



# Introduction

## Understanding Why Parents Use the ER for Pediatric Primary Care: A Prerequisite for Change

The passage of Children’s Medicaid Simplification (Senate Bill 43) in the spring of 2001 introduced two significant new elements into Texas Medicaid policy for children. A healthcare orientation is required for parents of newly enrolled children in Medicaid. Additionally, each child enrolled in Medicaid must be current with the Texas Health Steps check-ups. Both of these elements must be met in order to access mail-in renewal of Medicaid. A major goal of these provisions is to promote greater use of primary and preventive care from a consistent source, a medical home. Promotion of a medical home includes redirecting parents from using the hospital Emergency Room<sup>1</sup> (ER) for non-emergent care — care which could more appropriately be provided in a doctor’s office or clinic. While uninsured persons may understandably resort to the Emergency Room for basic medical care, it is hoped that parents of children with Medicaid and CHIP coverage should instead be able to access primary care in a manner that both fosters continuity of care and costs less.

The team responsible for this report saw a need for educational resources designed to encourage parents to value Medicaid and CHIP coverage enough to enroll their children, find and use a medical home and reenroll. However, better qualitative information about why parents use the ER was needed to inform the creation of those educational tools: what they should say, to whom they should be targeted, and where they should be distributed. To meet this need, the team decided to undertake a study of emergency department utilization for primary care treatable conditions of children.

### ABOUT THE STUDY

This study seeks to penetrate what lies beneath the endless stream of children whose parents think their best healthcare option for a primary care treatable illness is the emergency department of a hospital. It poses a central question: What drives the parents’ healthcare decisions? And finally, it investigates what parents think will help them use their healthcare benefits in the way the benefits were designed - to have a primary care provider and a medical home.

The study included hours of observation in children’s hospital ERs across the state, and discussions with healthcare providers about what they believe parents and children need to better utilize our healthcare system. The most extensive component of the study involved interviews with parents about hundreds of ER visits for children on Texas Medicaid or CHIP.

Sitting for hours in a children’s emergency department, chronicling one by one the children flooding through triage, one wonders why the parent did not take their child with just a sniffle, minor cut or case of diarrhea to their own doctor. The immediate questions that come to mind are: Do they have a doctor? Do they *know* their doctor? Did they call the doctor? If so, was the doctor too busy or overburdened with meeting overhead to accept more patients with an insurance that offers low reimbursement? Essentially, why are they here, and not there?

The answers emerged from in-depth discussions with parents. Parents who had utilized emergency departments for ailments for which their children were not admitted to the hospital<sup>2</sup> were recruited for this study: 248 respondents in seven field sites. The parents sat for one-on-one interviews lasting about an hour apiece. Nearly 85 percent of children represented in the study had current Medicaid or CHIP coverage. In revealing how they made the decision, parents provided many complex and multi-layered reasons for going to the emergency department. Their responses reflected that many parents have difficulty navigating a patchwork system of healthcare services and often make decisions in moments of fear and panic arising from a basic lack of understanding of childhood illness and child development.

In addition to describing the findings of each of the study components, this report first describes briefly some of the key contexts affecting use of the ER, such as national utilization trends and research findings, federal laws mandating open access to ERs and current Texas Medicaid and CHIP practices. This information clarifies the policy options available to the hospitals, health plans and public administrators who make up the partnership that is children’s Medicaid and CHIP as they try to discourage use of the ER for primary care.

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1 – In the literature reviewed and among healthcare professionals, “emergency department” or ED is the preferred term for what most Texans call the “emergency room”. This report uses the more commonly recognized term, ER, with apologies to the professionals and their preferred terminology.

2 – By excluding ER visits which resulted in hospitalization, the researchers were able to examine a higher percentage of primary care treatable ER visits.

**THIRTY MINUTES IN A CHILDREN'S HOSPITAL EMERGENCY DEPARTMENT:  
EXCERPTS FROM OBSERVATIONS AT THREE CHILDREN'S HOSPITALS**

San Antonio, July 2001

Santa Rosa Children's Hospital ER, Nurse Triage Station with Two Nurses

**3:12 p.m.:** A 5-year old boy stepped on a stick and hurt his foot. Mom is worried because it is swollen. The nurse says he needs an x-ray to make sure there is no glass, then asks him what he has learned. The nurse cautions him not to play barefoot outside anymore. Mom and son are sent back to the waiting room.

**3:18 p.m.:** A 3-year old boy from Mexico bit his tongue. His mother is crying, as her 10-year old son translates for her. As the mother gives her local address and answers the nurse's questions, the 3-year old patient wanders off. They are sent back to the waiting room.

**3:24 p.m.:** An African-American mother carries a limp toddler. The child's temperature is 104 degrees, so the clinic sent her to the emergency department. The mother had given her one teaspoon of Vicks 44D, but only had adult Tylenol. Her friend pats her shoulder reassuringly and says she has to go to work. She promises to pick her up later. The RN offers Tylenol, and sends them back to the waiting room.

**3:30 p.m.:** A teenager named Juan comes to the nurse and says he has a mole in his eye. He is sent back to the waiting room.

**3:33 p.m.:** A mother brings two children. One has a bee sting, and the other has had a 102-degree fever for 2 hours. When the other child is asked if the bee sting hurts, she says, "When I push on it." The family is sent back to the waiting room. Within 30 minutes, the children are observed fighting with each other.

**3:37 p.m.:** Grandmother brings in a 3-year old who got hit on the head. He has not vomited. The nurse cleans the wound, while the child hits the grandmother. She is assured he will not need stitches. They are sent back to the waiting room.

**3:39 p.m.:** Mother brings in a 3-year old boy who has had vomiting and diarrhea for two days. She says she has Medicaid, and no doctor can see her today. The RN asks if the child has fever. The mother says yesterday he "felt hot." The RN takes his temperature; it is 100 degrees. The nurse gives the boy Tylenol, and sends them back to the waiting room. On her way out, the mother asks, "Can you give me a pediatrician?" The RN tells her to call Community First. The mother asks, "Will they give me some medicine?" The RN explains, "If it is a virus they won't give medicine. If it is a bacteria, they will."

**3:42 p.m.:** A mother brings in a baby with an allergic reaction to ant bites. He is sent immediately to the back.

**3:43 p.m.:** A mother brings in a child whose ear got nicked when she cleaned it with a Q-Tip. They are sent to the waiting room.

A few hours later, many of them are still sitting in the waiting room.



### **Corpus Christi, September 2001**

#### **Driscoll Children's Hospital ER, Triage Area**

**12:50 p.m.:** A 7-year old boy presents with stomach pain. He has had no vomiting, diarrhea, gas or fever. The pain started two weeks ago, when school started. He is sent to the waiting room.

