
Staff Update

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

September 26, 2013

Legislative Program Review
and Investigations Committee

Connecticut General Assembly

2013-2014 Committee Members

Senate

John A. Kissel, *Co-Chair*

John W. Fonfara
Steve Cassano
Eric D. Coleman
Anthony Guglielmo
Joe Markley

House

Mary M. Mushinsky, *Co-Chair*

Christie M. Carpino
Brian Becker
Marilyn Giuliano
Brenda L. Kupchick
Diana S. Urban

Committee Staff on Project

Catherine M. Conlin, Chief Analyst
Maryellen Duffy, Principal Analyst

Legislative Program Review and Investigations Committee
Connecticut General Assembly
State Capitol Room 506
Hartford, CT 06106



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

Background

In June 2013, the PRI committee authorized a study to examine hospital emergency department 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.

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.

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. Several initiatives are underway to target certain populations in order to better coordinate care and ensure services are received.

In 1986, the federal Emergency Medical Treatment and Active Labor Act (EMTALA), was enacted. The law applies to any hospital that accepts Medicare, and requires that any person who presents on a hospital campus must be screened and if a medical emergency exists, be treated and/or stabilized before being discharged or transferred. This is required of the hospital regardless of a patient's insurance or ability to pay.

The federal Affordable Care Act (ACA) includes provisions aimed at increasing access to primary care and improving quality through reimbursement increases, as well as financial enhancements for practices that participate in model programs.

Main Points

Connecticut has 29 acute care hospitals, each providing 24-hour emergency room care at the hospital location. There are also 6 satellite hospital emergency departments. There were **1.76 million** emergency department visits in FFY 12, an **11 percent increase from** 1.58 million visits in FFY 08.

Most people who visit the ED are treated and discharged. **Less than 15 percent of all ED visits result in an inpatient admission.** The percentage is less for Medicaid clients, with about 7.5 percent of Medicaid ED visits resulting in an inpatient admission.

Overall, the number of ED visits by clients with commercial insurance has been declining from a high point in 2007. Further, the percentage of total **visits by clients with private insurance has declined from 41.5 percent in 2006 to 31.8 percent in 2012.**

There were 607,045 visits to the ED made by Medicaid clients in 2012 (not including those resulting in an inpatient admission or clients who are eligible for both Medicaid and Medicare). However, many Medicaid recipients made repeated visits, so the total number of patients was less than half the number of visits at 268,862.

Total ED costs for Medicaid recipients that were treated and discharged, including ancillary costs except ambulance services, were almost \$208 million in 2012, representing about 3.5 percent of the total Medicaid budget. **The average cost per ED visit (not including ambulance) was \$342 and the average cost per patient was \$773.**

Currently, Connecticut has a fee-for-service model for all its Medicaid programs. However, the health care for the state's Medicaid population is being overseen by a number of administrative services organizations (ASOs). Working with DSS and, in some cases, the Department of Mental Health and Addiction Services, the ASOs are under contract to improve access to care for Medicaid clients, identify gaps in services, and help manage care for clients with complex needs.

One of the primary ways Medicaid clients receive health care in the community is through the federally qualified health centers (FQHCs). **There are 14 FQHCs in Connecticut; about 60 percent of their clients are covered by Medicaid.**

Next Steps

1. Focus on frequent users of emergency departments – reasons they are coming to the ED; if and how they are determined for intensive case management, and how those services and programs are coordinated and monitored.
2. Examine availability (and capacity) to serve Medicaid clients in other settings.

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

PRI Staff Update

September 26, 2013

Presentation Areas

- Federal law
- State data on emergency department (ED) use
- Responsibilities of Administrative Service Organizations (ASOs) under contract to DSS to oversee Medicaid program services
- Alternative access to care for Medicaid clients
- Existing programs to divert ED use and/or prevent future use
- Centers for Medicare and Medicaid Services (CMS) - pilots, demonstrations and innovation grants in planning phase
- Issues and next steps

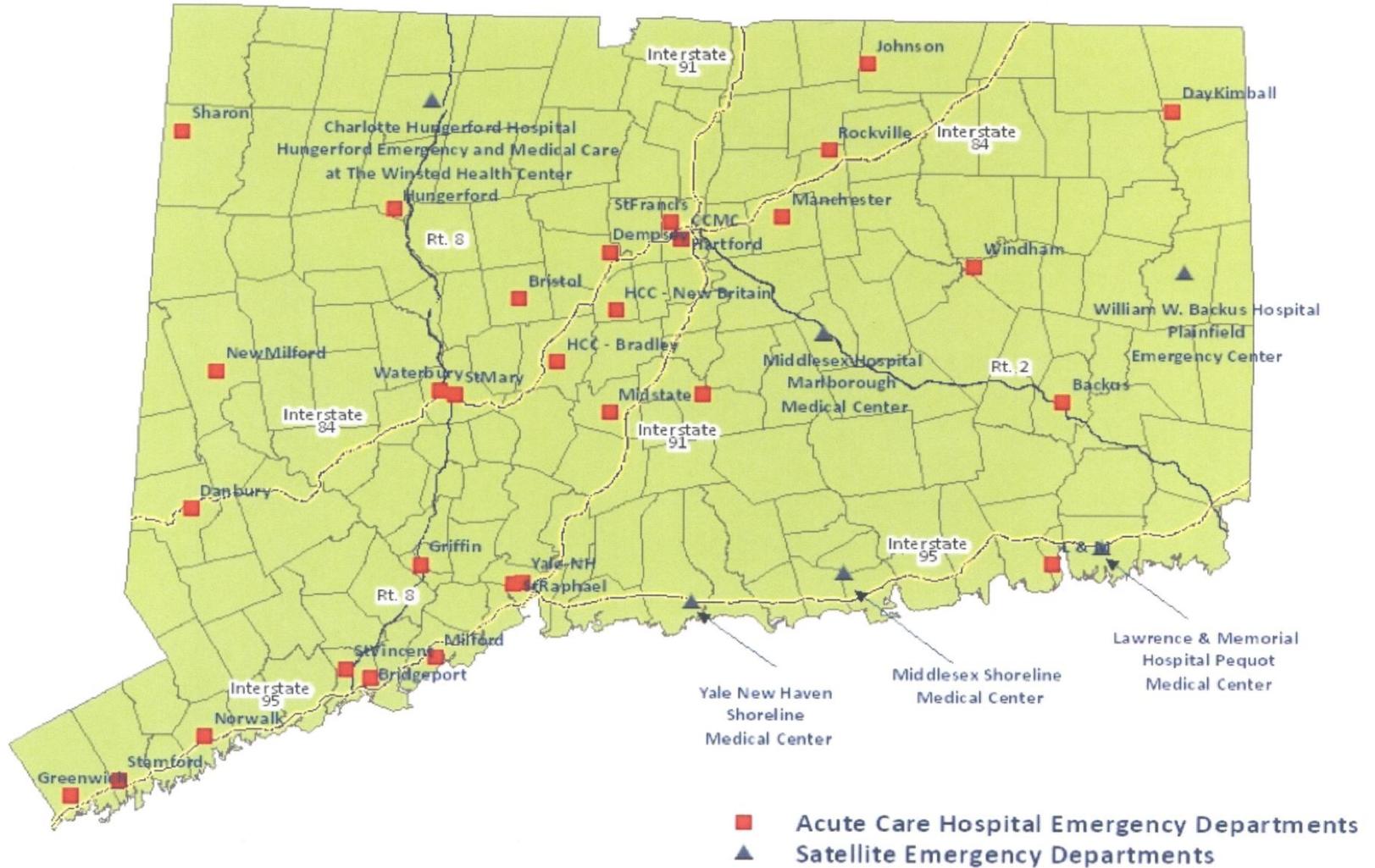
Federal Emergency Medical Treatment & Labor Act (EMTALA)

