to monitor the rate at which individual children enrolled in Medicaid managed care actually receive timely screening examinations. This rate is calculated by comparing the number of children screened on time with the number who were due for screens during that calendar quarter. Results are reported quarterly to the DSS. For details, contact Mary Alice Lee, Children’s Health Council, 85 Gillett Street, Hartford, Connecticut 06105; e-mail: malee@hartnet.org.
11. The Children’s Health Infoline is operated under a subcontract with United Way of Connecticut/Infoline.
12. HUSKY stands for Health care for UninSured Kids and Youth, a take-off on the University of Connecticut’s team nickname, the Huskies.
13. HHS, Medicaid Managed Care and EPSDT.