What Is a Usual Source of Care?
Who Provides the Children’s Health Care? (pt 3 of 3)

In the past two briefs we have defined a usual source of care (USOC) in two general ways: by place and by health-care provider. The definition based upon where the USOC is located was tested on two years of Medicaid claims data for Mississippi’s children (see second brief). We are continuing our use of Mississippi Medicaid administrative data for state fiscal years 2002 and 2003 (SFY02 and SFY03) to define a USOC as who, in terms of medical specialties, provided private health care services to children on Medicaid during these two fiscal years. We:

- Calculate percentages of all beneficiaries (eligible children with at least one health care visit) under 18 years of age with a USOC receiving health care from particular types of physicians;
- Compare the numbers of visits for all beneficiaries with a USOC;
- Examine more specifically only those Medical Doctors (MDs) and Doctors of Osteopathy (DOs) who were in private practices and clinics and were defined as the USOC for these children; and
- Consider the number of beneficiaries with a USOC as the Emergency Room (ER) or Emergency Department (ED) at a hospital.

All USOC Beneficiaries by Provider

Primary Care Providers (PCPs) are defined here as being trained in one of five areas: General Practice, Pediatrics, Obstetrics-Gynecology, Internal Medicine, or Family Practice. We have separated the Emergency Medicine specialty in our analysis from the remaining specialties provided by Medicaid in order to examine how frequently the EM specialty was designated as a USOC. The category “All Others” represents more than 50 specialties within the Medicaid files.

Figures 1 and 2 below show the proportion of family practitioners (FP) who represented the USOC for about 45 percent of MS children on Medicaid with a USOC. Nearly another 1 in 4 for SFY02 and 1 in 5 for SFY03 USOC visits were with other primary care physicians (general practitioners (GP), pediatricians (Ped), internists (IM), or Ob-Gyn.

While one-quarter to one-third of children were receiving their usual care from “all others” specialties, EMs (emergency medicine doctors) served as the USOC for three to four percent of all children with a USOC.

Next, we examine the categories of visits, in general, by the PCP, EM and All Others.
The Mississippi Health Policy Research Center is a division of the Social Science Research Center at Mississippi State University.

When comparing one year to another, the biggest change in the specific categories of visits was in the 2 to 5 visits category with a general drop in percentages from 2002 to 2003 for PCPs who served as a USOC. Therefore, in SFY02, all three specialty groupings peaked in the 2-5 visits category; however, this was not the case in SFY03. The EM specialty as a USOC was highest for 1 visit, while All Others and the PCP specialties peaked in 2-5 visits. The only actual increase over SFY02 numbers was in the percent of “All Other” specialties (e.g., in the 2-5 visits category, 14 percent in SFY03 compared to 12 percent in SFY02). Nearly all of the children with an EM physician as their USOC (4 percent in SFY02 and 3 percent in SFY03 as noted in figures 1 and 2) had five or fewer visits. So, children who were using an EM specialist as a source of usual care did not appear to be using this type of provider excessively.³

USOC BENEFICIARIES BY PRIVATE PROVIDER

There were 67,235 (SFY02) and 66,328 (SFY03) beneficiaries 0 up to 18 years with their USOC as physicians in the private sector.⁴ The remaining children with a USOC (about 49 percent in SFY02 and 53 percent in SFY03) were primarily served at public locations (Federal Clinics or FC, Rural Health Centers or RHC, and County Health Department or CHD Clinics). These numbers were fairly consistent across both fiscal years except for the increase in the use of physicians within the public sector in SFY03.

When examining physicians in the private sector who provided a USOC for children on Medicaid, we see that PCPs comprised 52 percent of the USOC provided by the private sector in SFY02, which fell to 49 percent in SFY03 (see figures 5 and 6). The category “All Others” included 50+ specialties, PCP contained five specialties, while EM had only one; therefore, 8 percent (SFY02) and 6 percent (SFY03) for the lone “EM” specialty as a USOC for these children is noteworthy.
In figures 7 and 8, we subdivided the percentages above according to age groups and level of enrollment to consider other patterns in these data. Infants represented 11 to 12 percent of those children with a private USOC, preschoolers composed just more than one-third, and more than half of school-age children had a private physician as their USOC for SFY02 and SFY03. Overall, about 80 percent of children with a private physician as a USOC were fully enrolled (see figures 7 & 8 below).