- Signed into law in 1986
- Ensures public access to emergency services regardless of ability to pay
- Three basic obligations under EMTALA
 - Any individual who comes and requests examination or treatment of a medical condition must receive a medical screening examination by a qualified medical provider to determine whether an emergency medical condition exists.
 - If an emergency medical condition exists, treatment must be provided until it is resolved or stabilized. If the hospital does not have the capability to stabilize the emergency medical condition, an "appropriate" transfer to another hospital must be done in accordance with the EMTALA provisions.
 - Hospitals with specialized capabilities must accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Definition of Emergency

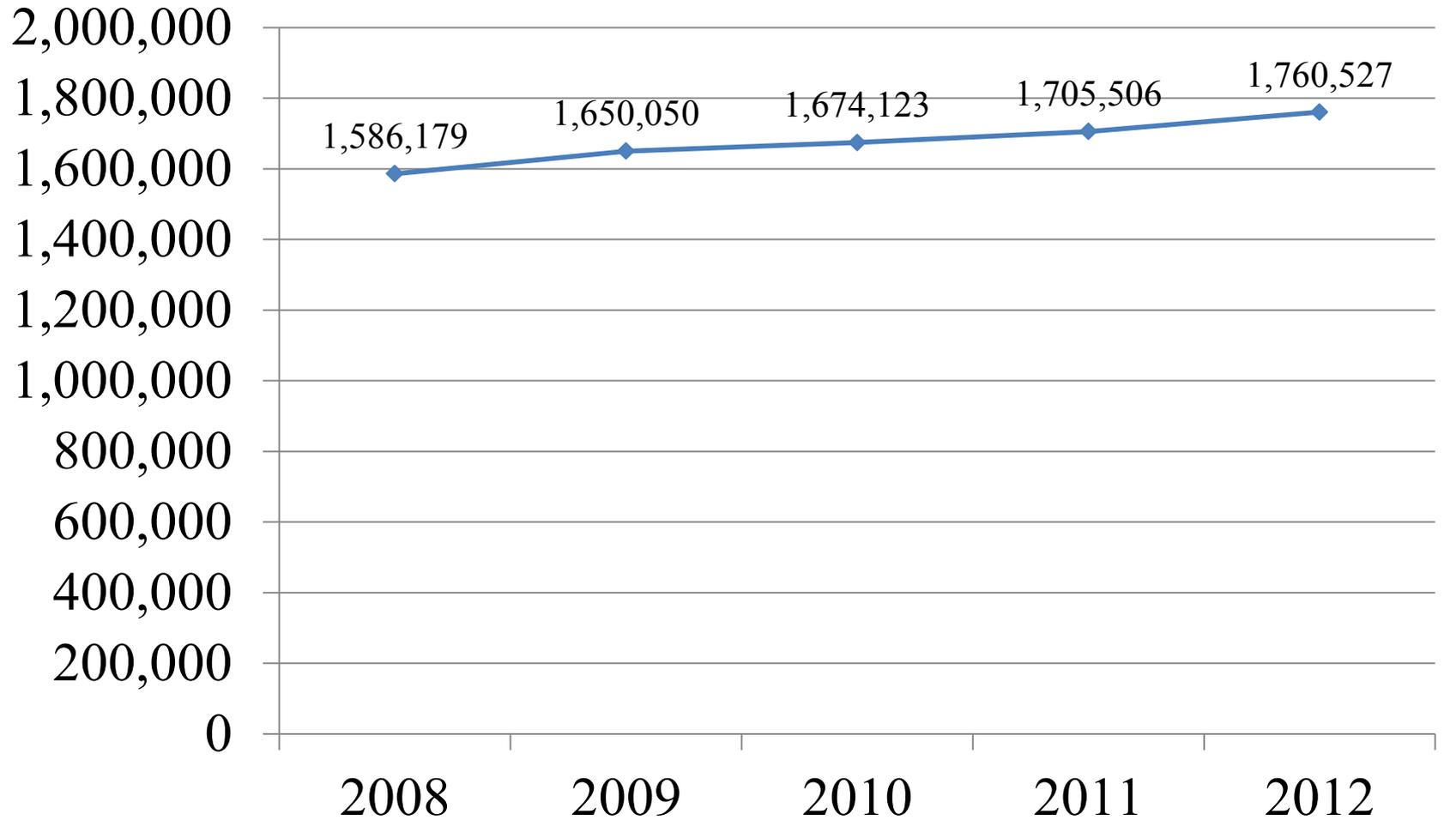
- Several definitions exist
 - Federal law and prudent layperson
 - Research purposes
 - Billing codes for claim submission and different amounts of reimbursement

Emergency Departments and Satellite EDs



Source: DPH Licensure Division and OHCA CON Database
Prepared August 2012 OHCA

Total ED Visits to CT Hospitals: FFY (includes those leading to inpatient admission)



