



*Written Testimony before the Program, Review and Investigations Committee*

*Roderick L. Bremby, Commissioner*

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Thank you for the opportunity to present written testimony. The Department of Social Services' leadership and staff members all consider this topic an important concern for our over 630,000 recipients and greatly appreciate the Committee's attention to this topic. We feel, however, that it is immensely important to view this topic in the context of health care delivery in Connecticut over all, and how this concern fits into the Department's overall health reform agenda.

Use of hospital emergency departments for care that could be provided less expensively in other settings is a national phenomenon. A report released by the National Center for Health Statistics in May 2013 released data from the 2011 National Health Interview Survey that demonstrated almost 20% of all adults aged 18-64 used the emergency department for care in the previous 12 months. When these adults were queried as to why they sought care in the ED, respondents covered by public insurance were more likely to answer that their doctor's office or clinic was not open or that they had no other place to go than were respondents with commercial insurance. However, the difference between commercially and publically covered respondents was less than 10% for both measures. Yes, Medicaid covered citizens often use the ED for care, but so do those who are commercially covered and almost as often and for many of the same reasons.

A survey published in the June issue of *Health Affairs* surveyed ED patients to ask why they sought care in the ED versus other care providers. The results echoed those cited earlier, but went further to determine that care in the ED was more convenient and more accessible than care in other settings, and were less likely to require a second or third visit to completely evaluate the same complaint.

In short, the ED is the Wal-Mart of healthcare, offering one-stop shopping. An individual can be evaluated at their convenience and not at their provider's convenience; if they need laboratory work or x-rays they can get them at the same time without making a trip to the lab or to the radiologist; if they require specialty care badly enough, the specialist will be called in to come see them, not the other way around. The ED is warm, safe, doesn't require cash, will feed you, and often has billboards along the highway telling you how long your wait will be.

With all of that said, the department has been active in implementing a number of measures intended to provide health care services for all of our members in a more clinically appropriate and less costly setting. Most of these initiatives are being coordinated through the department's administrative services organization model of care, which themselves offer one-stop shopping in that recipients and providers only need one place to go to help coordinate care. These initiatives include:

- Intensive Care Management (ICM) – recognizing that Medicaid disproportionately covers those Connecticut citizens with the most complicated health needs and health problems, very often in the context of grinding social and health inequity, ICM provides comprehensive care coordination for our neediest members in collaboration with the member’s many providers and especially their primary care provider. The goal is comprehensive care coordination so that members receive the care they need, when they need it and in the setting they need it, with an emphasis on early and preventive care.
- Person-Centered Medical Home. At last count, there are 68 practices with 265 sites and 982 practitioners who are fully credentialed in the department’s PCMH program. Each has met the criteria for and received NCQA recognition, which includes providing after hours and weekend availability for care and advice. Additional primary care strategies include:
  - The medical ASO is attributing Medicaid beneficiaries to primary care practices based on their patterns of use. This helps to support a regular and customary source of primary care.
  - Electronic Health Records (EHR). Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. EHR support more person-centered care and reduce duplication of effort across providers. DSS is collaborating with the UConn Health Center to administer a Medicaid EHR Incentive Program and to improve outreach and education to providers. Incentive payments disbursed from September, 2011 to January, 2013 include \$18,642,346 to 929 eligible professionals and \$22,268,898 to 25 eligible hospitals. “Eligible professionals” include physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists.
  - The Department has also recently implemented the requirement under the Affordable Care Act to increase reimbursement rates to eligible providers for specified primary care codes. This has in many cases more than doubled the Medicaid rates, and is anticipated to support retention of existing primary care providers as well as recruitment of new providers.
  - Combined hospital rounds – conducted twice weekly, clinical staff from the Department, and the medical and behavioral ASOs convene to discuss the care of complex members who are overusing hospital services. Many of the staff involved are posted in the hospitals so that they have immediate access to the members themselves. The purpose of these rounds are to help address one of the needs that brought all of us here to this meeting today, the problem of ‘super users’ of hospital services, ensuring that these members are transitioned to the appropriate community services before they leave the hospital and before they are lost to follow up. This approach is especially important to our members with co-occurring medical and behavioral disorders. A growing adjunct to this approach is the placement of a behavioral health worker in hospital emergency departments during high-risk times of the day to assist those with behavioral health concerns to access more appropriate and long term community-based care.

Although it is not exclusively a department initiative, the State Innovation Model (SIM) grant process should also be mentioned here. A CMS funded planning process, SIM seeks to find health delivery reforms that will impact at least 80% of the state's residents. This initiative brings together advocates, consumers, public and commercial payers, providers of all types and specialties, and other concerned experts and stakeholders around several tables to develop strategies to help Connecticut attain the triple aim. I encourage you to schedule a presentation from the SIM team on their tremendous work.

In closing, I would like to point out that this problem is extremely complex and reflects many of the problems we have in health care today. If a solution to excessive ED utilization among Medicaid recipients or among the remainder of the population were available, the department would be taking steps to implement these measures. However, there is no silver bullet and many in the healthcare delivery field wrestle with this issue just as we do. The Department looks forward to working with the Committee as you complete your work and welcome your thoughts and recommendations. We hope that you agree that we take this problem seriously and that we are working in many ways to address, not only the symptom of overuse of the emergency departments, but also the underlying disease causing that overuse.

Thank you for your kind attention.