

## Ambulatory Care Utilization by Children Enrolled in HUSKY A in 2005

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All children need high quality care to support healthy growth and optimal development during infancy, childhood, and adolescence. Ideally, this care should be available from known and trusted providers in medical homes that are “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”<sup>1,2</sup> Regularly scheduled care, aimed at early detection and treatment of problems, is particularly important for children with increased risks for poor health and developmental delays, a fact Congress recognized back in 1967 when it created Medicaid’s EPSDT program. The EPSDT periodicity schedule in Connecticut calls for annual well-child exams for children ages 2 to 5 and 11 to 19 and exams every two years for children ages 6 to 10.

### Purpose

To describe ambulatory care received by children in HUSKY A, to identify factors associated with utilization, and to analyze utilization trends.

### Methods

This report is the seventh annual report on ambulatory care in HUSKY A (Medicaid managed care).<sup>3</sup>

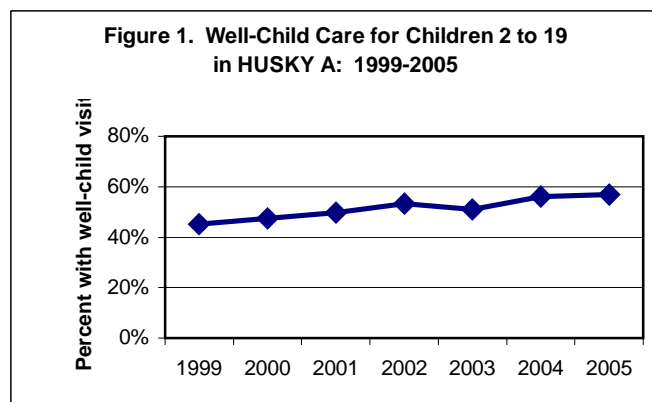
HUSKY A enrollment and encounter data for January 1 through December 31, 2005 were searched for records corresponding to ambulatory care (office visits, clinic visits, emergency visits) for children ages 2 to 19 years who were continuously enrolled for the entire year. Utilization rates for well-child care and other types of ambulatory care were determined.

### Results

There were 156,368 children ages 2 to 19 years continuously enrolled in HUSKY A in 2005, down slightly from the previous year (156,799 in 2004). Of these children, 86 percent received ambulatory care, an increase over the previous year (85%) that is statistically significant but not noteworthy.

**Well-Child Care:** Just over half of the children (57%) received well-child care in 2005, an increase over 2004 (56%) that is statistically significant but not

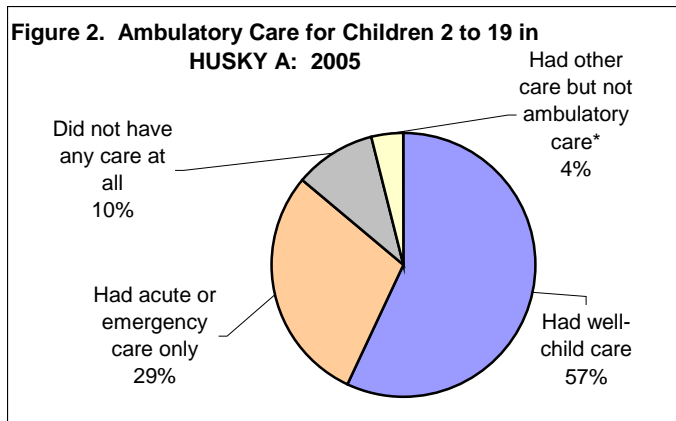
otherwise remarkable. Since 1999 when monitoring began, this rate is up 11 percentage points (Figure 1); the number of children who had well-child care increased by nearly 37,000.