**12:55 p.m.:** A 12-year old asthmatic Hispanic girl has been sick three days with the flu. She started coughing today and had "passed out several times." She has not seen a doctor. She has only had chips and 7-Up. She is sent to the waiting room.

**1:03 p.m.:** A 6-month old Hispanic boy has been crying. The mother says she has been "taking his fever." It went from 102 to 104 to 102. The RN takes the baby's temperature; it is 101.3. The mother had given him Tylenol and called for a doctor's appointment, but was told she would have to wait 2 hours. She chose to come to the emergency department instead. She is sent to the waiting room.

**1:10 p.m.:** A 4-year old Hispanic girl fell down at school and scraped her head. Her mother says she has a history of seizures, and is worried that she is going to have a seizure. They are sent to the waiting room.

**1:16 p.m.:** A Hispanic mother with a baby reports that she switched him to whole milk about a month ago. The baby has been constipated for a few weeks. Someone told her that it was not normal. He has not had a BM in a few days. She asks, "They can go one day without restroom, can't they?" She is sent to the waiting room.

**1:20 p.m.:** The mother with the 6-month old baby is called for treatment, but she has left.

### **Houston, December 2001**

#### **Texas Children's Hospital ER**

**2:15 p.m.:** Bruce, RN, the triage nurse, explains that as he triages his patients, he assigns one of three color codes. Code Red is a crisis, Code Yellow is urgent and Code Blue is non-urgent. Triage nurses use color stickers to mark the paper, and stack them according to priority. As Code Yellow patients come in, Code Blues move down the stack. Most of the color stickers are Code Blue.

**2:45 p.m.:** An obviously upset nurse is overheard talking on the telephone to a social service agency in the Rio Grande Valley. Apparently, the agency has sent a mother and her baby to Texas Children's Hospital for genetic testing. The mother has told this nurse that they were promised food, shelter, and medical care. The nurse is very concerned about her ability to help keep these promises.

**2:50 p.m.:** A nurse's aide walks up and down the halls calling out names of the "lucky" ones who will soon be treated. "Minor! Johnson! Avila! García!" A young child tugs at the aide's jacket and asks for some paper to draw pictures. A mother leaves her toddler, eating a bag of potato chips, unattended in a stroller.

**3:03 p.m.:** Walking up the hall to the respiratory bay, three children are lined up together: an African-American girl of about 9-10 years old, and two small Hispanic boys. The nebulizers hum, the mist pours out around the plastic purple eyes decorating the facemask. The observer notes the attempt to "make something as un-fun as asthma, fun."

**3:14 p.m.:** At the ambulatory care area, where the Code Blue (non-urgent) kids go, a child runs around the waiting room. Cartoons blare overhead. A 10-year old boy with his hand wrapped in gauze holds a Harry Potter book. He is waiting patiently for his mother to pay the bill.



## CHAPTER 1

# Emergency Department Utilization: Defining the Problem

These 30-minute slices of life from the ERs of busy urban children's hospitals in Texas capture a microcosm within a complex problem, one symptom of a much larger healthcare predicament in the United States.

Daily newspapers report that overcrowding in emergency departments nationwide has led to frequent ambulance diversions. Stories abound about the shortage of skilled nurses, trauma beds and emergency department beds in general. There is widespread acknowledgement that hospital ERs face serious problems, but a survey of research on the state of the ER in this country reveals no precise definition of the roots of those problems. Neither have any strategic solutions been presented to begin to address the complex issues.

It is important to note that use of the ER for primary care is just one of the challenges facing hospitals that operate an ER, and it is a distinct problem from the shortfalls in trauma care capacity faced by many communities. Redirection of primary care to more appropriate settings would not, in and of itself, solve the trauma care problem. Still, the two issues are linked. Demand for primary care in the ER adds considerably to congestion, and can add to the costs imposed on, or losses borne by hospitals, health plans, and public programs.

This chapter reviews briefly several areas of public policy that fundamentally affect ER use by children enrolled in Texas Medicaid and CHIP. First, recent information on national trends in ER use are reviewed. The role of federal law, specifically The Emergency Medical Treatment and Active Labor Act (EMTALA), in limiting how hospitals may redirect primary care from the ER is explained. Key findings from recent national research relevant to ER overcrowding and non-emergent ER use are described. The cost of providing primary care in the ER as contrasted with other settings is explored. Finally, current Texas Medicaid practices regarding the education of parents and incentives for providers are reviewed.



## NATIONAL TRENDS IN ER USE

Findings from the most recent National Hospital Ambulatory Medical Care Survey (NHAMCS), a nationwide<sup>3</sup> survey of hospital emergency department trends<sup>4</sup>, indicate that emergency department utilization is on the rise. Some of the findings provide background information which is needed to frame the discussion of non-emergent use of the ER.

**Emergency department use is growing while the number of ERs decreases.** There were about 102.8 million U.S. emergency department visits in 1999. The increase in overall emergency department use in terms of annual visits per 100 persons — from 36 in 1992 to 38 in 1999 — was not enough to be statistically significant. However, the total number of ER visits nationwide did grow more quickly from 1992 to 1999 than did the general population (14 percent more ER visits, compared to 8 percent U.S. population growth). The number of emergency departments has not grown along with the population, increasing by only 1 percent in that period, resulting in a substantial increase in volume of patients seen by each ER. The number of emergency departments grew from 5,707 in 1992 to 5,769 in 1999.

**Emergent vs. urgent visits<sup>5</sup>.** Twenty-seven (27) percent of U.S. emergency department visits in 1999 were not classified in hospital records as to urgency. Of the 73 percent of visits which were classified, 41 percent were true emergencies (“emergent”), and another 23 percent were urgent.

**Top reasons for emergency department visits.** With respect to symptoms, abdominal pain, chest pain, fever, and headache are the most common reasons for visiting the emergency department. The most common illness diagnosis is acute upper respiratory infection. From 1992 to 1999, the percentage of visits due to illness (as opposed to injury) increased, with injury and poisoning accounting for 36.6 percent of visits.

3 - Data on ER use at the state level are not collected.

4 - “National Hospital Ambulatory Medical Care Survey: 1999 Emergency Department Summary,” *Advance Data from Vital and Health Statistics, Number 320 (June 25, 2001)*, National Center for Health Statistics of the U.S. Department of Health and Human Services; “Trends in Hospital Emergency Department Utilization: United States, 1992-1999,” *Vital and Health Statistics, Series 13, Number 150 (November 2001)*, National Center for Health Statistics of the U.S. Department of Health and Human Services.

