



Hospital Emergency Department Use and Its Impact on the State Medicaid Budget

The PRI committee undertook the study in June 2013, after discussions between PRI and leaders of the Appropriations and Human Services committees. Concerns had been raised about the frequent use of hospital emergency departments (ED) by Medicaid clients and the impact that might be having on the state budget.

ED USE: The study found that **Medicaid clients had higher utilization** of the ED in 2012:

- Medicaid recipients made up about 16.5% of Connecticut's population;
- But Medicaid clients accounted for 36% of all ED visits, including those that resulted in an inpatient admission;
- Only about 15% of all ED visits end up with an inpatient admission -- Medicaid is about half that -- at 7%;
- Of the ED visits that did not result in an inpatient admission -- there were 97 visits for every 100 Medicaid clients;
- More than five times the utilization rate of 18.5 visits per 100 persons with commercial insurance.

Not every Medicaid client uses the ED:

- 43% of all enrolled Medicaid clients visited the ED in 2012, for a total of about 605,300 visits
- HUSKY C clients -- who are older clients and/or disabled -- had the most visits 3.3 on average, if they visited an ED
- HUSKY D clients -- who are low-income adults, many with disabilities and include former SAGA clients -- had an average of 2.7 visits.
- A small segment of the Medicaid population frequently visit the ED:
4,671 clients had 10 visits; 865 enrollees had 20 or more, and 196 had visited at least five different hospital EDs in 2012.

ED COSTS: The study concluded that ED visits, even including ambulance costs and other ancillary costs, are not a big cost-driver in the Medicaid budget.

- Medicaid costs in Connecticut are about \$6 billion or about 25% of the state's overall budget. **But ED visits that don't result in an inpatient stay account for about \$229 million or only about 4% of overall Medicaid costs.**
- The average cost for a **Medicaid visit was \$350**. But, because many clients have more than one visit, the **per-client costs were much higher -- \$791**. In fact, the average per-client costs were \$1,518 and \$1,094 for a HUSKY C and HUSKY D client, respectively.

FINDINGS and RECOMMENDATIONS: **Only about half of all adult Medicaid clients are attributed or linked to a primary care provider**; even fewer to a patient centered medical home, a model promoted through the Affordable Care Act.

The state contracts with **4 Medicaid administrative services organizations (ASOs) and pays well over \$100 million annually for their services**. DSS and other contracting agencies need to hold ASOs more accountable for: better linkages between Medicaid clients and primary care providers; and playing a more assertive role in ensuring client gets the services needed in the community rather than using the ED. These actions should save money in the long-term.

One of the functions the ASOs perform is intensive case management (ICM) which targets individuals with complex medical and behavioral health and/or substance abuse needs, and frequent ED users. **PRI found that those programs with more face-to-face client interaction, hospital emergency department**

involvement, ongoing rather than episodic client monitoring, and frequent community provider interaction in monitoring a client's progress have better outcomes.

The programs that demonstrated these features are the ICM programs implemented by Advanced Behavioral Health (under contract with DMHAS) and an independent program –the Community Care Team – at Middlesex Hospital in Middletown. The ABH general ICM programs showed for approximately 1,300 people:

- **57% reduction in inpatient episodes saving \$4.5 million**
- **612 fewer ED visits (18%↓) with a reduction in ED costs of \$218,000, but other outpatient services increased by \$42,000, for a net savings of \$176,000**

Middlesex Hospital reported outcomes for the 52 clients who received ICM services through its Community Care Team for six months or longer:

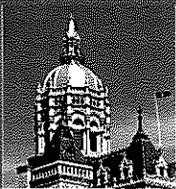
- **Inpatient hospitalizations were reduced from 75 to 31 (59%↓);**
- **ED visits declined from 849 to 415 (51%↓)**

Financial outcomes for the hospital also showed positive results as shown below:

Hospital Financial Outcomes Pre-and Post- CCT Intervention (52 Clients)			
<i>Total</i>	<i>Pre-CCT</i>	<i>Post-CCT</i>	<i>Difference</i>
Total Mdsx. Hosp. Costs	\$1,458,887	\$407,910	\$1,050,977 (72%↓)
Total Mdsx. Hosp. Collections	\$714,591	\$148,704	\$565,887
Total Loss	-\$744,296	-\$259,206	-\$485,090 (65%↓)
Average per Client	Pre-CCT	Post-CCT	Difference
Average Costs	\$28,055	\$7,844	\$20,211
Average Collection	\$13,742	\$2,860	\$10,882
Average loss per-client	\$14,313	\$4,984	\$9,329 (65%↓)
Source: Middlesex Hospital Materials Presented at PRI Public Hearing, September 26, 2013			