Well-child care utilization varied by age, gender, and race/ethnicity in 2005 (Table 1). Young children ages 2 to 5 years were most likely to receive well-child care. Young teens 11 to 15 were more likely to receive care than children 6 to 10 or older adolescents. Well-child care utilization by African American children was less than rates for White, Hispanic, and other children. For the second year in a row, utilization improved in Bridgeport and increased considerably over 2003 in other towns; however, utilization decreased almost 2 percentage points in Hartford. In 2005, the well-child visit rate for children in Preferred One was considerably higher than in previous years and nearly equivalent to the rates for other plans.

**Acute and emergency care:** About one-third of children received other primary care or emergency care for illness, injury or other conditions, but no well-child care. Four percent of children overall received emergency care only, unchanged from previous years.

**No ambulatory care:** Fourteen percent of children did not have even one office, clinic or emergency visit in 2005, down from the two previous years (15% in 2003 and 2004) but not meaningfully (Figure 2).



\*Some children without ambulatory care had other care, such as prescriptions, laboratory tests or dental care. Some children who did not have ambulatory care received other types of care (dental visit, prescription drugs, laboratory tests). However, 15,849 children, that

is, 10 percent of children who were enrolled for the entire year had no record of any care at all in HUSKY A in 2005.

## Conclusions

- Well-child care utilization, though improved over the early years of the program, continues to fall short of professional recommendations, federal goals for children in Medicaid and HUSKY A contract requirements.
- Gaps in ambulatory care utilization persist among children of different racial/ethnic backgrounds.
- Efforts to implement medical home in Connecticut will require considerable ongoing support to ensure that all children in HUSKY A receive timely, comprehensive visits that address their health care needs.

**Table 1. Ambulatory Care in HUSKY A: Trends and factors affecting utilization**

	Well-Child Care		No Ambulatory Care <sup>a</sup>	
	2005	2004	2005	2004
<b>Total:</b>	57%*	56%	14%*	15%
<b>Age (years):</b>				
2 to 5	81%*	79%	5%*	6%
6 to 10	47%	46%	16%*	18%
11 to 15	54%	53%	17%	17%
16 to 19	43%	42%	19%	20%
<b>Gender:</b>				
Female	58%	57%	13%*	14%
Male	56%	55%	15%*	16%
<b>Race/ethnicity:</b>				
African American	54%	54%	18%*	19%
Hispanic	58%	58%	12%*	13%
White	57%*	56%	12%*	14%
Other groups	58%	56%	16%	17%
<b>Language:</b>				
English	57%	56%	14%*	15%
Spanish	60%	60%	12%	12%
Other languages	62%	59%	13%	15%
<b>Residence:</b>				
Bridgeport	61%	59%	13%	13%
Hartford	53%*	55%	15%	15%
New Haven	53%	53%	18%	19%
All other towns	58%*	57%	13%*	15%
<b>Health plan:</b>				
BlueCare	58%	58%	14%	14%
Community Health Network	58%	57%	14%*	15%
Health Net	56%*	55%	14%*	15%
Preferred One	54%*	46%	18%*	22%
Changed plans	56%*	58%	13%	13%

Note: 156,799 children 2-19 were continuously enrolled in calendar year 2004; 150,843 were continuously enrolled in 2003.

<sup>a</sup> No office, clinic or ER visits; may have had other types of care (inpatient, prescriptions, dental, vision or hearing).

\*Utilization rate in 2005 is significantly higher or lower than rate for 2004 ( $p < .05$ ).

<sup>1</sup> American Academy of Pediatrics. The medical home (policy statement). *Pediatrics*, 2002; 110(1): 184-186.

<sup>2</sup> Honigfeld L, Fifield J, Peele M. Medical home: model of continuous, coordinated care for Connecticut's children. Farmington, CT: Child Health and Development Institute of Connecticut, June 2006. Available at [www.chdi.org](http://www.chdi.org).

<sup>3</sup> This report on ambulatory care was prepared under a contract between the CT Department of Social Services and the Hartford Foundation, with a grant to CT Voices. CT Voices 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. A detailed report on methods and results is available from [www.ctkidslink.org](http://www.ctkidslink.org).