5 - When an illness or injury is a matter of life and death, “emergent care” is the first and only choice. “Urgent care” is designed to treat injuries or illnesses that require *prompt* (generally, within 24 hours) attention, but are not life-threatening.

**Prescription Drugs.** About 73 percent of emergency department visits result in administration or prescription of a medication. Pain medications (ranging from acetaminophen and ibuprofen to prescription-only narcotic drugs) are the most common, accounting for 31 percent of visits where a drug is involved. Next in line are anti-microbial drugs, involved in 15 percent of these visits, with respiratory tract drugs following at 8.5 percent.

**Follow-up to emergency department visits.** About 13 percent of emergency department visits result in admission to the hospital. About 47 percent of visits result in a referral to another physician or clinic, and 24 percent are told to return to the emergency department if needed (e.g., if certain symptoms recur or worsen) or for follow-up at a specified appointment time. Only 9 percent of emergency department visits result in release with no follow-up planned.

**Medicaid enrollees use the ER more than others.** While Americans with private insurance have the lowest emergency department use rate at about 20.5 per 100 insured persons, Medicaid enrollees have a higher rate of emergency department use (64.3 per 100 enrollees) than other groups. Uninsured Americans use the emergency department at about the same rate as Medicare enrollees (40 to 42 visits per 100). However, ER use by Medicaid enrollees declined from 1992 to 1999, while the share of ER visits from uninsured and Medicare patients grew.

**Children are more likely to use ER for non-emergent care.** Children under age 15 of all races have the lowest rates of ER visits that are emergent or urgent (or, put differently, are more likely to visit the ER for semi-urgent or non-urgent situations). In contrast, emergency department visits for persons over age 65 were about twice as likely to be emergent as for all other age groups.



## The Role of The Emergency Medical Treatment and Active Labor Act (EMTALA)

A basic understanding of how federal law mandates open access to ER care is indispensable in considering how to reduce primary care use of the ER. The Emergency Medical Treatment and Active Labor Act (EMTALA) makes it illegal for hospitals to simply turn a person away from the ER, so any strategies Texas Medicaid, CHIP or any insurer takes to discourage the use of the ER for non-emergent or urgent primary care must be more sophisticated than “just saying no.”

### WHAT IS EMTALA?

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed into federal law in 1985 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The law was generally referred to as “the anti-dumping law” because it addressed the then-growing problem of some hospitals rapidly and inappropriately transferring uninsured or publicly insured patients admitted through the ER to public or nonprofit hospitals, at times without the knowledge or consent of the receiving hospital. Major requirements of EMTALA include the following:

- Any hospital that operates an ER must provide emergency care to anyone who comes in requesting care and who needs emergency care, regardless of that person’s ability to pay or insurance status.
- Specifically, the hospital must provide a Medical Screening Examination (MSE) to anyone on whose behalf a request for examination or treatment is made. This exam is to determine whether the person has an emergency medical condition.
- If the MSE reveals that an emergency medical condition exists, the hospital must either (a) provide, within its capabilities, all additional examination and treatment needed to stabilize the condition, or, if the hospital lacks these capabilities; (b) appropriately transfer the patient to another hospital for stabilization.
- Triage alone is not the same as an MSE. All diagnostic and therapeutic resources available to inpatients must be available as needed for the MSE.
- The hospital must provide an MSE not just to people who arrive at the ER proper, but to anyone who presents on hospital property within 250 yards of the hospital’s main



building, in an ambulance owned by the hospital, or to outpatient clinics operated as off-campus departments of the hospital. Proposed regulations issued by CMS on May 9, 2002, somewhat reduce the scope of the hospital's obligation to provide an MSE.

- Provision of care cannot be delayed by the collection of information about payment status. Hospitals must be able to prove all patients with similar conditions are treated the same, regardless of their insurance status.
- Any transfer to another hospital must involve either:
  1. A request from a patient for the transfer, after the patient has been informed both that the hospital has an obligation to examine and treat them and about any risks associated with transfer, or
  2. Certification by a physician in writing that the benefits "reasonably expected" from the treatment at the receiving facility outweigh any increased risk to the patient (or unborn child) from undergoing the transfer.
- Transfers must also meet several other requirements, including agreement to accept the transfer by the receiving hospital.

The law does not prevent a hospital from sending a parent with a child who has an ear infection to an urgent care clinic, but it does require that the hospital first do an adequate medical screening exam (MSE) to ensure that an ear infection is really all the child has. At that point, it may be more cost-effective to simply provide the treatment needed. Thus, diversion of parents bringing their children to the ER for routine or minor childhood illnesses would more ideally be achieved by educating parents in advance about healthcare options to prevent them from choosing the ER in the first place. Otherwise, once the obligation to provide the MSE has been triggered, the hospital or the health insurance payor cannot avoid the cost of that exam.

**EMTALA and payments to hospitals.** Another important implication of EMTALA comes into play when hospitals seek payment for the services they provide in the ER. The **Balanced Budget Act of 1997** (BBA) and regulations that followed clarified that Medicare, Medicaid (and all insurers and HMOs contracting with these programs) would pay for ER care that a "prudent layperson" would seek based on his symptoms; it also prohibited contracting insurers and HMOs

from imposing pre-authorization requirements for ER care. Hospitals, who must provide an MSE to all who request one, may seem to be held to a higher standard than insurers, who must pay only for care that a prudent layperson would seek; however, the law does not excuse insurers from paying for ER care that is non-emergent.

Still, there is little regulation regarding the nature of reimbursement, and hospitals, physicians and insurers continue to struggle over who will bear the financial consequences of the EMTALA standard of access. A closer look at specific issues in ER services reimbursement is provided later in the chapter, under "Cost Impact and Issues for Hospitals."

**EMTALA and doctors' beliefs about ER use.** In healthcare provider interviews for this study, it became apparent that legal definitions related to EMTALA have contributed to the absence of consensus about what constitutes "appropriate" emergency department utilization. For example, when asked the question, "When is emergency department utilization inappropriate?" the very term "inappropriate utilization," was deemed by many providers to be completely "inappropriate." Further probing of providers indicated that the definition of "emergency" is equally ambiguous. The more traditional concept of an emergency as including severe injury and other life-threatening conditions has been blurred by the definition of emergency included in the BBA.

*"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."*<sup>6</sup>

Medical Director Dr. John Hellerstedt of the Texas Health and Human Services Commission best paraphrased an interpretation of the above definition as this: "If anything hurts bad enough, by law, it's an emergency."