PRI recommends that the implementation of the Intensive Case Management services **take place through the current contracts in place with the ASOs.** This would require **no additional appropriations, but rather a requirement to co-locate ASO intensive case management staff at certain hospitals where Medicaid clients are frequent users of the ED.** Demonstrated savings to hospitals and ultimately the Medicaid budget -- from both reductions in inpatient and ED costs -- could be substantial.

Immediate savings of about \$2.2 million annually could occur if intensive case management services currently implemented by Advanced Behavioral Health were reimbursed by Medicaid, a process DMHAS indicates is currently underway.



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Background

In June 2013, the PRI committee authorized a study to examine hospital emergency department (ED) use by Medicaid recipients and the impact of that use on the state Medicaid budget.

According to the Connecticut Department of Social Services (DSS), in May 2013 there were more than 640,000 Medicaid recipients enrolled in the state's Medicaid program. In FY 13, annual Medicaid expenditures were approximately \$6 billion before any federal reimbursement, about one-quarter of the state's budget. Medicaid ED costs totaled \$229 million, only about 4 percent of the state's Medicaid budget.

Overall in 2012 there were 37 visits to the ED for every 100 persons in CT, while there were 97 visits for every 100 people in the Medicaid population. Those client enrolled in HUSKY D had the highest rate, with 184 visits for every 100 clients.

There are many reasons why Medicaid clients may use EDs at higher rates, but one area of particular concern is whether capacity for primary and/or specialty health care exists in community settings. In addition, Medicaid clients in need of behavioral health services are frequent users of emergency departments.

Another reason why Medicaid clients visit the ED is that they must be seen there regardless of ability to pay. The 1986 federal Emergency Medical Treatment and Active Labor Act provides that when a person presents at an ED, virtually all hospitals are required to screen that person, and, if a medical emergency exists, be treated and/or stabilized before being discharged or transferred.

The federal Affordable Care Act includes provisions aimed at increasing access to primary medical and behavioral health care, especially for clients who are dually diagnosed. The strategies support quality and coordinated care through reimbursement increases, as well as financial enhancements for practices that participate in model programs.

Main Staff Findings

There are 29 acute care hospitals and 6 satellite locations that provide 24-hour emergency department care in Connecticut.

In 2012, there were **approximately 1.76 million visits to EDs in the state, an 18 percent increase from the 1.49 million in 2006.** Medicaid clients accounted for 36 percent of all visits, even though Medicaid recipients make up about 17 percent of the state's population. Of the 605,506 Medicaid visits, the cost per visit was \$350.

While overall ED use among Medicaid clients is high, it is extremely varied, with **more than half of those enrolled not visiting an Ed at all during 2012.** There is a small segment of the Medicaid population who frequently visit the ED: **4,671 clients had 10 visits; 865 enrollees had 20 or more, and 196 had visited at least five different hospital EDs.**

Only about 15 percent of ED visits require an inpatient admission, but among **Medicaid clients this was even lower, with about 7 percent being admitted.**

Only about half of all Medicaid clients are attributed or linked to a primary care provider; even fewer to a patient centered medical home, a model promoted through the Affordable Care Act.

Intensive case management programs operated primarily by administrative services organizations under contract to DSS and DMHAS target individuals with complex medical and behavioral health needs, and frequent ED users. Those programs with **more face-to-face client interaction, hospital emergency department involvement, ongoing rather than episodic client monitoring, and frequent community provider interaction in monitoring a client's progress seem to have better outcomes.**

PRI Staff Recommendations

The study report contains 13 recommendations aimed at better educating Medicaid clients about alternate and more appropriate settings to getting health care than the emergency department.

PRI staff recommends improving Medicaid enrollment stability through 12-month continuous eligibility, a more active approach to ASO-attribution or linking of clients to primary care providers, and better measurement of network adequacy.

DSS should be statutorily required to implement a demonstration project using telehealth or telemedicine to help with access to specialists.

For clients who need intensive case management, staff proposes more face-to-face client interaction, especially at the ED. Better coordination of ICM services, and seeking Medicaid reimbursement for all ICM services, is also recommended.