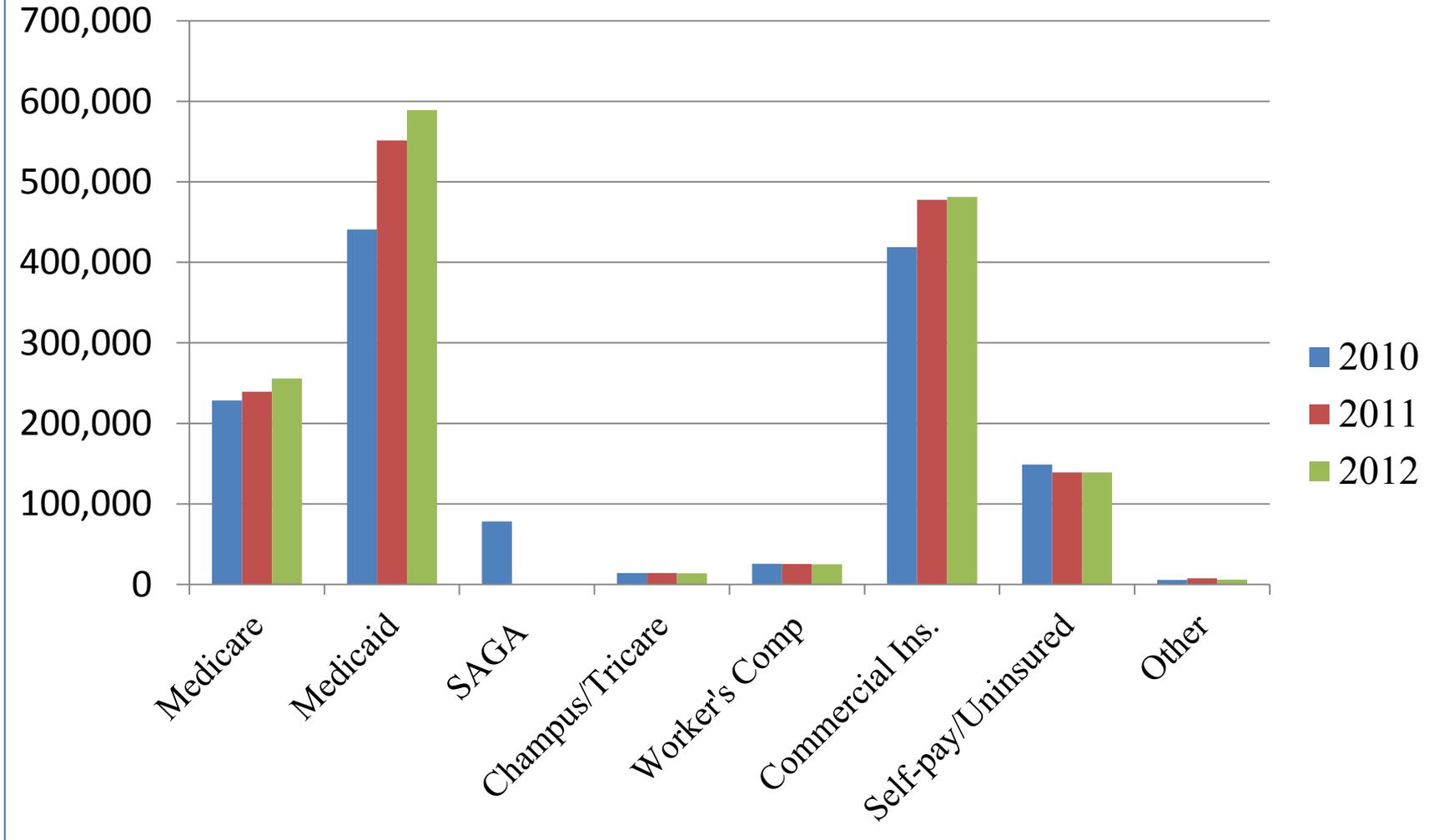
Source: Department of Public Health (DPH) Office of Health Care Access (OHCA)

Total ED Visits: FFY



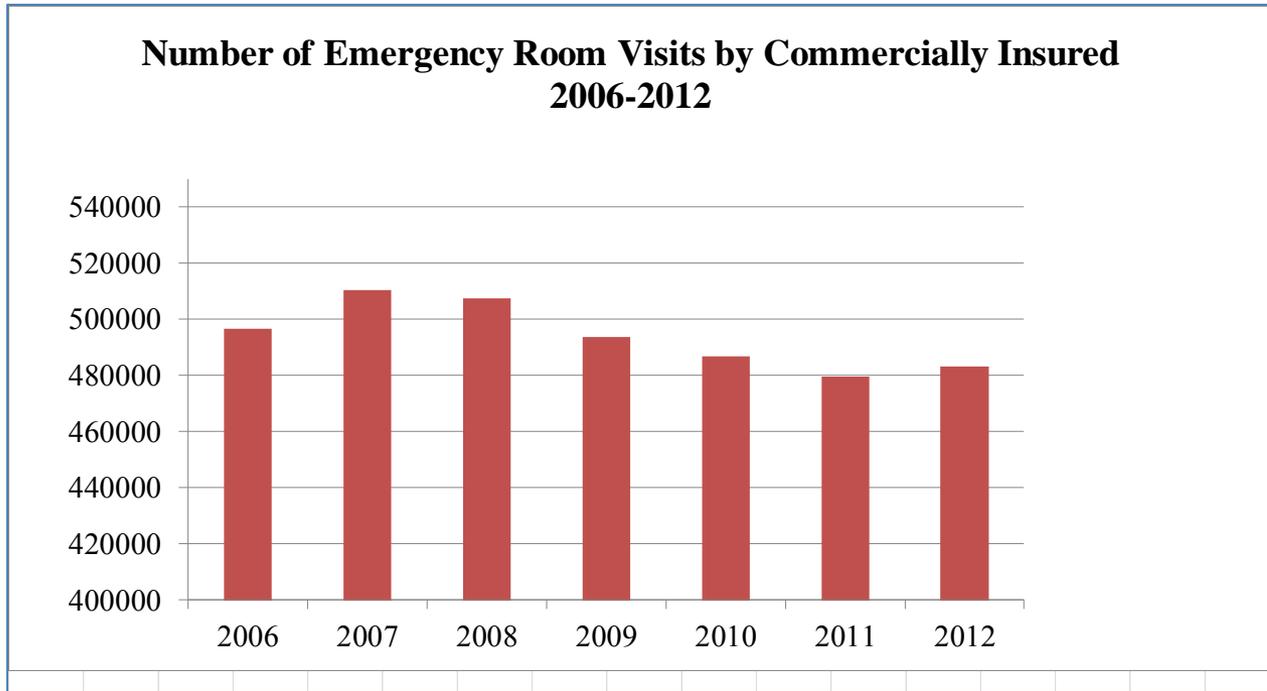
Source: DPH Office of Health Care Access

ED Visits by Payer Source: FFY (No Inpatient Admission)