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6 - P.L. 105-32, Balanced Budget Act of 1997, Title IV: Medicare, Medicaid and Children's Health Provisions, section 1852 (d)(3).

## RECENT RESEARCH ON ER USE

### Non-emergent ER use by New York Medicaid enrollees.

A study of ER utilization by New York City Medicaid recipients attempted to classify emergency department use. New York University researchers developed a profiling algorithm — that is, they used the medical record, rather than subjective measures — to classify some six million ER claims from 1994 to 1998. The algorithm classified ER usage into four categories: (1) Non-emergent; (2) Emergent/primary care treatable; (3) Emergent/emergency department care required but preventable/avoidable; and (4) Emergent/emergency department care required, not preventable/avoidable.

The researchers found that in nearly 75 percent of the six million cases reviewed, patients not admitted to the hospital<sup>7</sup> fell into either the non-emergent or emergent/primary care treatable categories. Further, for children, 34 percent of the emergent care received might have been prevented with proper primary care. The study noted that while Medicaid enrollees and the uninsured used the ER for non-emergent conditions, the trend was nearly as high for privately insured individuals, and concluded that the primary care delivery system in New York City is inadequate. Citing earlier studies, the authors note that those relying on the emergency department for primary health care most likely lack continuity in their health care, as well as use costlier services. The researchers concluded that systemic changes to improve primary care access are needed to reduce New Yorkers' reliance on the ER, and recommended reduced waiting times for doctors' appointments, enhanced telephone consultation capacity and reimbursement rates adequate to make these improvements possible.<sup>8</sup>

### Providers do not agree on when ER use is "appropriate."

Although subject to increasing interest over the past 40 years, attempts to define "questionable" situations at the ER have never resulted in a single best answer. Whether non-urgent ER use is appropriate is even more difficult to assess. Studies of emergency department use in the United States, many of which use subjective definitions of "appropriateness," report anywhere from 11 percent to 82 percent of ER use as inappropriate or non-urgent.<sup>9</sup> While different study locations account for some of this extreme difference, much of the difference in rates can be traced to very different definitions of "non-urgent" or "inappropriate." Categorization of ER visits in research have been based on criteria as varied as:

- nurse triage assessments (including subjective, standardized and simple "emergency or not" assignments)
- what tests, treatments or hospitalizations resulted from the visit
- patient self-assessments

According to one study reviewing research on this topic, no standards for "appropriateness" exist in the ER research literature which meet a rigorous test of reliability and validity. In fact, the author reported that several studies have shown poor correlation between any two measures of appropriateness, and wide variability in the proportion of ER visits that are classified as appropriate depending on which different classification criteria are applied.<sup>10</sup>

Qualitative studies of ER staff suggest that the wide variation that exists in providers' beliefs about the role of the ER understandably results in equally wide variation in what providers communicate to ER patients regarding appropriateness of non-urgent ER visits, and inconsistent strategies to reduce utilization.<sup>11</sup> As one researcher commented, "There are better ways to serve our patients than to blame them for seeking help."

**Why parents use the ER for pediatric primary care, and what ER providers consider "appropriate."** A number of studies and articles have explored the notable lack of consensus among medical professionals as to what constitutes appropriate use of the ER, and attempted to reach a definition of inappropriate use. Research into parents' reasons for using the ER for non-emergent care has been much more limited. Two projects sponsored by the Robert Wood Johnson Foundation looked closely at pediatric ER visits in urban New Jersey hospitals. Like previous research (and the Texas

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7 - ER visits that are followed by a hospital admission are presumed to be indisputably emergent. Due to exclusion of these claims, these statistics are not comparable to the NHAMCS findings described earlier.

8 - Billings, John, Nina Parikh, Tod Mijanovich, "Emergency Department Use: The New York Story," *Commonwealth Fund Issue Brief*, November 2000.

9 - Lowe, R. A., & Abbuhl, S. B. (2001). "Appropriate standards for 'Appropriateness' research." *Annals of Emergency Medicine*, 37(6), 629-632.

10 - Lowe, R. A., & Bindman, A. B. (1997). "Judging who needs emergency department care: a prerequisite for policy-making." *American Journal of Emergency Medicine*, 15, 133-136.

11 - Guttman, N., Nelson, M. S., & Zimmerman, D. R. (2001). "When the visit to the emergency department is medically non-urgent: provider ideologies and patient advice," *Qualitative Health Research*, 11(2), 161-178.



research reported herein), this study found that providers did not agree on criteria for identifying appropriate or urgent ER visits. The researchers also found that most of the ER professionals studied did not routinely counsel parents to seek future care in a primary care setting. A majority of ER providers were unaware of 24-hour nurse consultation lines available to their patients, and thus were not promoting their use.

The study reported parents' reasons for using the ER which are echoed in the Texas findings described in this report. Top reasons included: inability to promptly access care in the usual primary care setting; guaranteed "one-stop" service at the ER (e.g., immediate access to testing and specialty care); the ability to be seen without an appointment, and a need for reassurance about the child's health status. Two-thirds of parents had called a provider's office before going to the ER, and none of the parents cited monetary reasons for choosing the ER. Finally, a majority of parents reported having prior communications with a PCP about when to use the ER and how to deal with a child's fever, and just under half had talked to their doctor about managing their child's pain.<sup>12</sup>

**ER doctors worry about compromised care.** Some emergency physicians have expressed deep concern about overcrowding in emergency departments, claiming it can lead to a number of problems, including prolonged waiting times, increased suffering for those in pain, unpleasant therapeutic environments, potentially poor clinical outcomes, and in many cities, ambulance diversions to other hospitals. A recent study found that critical and urgent visits to California emergency departments increased from 1990-1999 by 59 percent and 36 percent respectively. Physicians worry that the burden of providing non-emergent primary care in the ER could reduce the quality of care received by those with serious emergencies.<sup>13</sup>

**A Texas snapshot.** While no formal research on ER utilization within Texas has been published, some health plans conduct internal analyses that draw links between continuity of health care through consistent primary care provision and levels of ER use. One San Antonio-area HMO serving commercial, Medicaid and CHIP populations routinely analyzes ER use by its enrollees. The plan administrators report that ER use by its Medicaid clients was much higher than for commercial enrollees (e.g., 733 visits per 1,000 Medicaid enrollees, versus 412 visits per 1,000 commercial enrollees in 2001), and that this finding was consistent over several years. Before CHIP was implemented, it was thought that the fact that the Medicaid clients were primarily children might account for most of the difference. But in the most recent year, CHIP enrollees used the ER at a rate of 370 per 1,000, even lower than the commercial population. While the rates of use were different, the top ten reasons for ER visits were very similar between the CHIP and Medicaid populations, with fever and otitis media (ear infection) leading the way.

