CONNECTICUT VOICES FOR CHILDREN

Emergency Care for Children in HUSKY A: CY 2004

January 2006

This report is the third annual summary of emergency care in HUSKY A (Medicaid managed care), issued in 2003 by the Children's Health Council and last year by Connecticut Voices for Children.[1]

Methods

Using HUSKY A enrollment data, children under 21 who were continuously enrolled from January 1 through December 31, 2004, were identified (n=170,937). Encounter data were searched for records corresponding to emergency (ER) visits.[2] The distribution of ER visits across diagnostic categories was determined. The ER visits described in this report do not include those visits that resulted in hospital admission.

The association between well-child care and any ER visits was determined by comparing the ER visit rate for children aged 2 and over who did and did not have an annual well-child visit. The timing of the well-child visit in relation to the emergency care was not determined.

Results

In 2004, 33 percent of children in HUSKY A made at least one ER visit, for a total of 107,881 visits with an average of 1.9 visits per child with any emergency care. These two measures of ER utilization are essentially unchanged from 2003. However, between 2002 and 2004, when enrollment increased 22 percent, the number of ER visits increased about 25 percent.

Among all children, the leading reasons for ER visits in 2004 were injuries (28%) and respiratory conditions (17%) (Figure 1), unchanged from 2003. However, the likelihood of an ER visit for a respiratory condition was lower in 2004 compared with the previous year when visits for respiratory conditions accounted for 21 percent of ER visits. The leading reasons for ER visits varied by age group (Table 1).

Figure 1. Leading diagnoses for ER visits: 2004

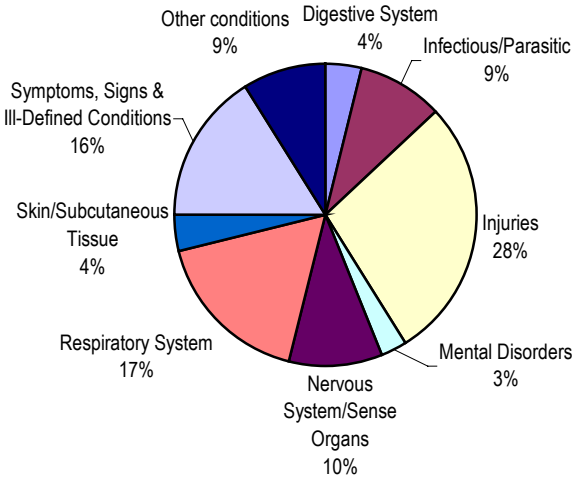

Table 1. Leading Reasons for ER Visits by Age

Age Group (years)	< 1	1-5	6-14	15-20
Total children	1,406	50,916	84,150	34,465
Percent with ER visit	52%	42%	27%	35%
ER visits per user	2.6	2.1	1.7	2.0
Reason for ER visit:				
Injuries	7%	***21%***	***36%***	***30%***
Respiratory conditions	***30%***	***21%***	14%	12%
Nervous system	12%	15%	8%	4%
Ill-defined conditions	28%	19%	13%	16%
Infectious/parasitic	12%	11%	8%	6%
All other conditions	11%	13%	21%	32%

Note: Leading reasons in each age group are shown in italics and blue or bold.

The percentage of children who had any emergency care varied significantly by managed care plan (Table 2). The rate for children in CHNCT (37%) was higher than the rate for other children. The rates for children in BlueCare (32%) and Health Net (31%) were significantly lower than the rates for other children. The rate for children in Preferred One (34%) was essentially the same as the rate for all other children. The leading reasons for visits did not vary by managed care plan.

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Table 2. ER Visits by MCO

Managed Care Plan	BC	CHNCT	HN	PO
Total children	67,171	27,275	50,245	11,201
Percent with ER visit	32%	37%	31%	34%
ER visits per user	1.9	2.1	1.8	1.8

Managed care plans: BlueCare Family Plan (BC), Community Health Network (CHNCT),Health Net (HN), Preferred One (PO)

Overall, 34 percent of children who had well-child care also had emergency care in 2004. This rate is significantly higher than the ER visit rate for children who did not have well-child care (29%). The difference is greatest among children 2 to 5: 40 percent of those who had well-child care also had emergency care, compared with just 34 percent of those who did not have well-child care.

Discussion

For the third year in a row, about one-third of children in HUSKY A had emergency care in the course of a year. Well-child care was not associated with a reduction in the likelihood of ER visits. This finding may be related at least in part to the fact that asthma, one of the leading reasons for ER visits, affects about 9 percent of children in HUSKY A and is most prevalent among the younger children who are more likely to have had emergency care. This lack of "protective" effect from well-child care may also be attributable to a qualitative difference between having an assigned primary care provider for check-ups and having a "medical home" that assures continuously available (24 hours a day, 7 days a week, 52 weeks a year) ambulatory care for acute illnesses and minor injuries. [3,4]

Data from Rhode Island show that emergency care utilization is significantly greater among children in Medicaid, compared to those covered in commercial managed care.[5] The ER visit rate for children in RIteCare was over twice as high as the rate for commercially insured children (5 visits per 10,000 children under 18 in Medicaid, compared with 2 visits per 10,000 children with commercial coverage; the comparable rate for HUSKY A in 2004 was 6.3 per 10,000 children under 21). The ER visit rate for treatment of ambulatory care-sensitive conditions was significantly higher for Rhode Island children in Medicaid, compared with commercially insured children.

In order to reduce ER utilization, every child in HUSKY A should have round-the-clock access to a primary care provider who knows the family and is responsible for providing and coordinating care for the child, especially for children with those health conditions that can be managed in the ambulatory care setting. To avoid unnecessary emergency visits or hospitalizations, comprehensive care for children should also include the kind of parent education and support that helps families avoid common acute illnesses, injuries, and exacerbation of conditions like asthma.

Conclusions

One-third of children in HUSKY A are seen in emergency care settings each year.

- **Leading reasons for emergency visits vary by age.**
- **Emergency care visit rates vary by managed care plan.**

Emergency care utilization is not reduced by well-child care.

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[1] Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on emergency care was prepared under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant to Connecticut Voices from the Hartford Foundation. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared under the direction of Mary Alice Lee, Ph.D., Senior Policy Fellow. This report is also available at www.ctkidslink.org.

[2] Emergency care: CPT-4 codes (99281, 99282, 99283, 99284, 99285) and UB-92 revenue codes (450, 456, 459) with any diagnoses other than well-child (v20 series, v70, v70.0, v70.3-v70.9) or pregnancy and childbirth (ICD-9-CM codes 630-677).

[3] Brousseau DC et al. Pediatric emergency department utilization within a statewide Medicaid managed care system. Academic Emergency Medicine, 2002; 9(4): 296-299.

[4] American Academy of Pediatrics. Policy statement: the medical home. Pediatrics, 2002; 110(1): 184-186.

[5] Vivier P. A comparison of ED use between commercially and Medicaid enrolled children. Presentation for Center for Health Care Strategies, August 2, 2005.