Source: DPH Office of Health Care Access

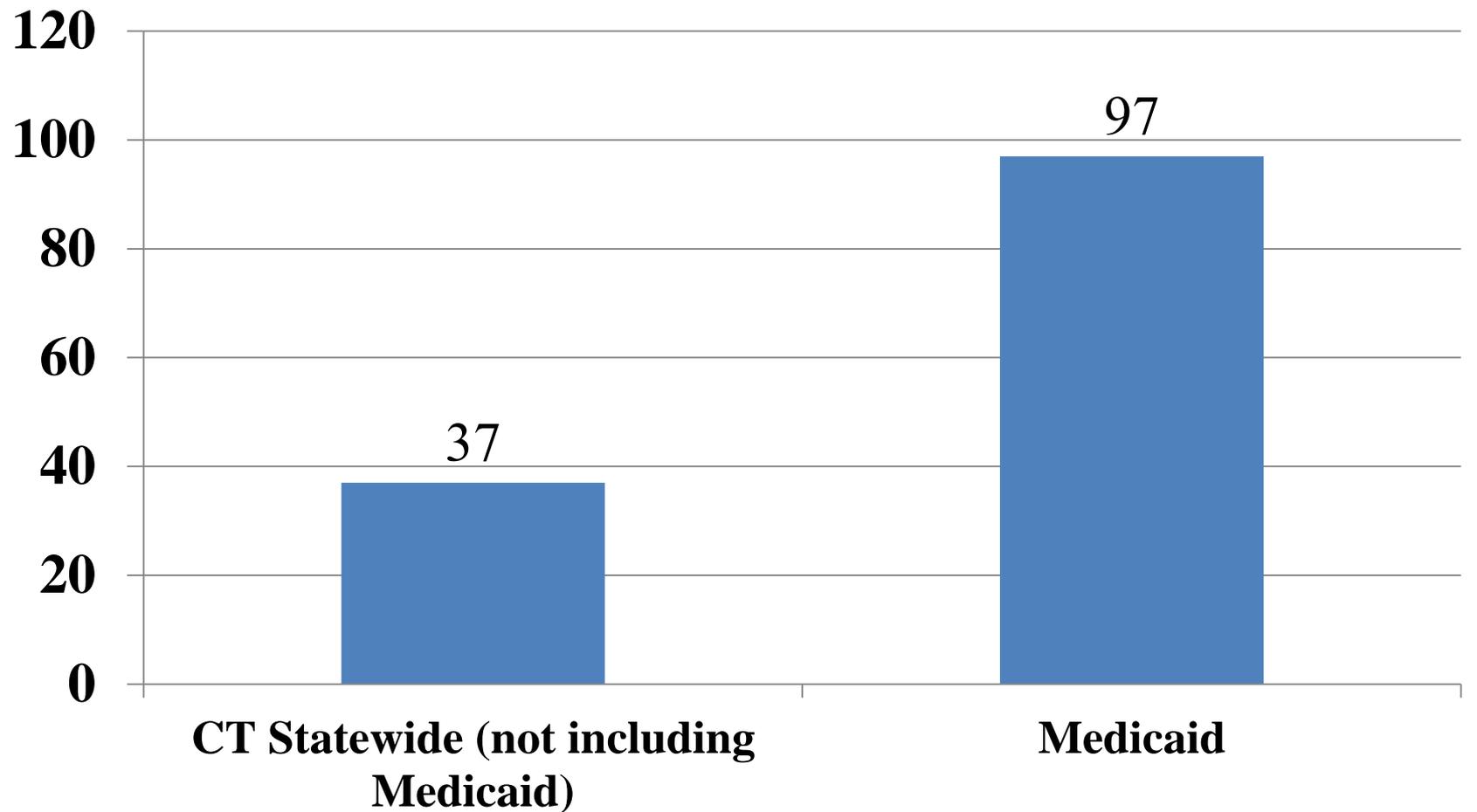
Privately insured use has declined



- Emergency room use by clients who are commercially insured has dropped by more than 30,000 visits from the high of 508,000 in 2007.
- The percentage of total visits by commercially insured clients has also dropped since 2006 – from 41.5% to 31.8% in 2012.
- Possible factors include: number of commercially insured declined, while public insured increased; increasing copays for private insured; greater access to care especially urgent care;