The plan administrators believe that CHIP's continuous eligibility makes it more likely that parents have or will establish a relationship with a primary care provider, thereby having a real medical home. They also note that CHIP parents are assessed co-payments for ER visits (though, as for every kind of insurance under EMTALA, the co-pay is not requested until **after** the ER visit is complete). Finally, the higher socioeconomic profile in CHIP may also be associated with parents who are better educated about dealing with childhood illness, and/or who are more likely to have a history of established relationships with primary care providers. The administrators say that when they analyze families with high ER use, they often find that though assigned, the family has never seen their PCP.<sup>14</sup>

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12 - Zimmerman, Deena, Nurit Guttman, "Emergency Department Visits by Children: Parents' vs. Providers' perspectives on Urgency," and "Study of Non-urgent Pediatric Visits to Emergency Departments," Robert Wood Johnson Foundation, Grant Results Report, June 2000 ([www.rwjf.org/health/030445s.html](http://www.rwjf.org/health/030445s.html)).

13 - Derlet, Robert W., M.D., "Overcrowding in Emergency Departments: Increased Demand and Decreased Capacity," *Annals of Emergency Medicine*, 39:4, April 2002.

14 - Telephone interview with Community First Health Plans Administrators, Charles L. Kight, President/CEO and Maurine Porto, M.D. Medical Director, April 22, 2002.

## **COST OF NON-EMERGENT ER USE IN TEXAS MEDICAID AND CHIP IS UNKNOWN.**

The Texas Medicaid and CHIP programs do not have comprehensive data on the total cost of ER use, nor is it possible to quantify the costs of the subset of total ER use that is related to ER utilization for non-emergent or urgent/primary care treatable illness. Still, though it is impossible to classify the precise extent of the problem or its price tag, there is little disagreement that providing primary care in the ER setting almost always costs more per patient than it would have in a primary care office or clinic setting. Certain Texas Medicaid policy interventions have been implemented based on the accepted assumption that primary care in the ER is not only more costly, but also less detrimental to the optimal care believed to result when a long-term medical home is established for a child<sup>15</sup>. Still, sources of the problem and appropriate interventions have not been systematically investigated or explored. A review of some of the information related to Texas Medicaid and CHIP ER costs that is available is provided below.

**Quantifying ER use and spending is difficult.** Texas state government has never undertaken an in-depth analysis of ER use by Medicaid enrollees. Because of the different billing and data systems used by fee-for-service, Texas Health Network (THN, also known as primary care case management or PCCM) and Health Management Organizations (HMOs), analysis of ER use and costs is not a simple task. In addition, a meaningful analysis would have to consider enrollees pre-existing diagnoses, medication use and prior and subsequent hospitalizations in order to capture either a true picture of the total costs, or to classify the “appropriateness” of ER visits. A typical ER visit may result not only in a hospital department fee, but also in separate physician fees, as well as miscellaneous billings for ancillary diagnostic services (e.g., x-ray, laboratory tests, CT scans). Follow-up prescriptions and return outpatient visits may also be associated with the visit. Moreover, Texas Medicaid’s fee-for-service claims processing systems and encounter data systems of HMOs were not designed to facilitate capturing all the costs related to a single ER visit. The complexity of the data analysis task that would be required to carefully analyze what Texas Medicaid spends on ER visits probably explains why none has ever been conducted, despite the fairly high level of rhetorical attention that has been given to the assumption that “inappropriate” ER use is a cost drain on the program.

**Analysis of ER use.** Texas Medicaid Managed Care reports in 1998 and 2000 have concluded that ER use is lower in HMOs and THN than in traditional fee-for-service Medicaid. These assumptions are based on managed care “encounter data” reported to the state’s quality monitor, as well as self-reporting by Medicaid enrollees. However, many people are first covered by Medicaid as the result of a hospital admission, and are only enrolled in managed care in the second or third month of Medicaid coverage. As a result, HMO utilization data understates somewhat the actual ER and hospital use of Texas Medicaid enrollees. In addition, quality monitor reports have found considerable problems with the collection and validation of reliable encounter data from Texas Medicaid Managed Care HMOs. While improved, these problems are not resolved.

Published information on CHIP ER use is limited to findings in a survey of new enrollees published in 2001. Prior to CHIP enrollment, 19 percent of families reported the ER or hospital clinic was their child’s usual source of care, compared to 10 percent of families after enrollment. Because the survey combines hospital clinics and ERs into the same category, it is not entirely clear how much of the reduction is related to ER use<sup>16</sup>.

*[A more detailed description of these analyses is found in Appendix A.]*

## **COMPARING THE COST DIFFERENCE: PRIMARY CARE VS. ER**

The complexity of the data notwithstanding, it is still instructive to make a simple “apples to apples” comparison of the cost of a basic primary care visit to a PCP vs. the ER. In an attempt to offer a basic analysis, the Texas Association of Health Plans circulated several scenarios to member health plans. For each scenario, the health plans were asked to contrast the plan’s estimated cost for treating the conditions both in the ER, and in a primary care office setting. The plans were asked to assume that all the children in the stories are on Medicaid and that all have established good relationships

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15 - For example, the Health Care Orientation (HCO) required for parents of newly-enrolled children in Texas Medicaid mandated by SB 43 addresses ER use, and HMOs may request that HHSC letters be sent to especially high uses of the ER.

16 - Shenkman, Elizabeth, “CHIP in Texas: The New Enrollee Survey Report,” Institute for Child Health Policy (January 2001), [www.hhsc.state.tx.us/chip/reports/ChipEnrolleeSurvey\\_012001.pdf](http://www.hhsc.state.tx.us/chip/reports/ChipEnrolleeSurvey_012001.pdf).



with a primary care provider. Scenario 1 was designed to illustrate a non-emergent condition. Scenario 2 was designed to illustrate an urgent but primary care treatable problem; and Scenario 3 was designed to show an urgent primary care preventable problem. These scenarios were derived from real stories told to researchers during the course of this study.

