



CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

A Chapter of the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

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Testimony for the RAISED BILL #5378/LCO 1740

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The American College of Emergency Physicians (ACEP) promotes the highest quality of emergency care and is the leading advocate for more than 28,000 US emergency physicians, their patients, and the public. The Connecticut Chapter (CCEP) represents close to 500 physician members living or working in the state of Connecticut.

The Emergency Departments (EDs) in the state of Connecticut continue to have increasing total patient volume, including an increase in visits from Medicaid patients. While the vast majority of ED visits are appropriate, at least prospectively from a patient's point of view, it is important to examine the areas for potential user reduction.

- CCEP is in favor with the provision of Raised Bill #5378 that frequent ED users insured by Medicaid would be referred to an intensive case management system that would emphasize the importance of primary care and specialist availability. Though the bill specifically mentions a one month time frame for primary care follow-up, CCEP would advocate for a significantly shorter window of 7-14 days. These frequent utilizers often have multiple ED visits within the 30 days after an index visit, and therefore need much quicker follow-up than 30 days. A major problem that Medicaid patients face is that few primary care physicians accept Medicaid patients due to low reimbursement rates. For outpatient specialty care, there are even fewer options for Medicaid patients; with months-long wait times for appointments. The Federally funded clinics (FQHCS) are often overcrowded, with limited hours, and may not be accessible to patients with transportation issues. So it is not uncommon to see a Medicaid patient in the ED multiple times for a problem that could have been managed in the outpatient setting. These issues are not seen in the Medicare population; therefore it seems reasonable that if Medicaid reimbursements reached parity with Medicare's, patients would have much more in the way of provider choices.
- CCEP wholeheartedly endorses legislation in Raised Bill #5378 that would provide additional support for Medicaid clients with substance abuse problems. A major group of ED superusers are those Medicaid patients with alcohol and other substance abuse

problems. Because of a deficiency of addiction treatment options, particularly rehabilitation programs and dual diagnosis programs, these patients are frequent ED users, some of them coming to the ED more than once a day. The lack of sober houses and the practice of bringing all patients who appear intoxicated to the ED causes unnecessary Medicaid ED visits. It is proposed that sober houses, staffed with midlevel providers (Advanced Practice Registered Nurses and Physicians' Assistants), could safely staff sobering houses to markedly decrease the number of expensive ED visits for this group of Medicaid patients.

- Another major group of ED superusers are those Medicaid patients with mental health problems. These patients often stay in the ED for days, awaiting inpatient psychiatric hospital beds. This problem is particularly acute for children and adolescents, as the state is woefully low on resources for this vulnerable patient population. CCEP endorses legislation that provides additional support to Medicaid clients with mental health diagnoses.
- As part of an effort to reduce national health care spending, ACEP has adopted a 5-facet "Choosing Wisely" campaign, one point of which is to engage available palliative and hospice care services in the emergency department for patients likely to benefit. Many patients spend the majority of their lifetime healthcare dollars in the last three months of their life. Numerous outcome studies have shown that patients enrolled in palliative care and hospice programs not only live longer, but also have higher quality of life ratings and at significantly reduced costs compared to aggressive care. However, Medicaid patients are much more likely to choose aggressive care rather than palliative or hospice care at end of life. Providing education to clients about the benefits of palliative care programs would reduce unnecessary health care utilization. An efficient way for lawmakers to increase the appropriate use of palliative and hospice care is by approving a MOLST (Medical Orders for Life-Sustaining Treatment) program. MOLST programs allow medical providers to document patients' wishes about end of life care, to be respected across settings, and have been shown to increase the percentage of physicians who have conversations with their patients about end of life care. MOLST programs exist or are in development in most states and those states with mature programs report significant increases in patients with documented wishes to limit expensive and aggressive care at end of life.
- CCEP continues to urge lawmakers to consider how Medicaid payments are made to Emergency Physicians. The manner in which the Department of Social Services administers the Medicaid insurance program creates significant barriers for Connecticut's Emergency Departments to fulfill their mission to provide timely and compassionate emergency care to a growing population of patients. Some of these decisions are based on an antiquated system when all emergency physicians were hospital employees. Other decisions are based on retrospective reviews and administrative maneuvers which result in under-funding emergency care, thus jeopardizing access to quality emergency care and patient safety. Unlike other insurers, Medicaid payments inappropriately bundle payments for professional and facility fees for emergency services. Emergency physicians should be treated like all

other hospital based physicians, which include the specialties of anesthesiology, radiology, surgery, and pathology. First, emergency physicians should be allowed to participate with Medicaid like all other specialties. Secondly, the invoice for emergency services provided at a hospital, should contain both a facility fee and a professional physician component. Currently, the emergency physician's professional component for admitted Medicaid patients is bundled in to the hospital's per diem rate. The professional component for a discharged patient goes to the hospital and the physician must negotiate with the hospital for that reimbursement. Regardless of the employment structure, DSS should pay for the specialized and essential service the Emergency Physicians provide. Emergency physicians should not be singled out and required to negotiate with hospitals for fair payment of services provided. Medicaid fees are already below cost. To then deny these fees would force less coverage and result in longer waiting times and decreased access to quality emergency care.

I appreciate this opportunity to testify.

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