Source: Office of Health Care Access

ED Visits Per 100 People: CT Statewide v. Medicaid – CY 12

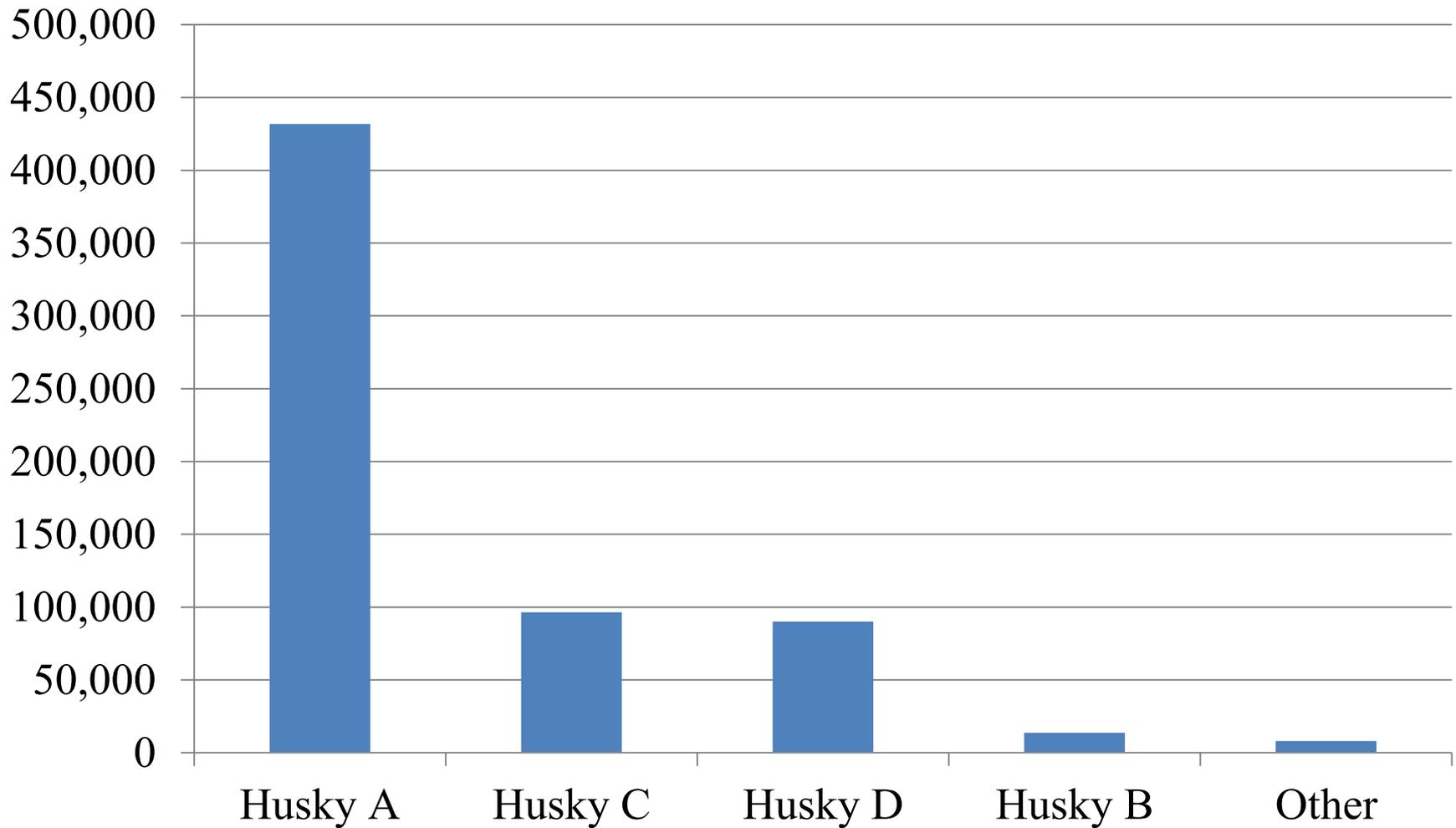


PRI staff analysis of DSS data

Medicaid Programs

- HUSKY A – eligible children, parents, relative caregivers, elders, individuals with disabilities, low-income adults, and pregnant women.
- HUSKY B – Non-entitlement State Children’s Health Program (SCHIP) for children under age 19 -- co-pays and/or monthly premiums
- HUSKY C – available for low-income Aged, Blind and Disabled Connecticut residents who are aged 65 or older, blind or have a disability. Many of those eligible also have Medicare.
- HUSKY D - low-income Connecticut residents aged 19 through 64, who do not receive federal Supplemental Security Income or Medicare (used to be State Administered General Assistance program (SAGA)).

Total Enrollment in All DSS Medical Programs as of 5/1/13



Source: DSS

Excluded from Medicaid Data Presented in Update unless Noted

- Number of and Cost of ED care for Medicare Medicaid Eligible (MME) clients
- Emergency transportation (i.e., ambulance) costs for all Medicaid clients brought to ED by ambulance
- ED visits leading to an inpatient admission

ED Cost/Use by Medicaid Recipients with No Inpatient Admission): CY 12

- Total ED Costs - \$207,805,723 (includes ancillary except ambulance services) – about 3.5 percent of \$6 Billion Medicaid budget
- Total ED Visits – 607,045*
- Average cost per ED visit (outpatient only) - \$342
- Total number of ED patients – 268,862
- Average cost per ED patient - \$773

Source of data is DSS and based on calendar year and therefore, number of visits differ from those provided by DPH Office of Health Care Access, which is based on federal fiscal year

ED Visits Leading to Inpatient Admission

- About 50% of all patients admitted to hospital inpatient come through the ED
- Based on OHCA data from FFY 2010, about 15% of all ED visits lead to inpatient admission
- 49,074 ED visits by Medicaid patients led to inpatient stays in CY 12
- 7.48% of all ED visits by Medicaid patients result in inpatient admission

**Average Monthly Individuals and Total ED Visits
By Type of Medicaid Program: CY 12
(No Inpatient Admission)**

<i>Medicaid Program</i>	<i>Avg. Monthly Members</i>	<i>Total Visits</i>	<i>Visits per 100 People</i>
HUSKY A	423,484	376,838	89
HUSKY B	13,965	5,786	41
HUSKY C	95,920	61,659	64
HUSKY D	86,086	158,025	184

Source: Community Health Network of Connecticut (CHNCT) and DSS

Frequency of Hospital Emergency Department Visits by Medicaid Clients That Did Not Result in Inpatient Admission: CY 12

# of Annual Visits	Number of Individuals	% of Visits
1 – 4	244,154	90.81%
5 – 9	20,037	7.45%
10 – 14	2,941	1.09%
15 – 19	865	.32%
20 or more	865	.32%
Total	268,862	100%

Source of data: CHNCT and DSS

Reasons for Frequent Use of ED

- Behavioral health
 - mental health
 - alcohol
 - drug-seeking behavior
- Acute medical conditions
- Chronic medical conditions
- Need access to specialists

Behavioral Health ED Visits (Children and Youth Ages 0-17)

- 6,176 ED visits in CY 11:
 - 2,337 admitted for inpatient treatment (inpatient psychiatric, inpatient detoxification and inpatient medical boarding admissions) – 38.49% of ED visits
 - 328 readmission to ED within 7 days of prior ED visit – 5.31%
 - 1,085 readmissions within 30 days of prior ED visit – 17.57%
 - 1,198 children or youth had no Medicaid claim for BH services within 30 days of ED visit – 19.40%
- Data may underreport BH visits depending on how hospital codes ED visit on claim submission

Source: ValueOptions

Behavioral Health ED Visits (Adult – 18+)

- 41,049 ED visits in CY 11:
 - 13,814 admitted to inpatient treatment (inpatient psychiatric, inpatient detoxification and inpatient medical boarding admissions) - 33.70% of ED visits
 - 4,975 readmissions to ED within 7 days of prior ED visit – 12.12%
 - 11,461 readmissions within 30 days of prior ED visit – 27.92%
 - 15,504 adults had no BH service within 30 days of previous ED visit – 37.77%
- Data may underreport BH visits depending on how hospital codes ED visit on claim submission