**Scenario 1:** An 8-month old baby has minor congestion, loss of appetite, pulls on his ears, and “feels hot.” Fearing high fever and seizures, his mother takes the baby to the emergency department, where he is given Tylenol drops for a 99.2 degree fever. After waiting four hours, she sees a doctor, who diagnoses teething. **How much would it cost the mother to take the baby to the PCP vs. this ER visit?**

**Scenario 2:** A single working mother earning hourly wages takes her two children to the emergency department for after-hours care after the school nurse calls to say that one child has a fever of 101 and needs to go home. Thinking that the child’s sibling “looked strange, too” and has a little cough, she takes both children that night because she wants to avoid a recurrence of ear infection, of which both of her children have a history. At the emergency department she waits two hours and then asks the doctor for antibiotics. The ER does lab work on the child with fever and prescribes antibiotics. The second child is prescribed over-the-counter Robitussin for cough. **Assuming that the 6-year old daughter’s PCP knows her propensity to ear infections and would not have drawn blood, what is the cost of the ER visit for this family vs. waiting 2 days for a PCP visit? Also, how much did the ER charge to check the sibling?**

**Scenario 3:** A mother who cannot tell the difference between simple congestion and an asthma attack takes her 8-year old to the emergency department because she is uncertain about how to use his asthma medication. She does not have a nebulizer<sup>17</sup> at home and may have treated him at home if she did. She complains to a friend that she does not think her child has the specialist he needs, and she also doesn’t have a case manager. Because she has no one to call when she fears he is having an attack, she goes to the ER for assurance. Depending on the day or time and the anticipated wait, she goes to different emergency departments. Every time she goes, they x-ray his chest. **How much would one case**

**manager or health educator visit have cost? Assuming that it could have prevented at least one of the three visits to the ER, would a cost savings have been realized for this one client with proper education and medical support?**

Three health plans answered the survey<sup>18</sup>. The difficulty of data analysis is illustrated in their responses. Even working from identical scenarios, current procedural terminology (CPT) codes were applied similarly, but not identically. Therefore, only a basic average can be offered in the cost difference.

For the first scenario (baby teething), two plans<sup>19</sup> applied CPT code 99213, the code for an existing patient visit, for the cost of the primary care provider visit; the average cost among four cities (Dallas, Fort Worth, Lubbock, and Houston) was \$29.09. The average professional fee for treatment in the emergency department (**not** including emergency department usage fee) was \$54.48. For the doctor’s fees alone, based on these averages, an emergency department doctor’s visit costs \$25.39 more per visit. The third plan also added in the cost of the emergency department fee on top of the professional fees. A look at that comparison shows that the Scenario 1 ER cost was \$168.76 more than at the primary care provider.

For Scenario 2 (siblings with virus), the cost of using the ER was \$337.52 more than going to a primary care provider who knew both children. For Scenario 3 (the child with asthma), the estimated cost difference is \$150.<sup>20</sup>

While this method of cost comparison is simplistic, it serves to put in concrete terms what is well known intu-

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17 - A nebulizer uses a spray-like device to change a liquid into a fine mist. Another name for a nebulizer treatment is aerosol therapy. Nebulizers are often used by children who are too young to use an inhaler.

18 - The plans are not named in this report, as information about cost reimbursements is considered proprietary.

19 - One plan’s reimbursement to physicians pays PCPs a percentage above the fee schedule for the code analyzed, and in some cases, that percentage is 140 to 170 percent above the fee schedule. That would place those PCPs at close to \$40 per visit, which is about \$11 higher than most. Therefore, their reimbursement rate was omitted from the average reimbursement calculation because it would have artificially raised the state average. The director of the plan explained that physician reimbursement was so much higher in an attempt to provide an incentive for physicians to see the Medicaid and CHIP patients along with others. When asked whether he thought the higher reimbursements were working to expand access, he responded that he did not know.

20 - A representative of the plan also explained that this plan (and some others) opt to pay a flat \$150 ER contract fee, regardless of what tests are performed. The plan asserts that actuarial figures show that this figure amounts to the average charge of an ER visit.

itively: the emergency department costs more money than a primary care provider. The unknown factor is how many visits of this kind there are; therefore, the actual cost to Medicaid is uncertain.

### **COST IMPACT AND ISSUES FOR HOSPITALS**

The cost impact of non-emergent ER use is not the same for every hospital. For example, for some hospitals in smaller cities and rural areas with emergency departments that are not overwhelmed with patient traffic, treating non-emergent patients who have public or private insurance may actually be beneficial, as they help to cover the marginal costs of staying open.

For Texas' large public and nonprofit hospitals in urban centers, emergency departments today are more likely to suffer from overcrowding, which creates incentives for the hospital to find ways to discourage non-emergent ER use within the limits of what is allowed by EMTALA. In some cases, this has meant creation and promotion of urgent care walk-in clinics and 24-hour nurse triage lines.

Whether or not the ER is overcrowded, hospitals face increasing challenges getting insurers and HMOs to pay for ER visits. Hospital representatives contend that the use of global fees (without payment for ancillary diagnostic or therapeutic services) allows certain Medicaid HMOs to reduce their financial exposure for non-emergent ER use. Dispute over whether a claim was urgent or emergent also can result in lower reimbursement. Because EMTALA requires hospitals to provide emergency medical screening exams and stabilization services regardless of the patient's ability to pay, hospitals cannot avoid costs of certain potentially costly diagnostic procedures needed to rule out a medical emergency. While the provisions of BBA (described previously) clearly require managed care organizations to pay **something** for ER care, the regulations do not specify how HMOs put this into practice. Thus, the law and rules do not prohibit paying a flat global ER fee.

Texas Medicaid's HMO contract specifically requires the payment for ancillary services. Hospitals maintain that this provision is not consistently applied by all HMOs. Hospitals also believe that the use of the global fee payment method results in an artificially low record of the true cost of care per Texas Medicaid client, which in turn reduces the per member/per month premium which the HMOs can justify requesting from the state. Health plans maintain that their global fees are actuarially valid, and based on actual average costs of care.

*[A more detailed discussion of how ER visits are paid for in Texas Medicaid fee-for-service, PCCM and HMOs is provided in Appendix B.]*

### **COMMUNICATING WITH PARENTS ABOUT USING A MEDICAL HOME INSTEAD OF THE ER**

Expectations of Medicaid have changed dramatically over the past 15 to 20 years. Prior to the expanded coverage of children in the late 1980s and the implementation of Medicaid Managed Care in the 1990s, Medicaid programs across the nation generally just paid the bills. No promise of a link to a consistent medical home was made, nor were many resources directed to outreach and education for parents. Most of Medicaid's earliest efforts to educate parents were related to either EPSDT (Medicaid's program of check-ups and comprehensive care for children, known here as Texas Health Steps) or to the implementation of Medicaid Managed Care. With the implementation of CHIP programs nationwide (many of which take the form of Medicaid expansions), both outreach to parents and coverage of children have expanded rapidly.