Following the ACEP guidelines for prescribing controlled prescription drugs in the ED, including a check of the state's prescription monitoring system, is also proposed.

PRI Recommendations

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1. The Department of Social Services should develop brochures about alternatives available to the emergency department if a client does not need immediate attention. The brochures should be distributed and made available to clients at federally qualified health centers and primary care offices, including those enrolled as patient centered medical homes, with high Medicaid patient caseloads.
2. The Department of Social Services shall require its Medicaid contractor with access to complete client claim adjudicated history, to analyze and report on Medicaid clients use of the emergency department on an annual basis, and the report should include, at a minimum:
 - a breakdown of the number of unduplicated clients visiting an emergency department by range; and
 - for those clients with 10 or more annual visits to any hospital:
 - the number of visits categorized into specific ranges as determined by the department;
 - time and day of visit;
 - the reason for the visit;
 - if the client is attributed to a primary care provider;
 - if the client had an appointment with a community provider within 30 days after the visit; and
 - the cost of the visit.

The department should use this report to monitor contractor performance, particularly with linking frequent users of emergency departments to primary care providers within a 30-day timeframe following an ED visit. In addition, the report shall be provided to the Council on Medical Assistance Oversight.

3. The Department of Social Services shall require the administrative services organizations to conduct the mystery shopper survey of primary care providers and specialists, including whether the providers are accepting new patients, and wait times for appointments for new and existing clients to measure ease of access, as required in the administrative service organization contracts.
4. Once a person is determined eligible for Medicaid and the ASO is notified of the eligibility, the ASO should contact the member to provide information about primary care providers in their geographic area accepting Medicaid clients. Further, the ASO should inform the client of the advantages of the PCMH – like extended hours, urgent care, and same-day appointments – and offer to work with the client to make that primary care connection.
5. Once a Medicaid client has been attributed to a primary care provider, that provider's name and contact information should be printed on the Connect (Medicaid) card issued (or reissued at redetermination) to the client.

6. **Statutorily adopt a 12-month continuous eligibility provision for children during the 2014 legislative session. Further, DSS shall immediately seek an amendment to its 1115 waiver from the Centers for Medicare and Medicaid Services to implement 12-month continuous eligibility for all adult Medicaid recipients.**
7. **the statute be modified to mandate that by January 1, 2015 DSS engage in a demonstration project as authorized in P.A. 12-109 and that at least one demonstration project reimburse for specialist services delivered by a telemedicine or telehealth model. The department should file any Medicaid state plan amendments with CMS necessary to implement the project. The commissioner shall submit a report, including the cost effectiveness of the program, and whether it should extended to other areas of the state, to the legislature's appropriations and human services committees.**
8. **The Department of Social Services monitor its administrative services organizations' reporting requirements to ensure all contractually obligated reports, including the Emergency Department Provider Analysis Report by ValueOptions, are issued as required.**
9. **The Department of Mental Health and Addiction Services, in conjunction with DSS financial staff and the Office of Policy and Management, ensure that expenditures for all intensive case management services eligible for Medicaid reimbursement be submitted to the Centers for Medicare and Medicaid Services.**
10. **DSS and DMHAS should contractually require that the intensive case management teams of CHN-CT, ValueOptions and ABH: identify hospital EDs for the program based on the number of frequent users; and engage ED staff of the relevant hospitals in helping to identify Medicaid clients who would benefit from this community care intensive case management.**

DSS and DMHAS should contractually require that at least one staff member from the regional intensive case management teams be co-located at hospital EDs participating in the program, at hours when frequent users visit the most and when ED use is highest.

11. These ICM staff should:

- work with ED doctors to develop a care management plan (and accompanying release of information) for clients who agree to participate;**
- be knowledgeable about the community services and providers in the area;**
- serve as liaisons between the hospital ED staff and the community providers identified in the client's care plan; and**
- meet weekly with providers to monitor clients' progress.**

12. Emergency department physicians, should, as a first step follow ACEP guidelines, which includes checking the state's prescription drug monitoring program, prior to prescribing controlled prescription drugs to a patient in the ED.

13. The CMS strategies bulletin should be circulated among the Program Integrity and Pharmacy Management staff of the Department of Social Services. In addition, the Office of Quality Assurance shall identify Medicaid clients who are outliers in the state's Prescription Drug Monitoring Program and refer these clients to the review team to determine whether these clients should be placed on the Medicaid prescription restriction program.