Source: ValueOptions

Access To Care for Medicaid Clients

- Primary Care
- Behavioral Health
- Urgent Care/Clinics
- Specialists

Access to Primary Care: Medicaid Clients

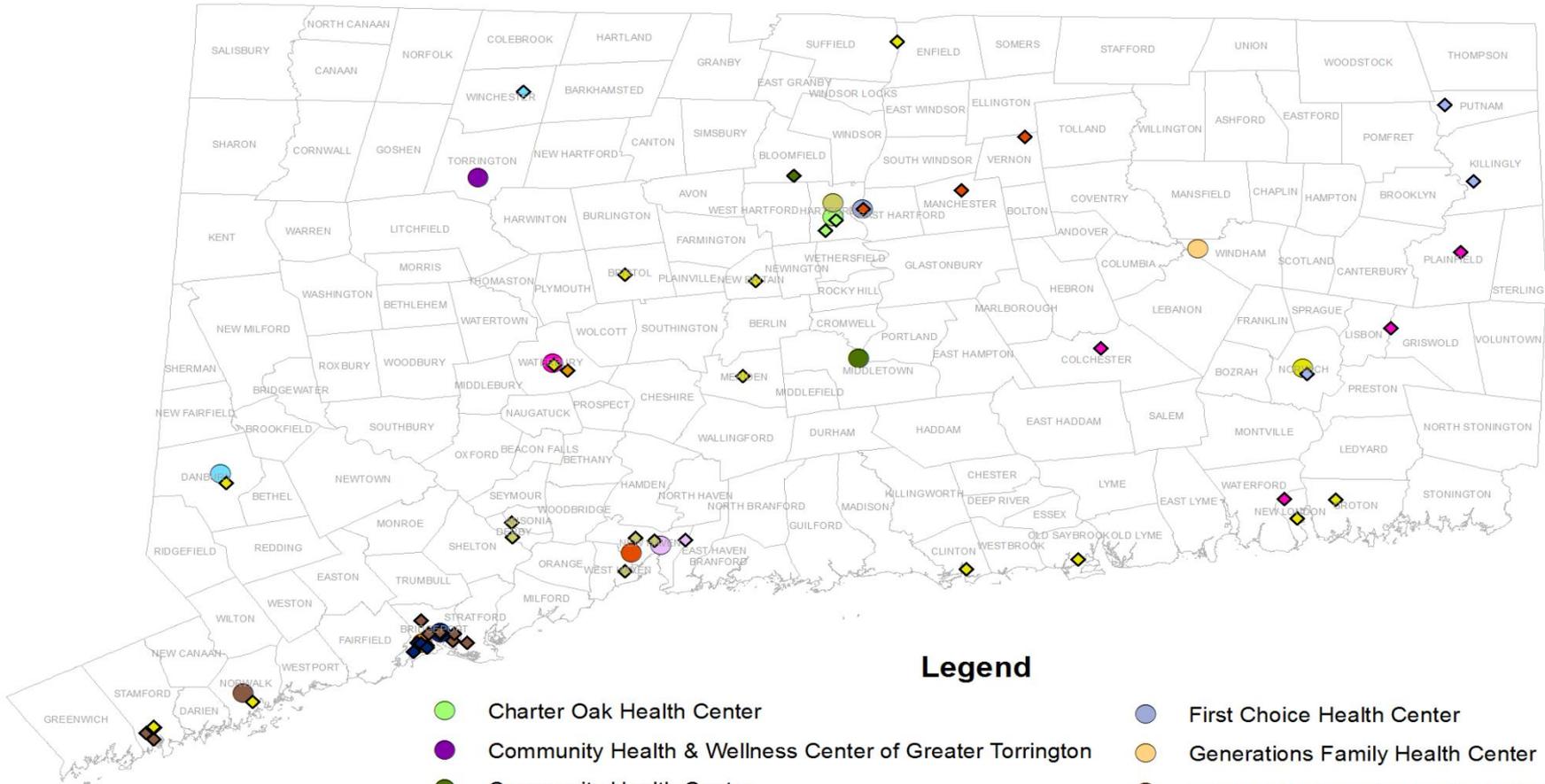
- Major providers are the 14 Federally Qualified Health Centers

In addition:

- 12 hospitals operate primary care clinics at 26 locations – some with expanded hours;
- 121 school based health centers, although some provide only dental care;
- 15 well-child clinics;
- 21 family planning clinics.

Source: Office of Healthcare Access, Inventory of Healthcare Facilities, 2012

Federally Qualified Health Centers and Sub Locations



Legend

- Charter Oak Health Center
- Community Health & Wellness Center of Greater Torrington
- Community Health Center
- Community Health Center of Greater Danbury
- Community Health Services
- Cornell Scott-Hill Health Center
- Fair Haven Community Health Clinic
- First Choice Health Center
- Generations Family Health Center
- Norwalk Community Health Center
- Optimus Health Care
- Southwest Community Health Center
- StayWell Health Care
- United Community and Family Services
- Sub Locations



Federally Qualified Health Centers

Also known as **community health centers**, FQHCS are federally authorized, nonprofit entities that provide comprehensive, family-oriented health care

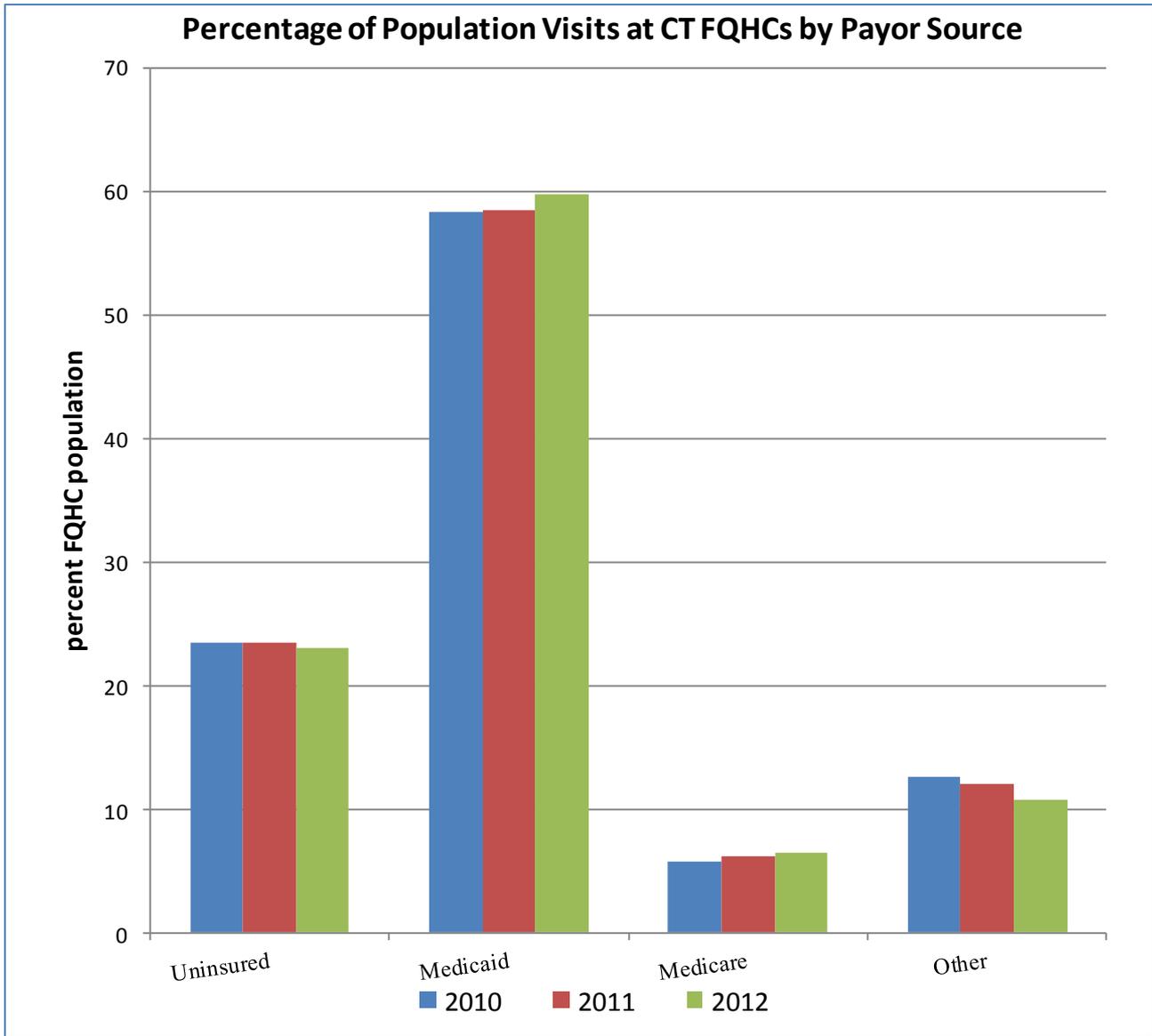
14 FQHCs in CT

- All provide **Medical**
- 11 offer **Behavioral Health**
- 10 provide **Dental**