A look at what has been learned as these changes have occurred is helpful in understanding the context in which Texas parents whose children have Medicaid or CHIP coverage are operating. The section that follows reviews some general research findings, in Texas and the U.S., about the challenges involved in effectively informing parents. Finally, a review of what Texas Medicaid currently tells parents about finding and using a medical home — vs. using the ER — is provided.

**Educational efforts in managed care areas.** A study sponsored by the Commonwealth Fund and published in May 2000 reported a lack of consumer understanding in managed care areas.<sup>21</sup> The study compared Medicaid Managed Care educational efforts in 13 U.S. metropolitan areas (including Houston) with high penetration rates of managed care and/or innovative managed care outreach and education practices. Researchers gathered and compared enrollment materials and Medicaid agency contracts with managed care plans and enrollment brokers, analyzed public information campaigns, counseling sessions and presentations, and

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21 - Kaplan, Sue A., Jessica Greene, Chris Molnar, Abby Bernstein and Susan Ghanbarpour, "Educating Medicaid Beneficiaries about Managed Care: Approaches in 13 Cities," *The Commonwealth Fund*, May 2000.



conducted interviews with state Medicaid or managed care representatives. They reviewed the packet materials, looking at development, design and content, and also assessed how well these efforts are monitored.

The researchers found an absence of assessment of the effectiveness of educational interventions, and a lack of consultation with education experts despite the major education task presented by managed care implementation. Enrollment brokers, managed care companies and state agencies were producing materials with a wide variation of effectiveness. The authors concluded that all programs would benefit from greater attention to assessing the effectiveness of educational efforts, coupled with educational messages more carefully tailored to meet audience needs.

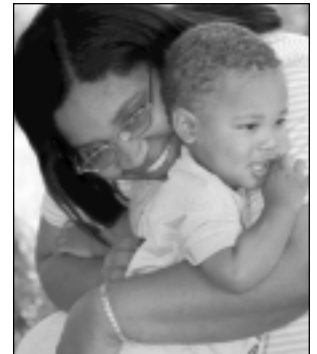
**Texas observations.** In the course of earlier studies conducted by Orchard Communications, Inc., researchers interviewed more than 1,000 Texas parents of children on or eligible for Medicaid or CHIP.<sup>22</sup> Throughout these studies, Orchard researchers noticed a significant lack of understanding about health insurance and how to use it. Managed care implementation resulted in confusion over the concept of, or how to choose, a primary care provider (PCP); assignment to doctors parents did not know or who were far away; and anger at being told not to use emergency departments if they had not contacted a PCP. In a few extreme cases, clients dropped out of the Medicaid program altogether because the changes were simply too overwhelming. Among the causes of confusion were member benefit handbooks which some parents found were too complex; state-imposed marketing restrictions<sup>23</sup> preventing outreach workers from recommending primary care providers; and information hotlines that were poorly advertised, if advertised at all. Orchard researchers hypothesize that this observed lack of access to comprehensible, acceptable, relevant and persuasive information provides a potentially enormous barrier not only to enrollment and re-enrollment, but also to optimal utilization of benefits.

**What Texas Medicaid tells parents about ER use.** As noted previously, while uninsured children may go to emergency departments when they are sick for lack of a better option, many children presenting in the emergency departments actually have Medicaid or CHIP, and thus in theory should have access to a primary care physician. In considering what kinds of new educational efforts might be

effective in reducing primary care use of the ER, it makes sense to first take note of what parents are **currently** being told about use of the ER and a medical home by Texas Medicaid.

Depending upon where a family lives, or what type of Medicaid coverage they have, messages about emergency department utilization are different. **On any given day the majority of Texas Medicaid enrollees are enrolled not in managed care, but in traditional fee-for-service Medicaid.** To illustrate, in December 2001 about 621,000 out of 1,959,000 enrollees (32 percent) were in managed care.<sup>24</sup> **Thus, a majority of Texas Medicaid emergency department claims are billed as traditional fee-for-service directly to the Texas Medicaid program.** This is important, because the two-thirds of Medicaid enrollees who are in fee-for-service coverage are not explicitly assigned to any PCP. There is no process in place to create a medical home for child Medicaid enrollees in fee-for-service Medicaid. Their parents can request help finding a PCP from Texas Health Steps staff, and they will be contacted and provided assistance if the children do not get check-ups, but finding a Texas Health Steps check-up provider is not the same as guaranteeing a medical home. In contrast, enrollment in Medicaid Managed Care ensures that a PCP will either be chosen or assigned. Moreover, the managed care plan and the PCP both have a contractual obligation to provide “24/7” access to care.

With these differences in mind, managed care member handbooks and the Medicaid User’s Guide were analyzed to



22 - “Texas Health Steps Outreach Efficacy Study,” Orchard Communications, Inc., for the Texas Department of Health Texas Health Steps program, October 1999; “A Marketing Identity for the Children’s Health Insurance Program: Findings from Focus Groups,” Orchard Communications, Inc., August 1999.

23 - These restrictions are intended to prevent enrollment contractors from favoring one health plan over another. However, as an unintended result, the restrictions can prevent a worker from helping a parent find a doctor who is located nearby, speaks Spanish, or meets the family’s needs in some other specific way.

24 - There are several reasons for this. First, outside of the largest urban areas of Texas there is not a Medicaid Managed Care option. In every urban area but Houston, managed care participation is optional for SSI recipients, and in most of the state persons dually eligible for Medicaid and Medicare (which is the case for most of the poor elderly on SSI) cannot participate in Medicaid Managed Care. StarPlus in the Houston area is an exception.

review messages to parents about emergency department usage.

**Traditional fee-for-service Medicaid.** Prior to the January 2002 implementation of the Health Care Orientation (HCO)<sup>25</sup>, the two-thirds of Texas Medicaid enrollees in fee-for-service areas had not received much in the way of formal direction about “appropriate” ER use. The Texas Medicaid **User’s Guide**, still in circulation as of March 2002<sup>26</sup>, mentions ER care as a type of hospital service covered when medically necessary; however, there is no discussion of what constitutes a medical emergency. Neither is there any discussion of the concept of a PCP or medical home, except for a single statement that STAR clients (Medicaid Managed Care) should go to their PCP for physician services, except in an emergency or for family planning services.

**PCCM: the Texas Health Network.** The member handbook for Texas Health Network (THN) attempts to educate the enrollee (or parent) about routine care, and devotes several pages to describing the role of the PCP. The handbook explains the availability of THN’s FirstHelp nurse triage hotline and provides a list of examples of conditions that are “urgent” for which a call to FirstHelp or the PCP is suggested. (Examples include earache, toothache, cold, cough, sore throat, flu or sinus problem.)