**USOC BY PLACE OR BY PROVIDER?**

By age, numbers of visits, and level of enrollment, the results for USOC beneficiaries were very similar across fiscal years. Additionally, we do not see conflicts between data runs with respect to USOC beneficiaries 0 up to 18 years by location or by provider. In fact, they tended to complement or reinforce one another. Depending upon the research or policy question of interest, researchers should carefully consider which definition of USOC is more appropriate. For example, when considering public versus private spending for state and federal dollars on Medicaid, place may make more sense (e.g., the ED in a hospital); whereas, when deciding how many providers of a certain specialty are available for the health care needs of Medicaid beneficiaries, defining USOC by person may be optimal.

**Recommendations & Conclusions**

This series of briefs was designed to determine the most valid and reliable measures of USOC that can be calculated using Medicaid administrative claims data. Even though nearly 40 percent of all children up to age 18 on Medicaid have a USOC, about 30 percent never had a claim filed by a health care place or provider within a fiscal year; and another 32 percent had no USOC according to our definition and applied to the claims data.

Future studies in regards to the Mississippi Medicaid Medical Home (MMMH) program should include the following:

- Continue with measurement of USOC by place and by provider to check stability of SFY04 numbers and later numbers after implementation of this program;

- Track ED hospital visits closely for stability and continue to analyze the rates at which EM specialists provide a USOC to children on Mississippi Medicaid;

- Follow the data for those children without a USOC. How are they alike or different in terms of age, level of enrollment, public versus private visits, and other demographic factors when compared to children with a USOC?

- Connect ED hospital visits to their respective levels of emergent care (e.g., urgent, semi-urgent, or non-urgent); and

- Follow changes over time in the percent of beneficiaries with a USOC, levels of urgency of ER hospital visits, and benefits-costs with the diagnoses of conditions or diseases in a timely manner.
This series on a USOC for Mississippi children on Medicaid should help in the creation of a reference point for comparison between those beneficiaries with a USOC or “medical home” and those without. When examining future data, we should be able to gauge and assess changes in cost, ED utilization, and the diagnosis of medical problems or conditions. All of these analyses will be informed by our development of measures as presented in this series of briefs. As with any study, we have made certain assumptions and there are also definite limitations to the use of Medicaid administrative data files.

ENDNOTES

1The percentages of those children with no visits (30 percent & 29 percent in SFY02 & SFY03, respectively) and no USOC (32 percent in SFY02 & SFY03) were not included in these figures.

2In SFY03, this total was about 83 percent for 15 or fewer visits, leaving 17 percent of USOC children with 16 or more visits.

3We may be able to assume that EM specialists predominantly practice in ED-Hospitals; however, they may also set up private practices, such as EM Clinics, with extended weekday and weekend hours and services.

4A very low percentage (about 1.2 percent of the total for each SFY) of the USOC beneficiaries had a Nurse Practitioner (NP) or Physician Assistant (PA) as their USOC.

5Any reference to “level of enrollment” or “categories of enrollment” in this series of three policy briefs simply adds a dimension of time to the term eligible. We argue that the level of enrollment (fully and not fully) may have an impact on the quality of care these children can receive within the system.

6First, since the analyses for these three briefs depended upon Medicaid administrative data, we were relying upon the quality and accuracy of such claims for SFY 2002 and SFY 2003. Moreover, these claims as well as their formatting were not specifically designed with research purposes in mind. Secondly, we made certain judgments or assumptions about how to measure certain concepts, such as: a) at least one claim or more in a 12-month period being sufficient to determine a USOC; b) a USOC being defined as a beneficiary with at least 75 percent of healthcare visits to one main place or provider; c) a USOC being viewed from the perspective of either a place (where) or as a provider (who); d) determining the break points for number of visits, subgroups within the age groups of 0 through 17 years, and the level of enrollment (fully vs. not fully); e) separating the designation of places by either public or private; and, finally, f) examining ER visits to hospitals and making comparisons to those in the EM specialty. Third, these analyses are mainly descriptive in nature and simply indicate possible relationships, not cause-and-effect.