- In **2011**, there were **1.62 million** visits to FQHCs in CT (total visits for 2012 are not reported yet)

- Slightly more than **332,000** unique patients

- Percent of Patients Who Used Services:
 - **80% medical**
 - **27% dental**
 - **8% behavioral health**
 - **8% supportive**



- The FQHCs in CT served over 332,000 patients in 2012; 10% increase since 2010
- Medicaid is greatest population served by FQHCs – accounted for almost 60% of patients in 2012;
- Uninsured are almost one-quarter of patients.

Federally Qualified Health Centers

Rates

- Not all FQHCs have the same rates – but all have bundled rates
- Cannot bill for 2 services at same visit

CT FQHC Rates 2013

Service	Average	Range
Medical	\$143.47	\$128.92 - \$155.60
Behavioral Health	\$135	\$123.50 - \$148
Dental	\$163.53	\$149 - \$192

Source: Community Health Center Association of Connecticut

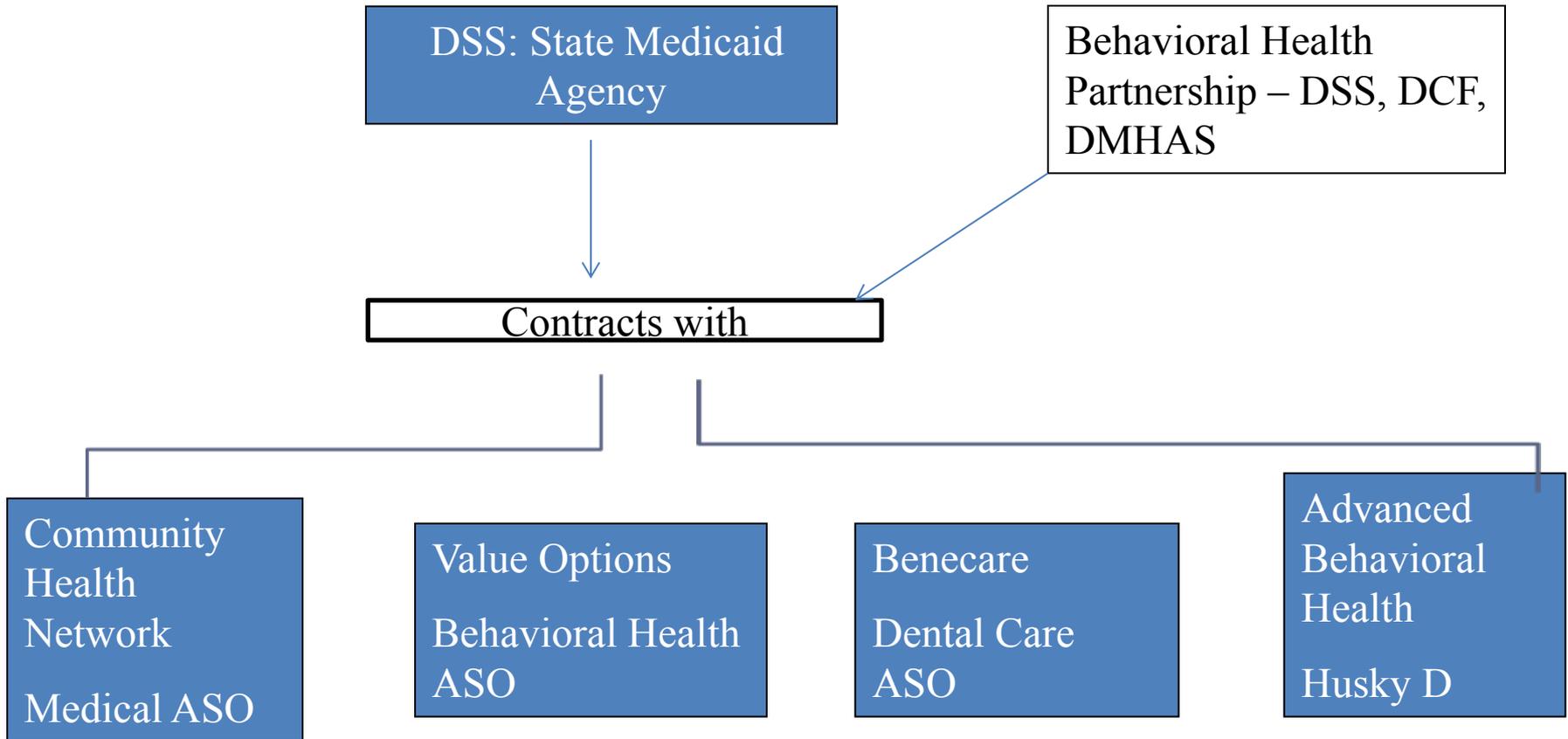
Federally Qualified Health Centers

- No requirement for extended hours
- Most provide some extended evening and Saturday hours, at least for some services
- Funding and Expenditures --2012
 - Fee for service reimbursement
 - Federal grants -- \$29.5 million in 2012
 - State grants – DPH Community Health Services \$5.7 million; other minor grants from DSS and DMHAS
- Total Costs – almost \$286 million in 2012
 - \$869 per patient

Primary Care: Change in Model

- Focus on Medicaid clients access to care
 - HUSKY A
 - HUSKY B
 - HUSKY C
 - HUSKY D
- Husky A and B had been in Managed Care until January 2012
- Husky C has always been fee-for-service
- Husky D (formerly SAGA)
- Currently all fee-for-service with CT Medicaid (DSS) being “self-insured”
- BUT major initiatives to ensure this FFS care is managed through **Administrative Services Organizations** using a variety of ways –
 - attribution
 - medical homes
 - enhanced payments

Administrative Services Organizations (ASOs)