This is followed on the same page by a list of conditions that may indicate a “true emergency,” and explicitly directs that a person should go directly to the ER without calling the PCP. (Examples include risk of death, loss of limb, severe chest pain, choking or difficulty breathing or bleeding “a lot.”) This information is located along with guidance about accessing after-hours and out-of-network care. Several pages later, there is also a mention that an enrollee might be dropped from THN for repeatedly going to the ER. Notably absent from this information is guidance for parents regarding how to classify or care for fever, prolonged vomiting or diarrhea.

**HMOs in Medicaid Managed Care.** Because THN and HMO member education materials are subject to oversight and approval by the state, information about PCPs, and routine, urgent and “true emergency” care in HMO member handbooks very closely tracks the THN description above. HMO handbooks also direct enrollees to HMO-specific 24-hour nurse hotlines.

**The new Medicaid Health Care Orientation.** A Health Care Orientation (HCO) required for parents of newly

enrolled children in Texas Medicaid was mandated by SB 43 (77<sup>th</sup> Texas Legislature) and first implemented in January 2002. The script now in use is slated for ongoing revision and improvements. As of this writing (April 2002), the HCO includes very limited information regarding emergency care, listing examples of “true emergencies” consistent with those described above in the managed care member handbooks, and directing parents to contact the PCP or managed care nurse help line for all other care. A Medicaid/CHIP Consumer Information Guide will soon replace the Fee-for-Service Users Guide mentioned above and will be distributed in conjunction with the HCO. This new guide is currently being drafted to include urgent care and emergency care guidance very similar to that now included in the managed care member handbooks.

**What information is missing?** As the practices above illustrate, the majority of Texas Medicaid enrollees (i.e., those in fee-for-service Medicaid) are receiving little or no guidance about the “appropriate” use of the ER. And even the somewhat greater level of guidance about urgent care and ER use currently being provided to recipients completely fails to address the top conditions and symptoms that this study addresses. This study’s findings drive the majority of non-emergent pediatric trips to the ER: parents’ concerns about fever (as associated with various kinds of childhood illness); vomiting, diarrhea and fears of dehydration; and situations in which parents (particularly younger and less experienced parents) are unable to relieve a child’s discomfort.

**The role of Texas Medicaid providers and health plans.** The two-thirds of Texas Medicaid enrollees who are not in managed care at any given point in time do not have a designated primary care provider, whether doctor or clinic, responsible for providing a medical home and continuity of care. Physicians in fee-for-service Medicaid are not subject to any explicit obligations regarding the provision of a medical home or after-hours availability. In Medicaid Managed Care, PCPs are specifically obligated to arrange for “24/7” coverage,

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25 - The Health Care Orientation requirement under SB 43 of the 77<sup>th</sup> Texas Legislature is currently directed only to parents of newly enrolled children. While in the future it may be extended to other Medicaid recipients, such as parents, seniors, and persons with disabilities, that is not currently the case.

26 - A revised Texas Medicaid User’s Guide, which will incorporate information about “appropriate” ER use, is under development by the Texas Health and Human Services Commission as of March 2002.



and the HMOs themselves are required by contract to have adequate numbers of providers to ensure that clients may access urgent care within 24 hours of request. The HMO is expected to monitor this access. Requirements for PCCM PCPs are very similar. The state's PCCM network coordinator contractor monitors PCPs' compliance with this requirement, but it is not clear whether the contractor is obligated to ensure adequate numbers of THN PCPs to guarantee the same level of access as is required of HMOs.

*[See Appendix C for a more detailed discussion of provider and contractor requirements.]*

### **SUMMARY: DEFINING THE PROBLEM**

Research suggests that emergency department utilization for primary care treatable ailments is probably greatest in the Medicaid population; for children under 15, a large proportion of ER visits will be for primary care treatable or preventable ailments. Nationally, rates of ER use seem to be on the rise, while the number of ERs is declining. EMTALA makes it illegal for hospitals to simply turn a person away from the ER, so any strategies to discourage the use of the ER for non-emergent or urgent primary care must be more sophisticated than "just saying no."

National and Texas research find that healthcare providers disagree about what constitutes "appropriate" ER use, and studies attempting to categorize ER visits have used highly inconsistent classification systems. A lack of access to routine primary care and urgent care in a primary care setting have been identified as major drivers of non-emergent ER use, as has a lack of parental knowledge of available alternatives.

As stated earlier, Texas Medicaid does not have solid aggregate data on either the prevalence of ER utilization for non-emergent conditions, nor do program administrators know how much is spent as a whole on emergency department utilization. Fee-for-service ER fees are less than 1 percent of the total Medicaid budget, but the addition of missing Medicaid managed care data and ancillary costs could result in a total several times that size. Despite the lack of comprehensive statistics on Texas Medicaid ER use, all available data supports the conventional wisdom that treating minor ailments in the ER is significantly more expensive than in a primary care medical home.

In addition to costing more, the lack of continuity of care resulting from a pattern of primary care use of the ER may negatively affect health outcomes. For certain hospitals,

inadequate reimbursement for primary care use of the ER may represent a real financial challenge. Finally, national trends pointing to an increase in urgent and emergent cases appearing in the ER, nursing shortages, shortages of trauma and ICU beds and other realities of today's hospital emergency departments increase the likelihood that the demand on resources made by patients with non-emergent or primary care treatable or preventable ailments could result in lower quality care for the persons in need of care for serious emergent conditions.

Texas Medicaid has different ways of explaining utilization to parents, depending upon whether they have fee-for-service, managed care or PCCM Medicaid. On a given day, about two-thirds of Texas Medicaid enrollees are in fee-for-service care, and have not historically been targets for education about either a medical home or ER use. Even in managed care, an examination of user's guides and booklets indicates that the information currently provided does not address the most common reasons parents seek urgent care, and thus is inadequate to promote the behavior expected of these parents. Guidelines for providers, like consumers, vary according to how the Medicaid program is administered in their area. Primary care providers in managed care are expected to provide "24/7" coverage, while fee-for-service providers have no mandates for ER referral or their own availability.

**Looking ahead.** The context described in this chapter is one in which little is certain beyond the fact that primary care in the ER is more expensive than in the doctor's office. Within this context, thousands of Texas parents are confronting childhood illnesses, most of them routine, with differing levels of understanding about their options. In the absence of clarity or quick access to information on appropriate healthcare utilization, they often get information from each other, or by trial and error. The research described in the remainder of this report was therefore designed to collect information about how parents learn about and use their children's healthcare benefits, in the hope that the information gained can contribute to the development of educational tools that are effective in promoting optimal healthcare utilization and improved health outcomes.