Administrative Services Organization

- Roles and Responsibilities:
 - Member and provider services
 - Referral assistance and appointment scheduling
 - Provider recruitment
 - Health education
 - Utilization management
 - Case management including intensive case management
 - Quality management
 - Health data analytics and reporting

Source: DSS Presentation to Appropriations Subcommittee, February, 2012

Model of ASOs to Manage FFS Care

- Centralized management is supposed to:
- Develop and analyze data to inform about the system is working including client care and utilization
- Use data to:
 - identify and target beneficiaries in greatest need of assistance
 - improve both health outcomes and client experience
 - help control Medicaid costs and spending

Access to Care: Medicaid Clients

Medical Access to Care

- **Geographical access** to care is standard used by Community Health Network – standard is:
- one enrolled **primary care provider within 15 miles** of any Medicaid member
- one enrolled **pediatrician within 15 miles** of any Husky member under age 19
- one enrolled **OB/GYN within 15 miles** of any female Medicaid client age 10 and over

Results reported by CHN:

- **3,302** PCPs enrolled at 6,129 locations – access standard met for 100% of adult clients
- **926** pediatricians at 1,394 locations - access standard met for 100% of clients < age 19
- **715** OB/GYNs at 1,592 locations - access standard met for 99.9% of female clients

Issues with Primary Care Access Measurement

- Geographic standard only
- Closed panels – i.e., not every provider enrolled in Medicaid is currently accepting new Medicaid clients
- Length of wait time for an appointment not a measured standard
- Access to urgent care not a standard
- Access to specialists not a standard
- As limited as measurement is, no similar standards for behavioral health

Access to Care: Medicaid Clients

To help ensure that Medicaid clients are receiving primary care:

- ASO also oversees the process of Medicaid clients being “attributed” to a primary care provider;
- Process is voluntary, clients are not “assigned”;
- Medicaid member may select a provider; or
- ASO will attribute based on source of care -- analysis of recent claims activity.
- Results as of May 2013:
 - 50% of adults attributed
 - 80% of children attributed
 - Overall rate of 64%

Access to Behavioral Health Care

- There do not appear to be similar standards for measuring access to behavioral health care.
 - Most of the FQHCs have a behavioral health component for adults and children
 - Additionally, 18 state-operated or private non-profit local mental authorities serve 23 different catchment areas covering the state
 - These agencies provide (or contract for) a wide range of therapeutic programs and crisis intervention programs throughout the state ---
 - There are also a number of inpatient facilities that DMHAS operates or contracts for services for mental health and/or substance abuse
 - All accept Medicaid, but demand may at times exceed capacity – depending on program type and needs.

Affordable Care Act Initiatives to Improve Access to Primary Care

- Effective January 1, 2013, under the Affordable Care Act, the reimbursement rates for primary care will be 100% reimbursed at Medicare rates
- In CT, reimbursement for outpatient primary care office visit will go from the previous Medicaid rate of \$67 to the Medicare rate of \$123.53 – almost double
- Retroactive to January 1, 2013 - fully federal reimbursable for 2 years

ACA Initiatives at Improving Access

(cont'd)

To be eligible for increases rates:

- Requires Medicaid provider enrollees to give officially affirm they are in primary care practice:
 - primary care physician, family physicians, pediatricians, physician assistants, APRNs
- DSS and ASO supporting enrollment efforts – as of July about 2,300 had enrolled
- FQHCs not eligible for increased rates

ACA Initiatives to Improve Quality of Care

- **Person - Centered Medical Homes** to increase individual attention to care; improve availability to hours; electronic health records; use of data to improve performance and outcomes. Any primary care practice can participate
 - National standards to be a PCMH
 - Accreditation required
 - As of early September, more than 250 sites, involving almost 1,000 providers were either already approved or in the approval process in CT
- Enhanced payments for PCMHs – various types, methods, and amounts depending on type of practice and accreditation level
- FQHCs eligible for PCMH

Additional Initiatives

- **Health Neighborhoods**– integrating full range of services for specific population – Medicare/Medicaid Eligible -- over age 18
- **Health Homes** for Medicaid clients with serious and persistent mental illness. Will focus on incorporating medical supports with behavioral into the local mental health authorities.
- **Intensive Case Management** – various programs being implemented by:
 - ASOs, both chronic medical illness and behavioral health
 - DMHAS, primarily on behavioral health
 - community providers
 - Middlesex Hospital model
- **Accountable Care Organizations** – provider networks for Medicare clients

Alternatives to Emergency Departments

- Urgent Care Centers – approximately 100 throughout the state – but primarily in suburbs
- Not licensed as **facilities** by DPH so difficult to know exact #
- Extended hours but not 24 hours
- No appointment needed
- Provide minor medical care – e.g., stitches, sprains and x-rays
- Co-pays typically \$20-\$30
- **Most do not accept Medicaid**

Alternatives to Emergency Rooms

- Retail health clinics like the “minute clinics” at CVS – DPH licenses providers, not the facility, so difficult to get exact #
- Convenient for minor health issues, colds, sore throats, or flu shots
- Low co-pay – typically \$20-\$30
- Many accept Medicaid, but limited scope of services
- Most not located in urban areas

Financial Disincentives on ED Use

Commercial Insurance:

- Commercial insurance plans typically charge a high co-pay for ED use
- Connecticut Insurance Department in 2002 established a cap on co-pays for Emergency Room use -- cannot exceed \$150
- No compiled list of what various insurers charge for co-pays – Anthem notes on its website \$75-\$100
- Anecdotally, some insurance plans charge the \$150 limit

Medicaid:

- Historically, no co-pay for ED use
- P.A. 13-234 authorizes DSS to impose a co-pay for non-emergency use of ED, to the extent permitted by federal law
- CMS allows states to impose such a co-pay without a waiver – up to \$8.00 co-pay

Issues

- Lack of primary care providers and FQHCs, especially in rural areas
- Lack of specialists who accept Medicaid – wait for appointment may be increasing visits to ED
- How police and EMS handle publicly intoxicated persons
 - if alternative locations to EDs exist
 - legal implications
- EMTALA – parameters of what federal law requires
 - Standard of proof in legal actions
 - Patient satisfaction
- Standards for EDs and pain management

Issues

- Complex system with many entities involved
- No agreement on what is “inappropriate” use of ED
- Several initiatives to better coordinate care but at various stages of planning or implementation – issues:
 - Identifying all programs
 - What agencies/entities are implementing
 - How clients are being identified, targeted and issue of participation
 - Coordination of programs and clients
 - Outcome measures and impact on ED
- Data availability/access within ED and across other programs to evaluate

Next Steps

- Focus on Frequent Users of ED – HUSKY D
 - describe how frequent ED users are targeted for state programs
- Examine availability of care in other settings (i.e., capacity) for all Medicaid populations