Staff Findings and Recommendations

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

January 31, 2014

Legislative Program Review
and Investigations Committee
Connecticut General Assembly

2013-2014 Committee Members

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PRI Staff Findings and Recommendations Highlights

January 2014

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 (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 (ACA) 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.

Improve 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 client interaction, especially at the ED. Better coordination of ICM services, and seeking Medicaid reimbursement for all ICM services, is also recommended.

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

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Acronyms

ABH	Advanced Behavioral Health
ACA	Affordable Care Act
ACEP	American College of Emergency Physicians
ACP	American College of Physicians
ADRC	Alcohol and Drug Recovery Center
APRN	Advanced Practice Registered nurse (nurse practitioner)
ASO	Administrative Services Organization
ATH	Alternatives to Hospitalization (program)
CCT	Community Care Team
CHA	Connecticut Hospital Association
CHCACT	Community Health Centers Association of Connecticut
CHNCT	Community Health Network of Connecticut
CMS	Centers for Medicare and Medicaid Services (federal under DHHS)
CT BHP	Connecticut Behavioral Health Partnership
DCP	Department of Consumer Protection
DMHAS	(state) Department of Mental Health and Addiction Services
DPH	(state) Department of Public Health
DSS	(state) Department of Social Services
ED	Emergency Department
EMTALA	Emergency Medical Treatment and Labor Act (federal law)
FH	Family Health section within DPH
FQHC	Federally Qualified Health Center
HID	Health Information Designs
HIPAA	Health Insurance Portability and Affordability Act (federal law)
ICM	Intensive Case Management
MAPOC	Council on Medicaid Assistance Oversight
MCO	Managed Care Organization
NSDUH	National Survey on drug Use and Health
OHCA	Office of Health Care Access (within state DPH)
OQA	Office of Quality Assurance (within state DSS)
PA	Physician Assistant
PAR	Provider Analysis Report
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Program
PHI	Public Health Initiatives Unit (within DPH)
ROI	Release of Information
SAGA	State Administered General Assistance (now HUSKY D)
SATEP	Substance Abuse Treatment Enhancement Project
VO/VOI	ValueOptions

Executive Summary

Hospital Emergency Department Use and Medicaid Clients

In June 2013, the PRI committee undertook a study of emergency department (ED) use by Medicaid clients in Connecticut and what impact that might be having on the state Medicaid budget. The study was undertaken after discussions between PRI and leaders of the human services and appropriations committees. Concerns had been expressed about the frequent use of hospital EDs by Medicaid recipients, and whether there are adequate programs in the community to help prevent and divert people from ED use and obtaining access in more appropriate settings.

These concerns are heightened by the expansion of Medicaid to an increasing number of low-income residents through the Affordable Care Act (ACA), and whether there is an adequate network of medical professionals and other community providers to meet what will likely mean increasing demand for services.

Overall Use of Emergency Departments

There were more than 1.75 million visits to hospital emergency departments by the general population in Connecticut in 2012. The vast majority of persons are seen and discharged, with only about 15 percent requiring an inpatient admission. While Connecticut's overall hospital emergency department use is somewhat higher than the national average, it is lower than any of the other New England states.

The study found that the number of emergency department visits by commercially insured Connecticut residents has declined by about 30,000 visits since 2007, and the percentage of overall visits by clients with private insurance has dropped from 41.8 percent of the population to about 31 percent in 2012. However, because the number of people with private insurance has also declined, the overall rate of ED visits per 100 with commercial insurance has remained fairly constant at about 18.5.

Medicaid Use of Emergency Departments

In comparison with overall ED use, the number of Medicaid visits to the ED has increased from 519,312 in 2010 to 589,260 in 2012, with visits by Medicaid clients in 2012 accounting for the greatest percentage of overall visits by payer source, at 36 percent. However, since the Medicaid population has also grown, and the rate per 100 has actually declined somewhat from about 116 to 106 visits between 2010 and 2012. Thus, on average there is more than one visit for every Medicaid recipient, over three times the rate of the rest of the population.

Although the average number of ED visits by Medicaid clients is high, more than half of Connecticut Medicaid recipients did not visit an ED at all during 2012. However, when data are examined across the four Medicaid populations in Connecticut, not surprisingly the HUSKY D program that serves low-income adults, many of whom were formerly SAGA clients, had the highest rate with 184 visits for every 100 clients. Further, if a HUSKY D client visited the ED, that client had an average of 2.72 visits. This was surpassed by HUSKY C clients -- which serves

older and disabled clients -- who, if they had an ED visit during 2012, went to the ED an average of 3.3 times.

Costs of overall ED use in the Medicaid program totaled $229 million, which is only about 3.8 percent of the approximate $6 billion state Medicaid budget. The cost per ED visit, excluding ambulance, was about $350 for the entire Medicaid population. However, the cost per client with an ED visit was substantially higher, ranging from an average per client cost of $439 in HUSKY B to an average of $1,518 for each HUSKY C client with an ED visit.

While the majority of Medicaid clients who visited the ED in 2012 went only once, a small percentage of Medicaid clients had 10 or more visits during 2012, and 865 of those had 20 or more visits. The vast majority of Medicaid clients, including frequent users, had a *primary* diagnosis of a medical condition, with only six percent of visits coded as primarily behavioral health and two percent as alcohol-related.

However, when both the *primary and secondary diagnoses* codes were captured for adults, the secondary diagnosis of behavioral health or alcohol-related were the top five diagnostic codes and accounted for 20 percent of those with a secondary code. Those data seemed to support more closely what emergency department doctors indicated to the PRI committee and staff about what they were experiencing with clients, especially frequent users of the ED.

Alternatives to Emergency Department Use

It is important that Connecticut ensure that there are alternatives to emergency department care for Medicaid clients, especially as the state gears up for a substantial expansion of the Medicaid population through the federal ACA. Compared to national statistics, Connecticut appears to have an adequate supply of physicians, including primary care providers and other mid-level providers like physician assistants and APRNs to address the health needs of the state's overall population. However, that assessment is based on ratio of the supply for the overall population, and does not address how many of those providers are available to serve Medicaid clients.

The Affordable Care Act has increased the Medicaid rates for primary care providers to the Medicare levels and makes them fully federally reimbursable for two years. This provision has prompted a substantial increase in the number of providers who are enrolled in Medicaid, with the number of primary care physicians increasing by more than 1,000 and the number of other providers almost tripling, from 260 to 777, over the past two years. Other ACA provisions, like offering financial enhancements for primary care providers who manage and coordinate a patient's care, known as patient centered medical homes (PCMHs), will also help. However, data on Medicaid clients show that only about 60 percent of recipients overall are "attributed" or linked to a primary care provider, even fewer to a PCMH. PRI staff believes the ASO that are contractually obligated to ensure Medicaid clients are accessing care at the appropriate level should be more diligent in its efforts to make those connections.

Providers might also be more willing to accept Medicaid recipients if client eligibility in the program were more stable for a determined period of time. It is a deterrent for a provider to

accept Medicaid clients if at the time of the appointment, or later when a claim is submitted, the provider finds the client's eligibility has been discontinued. The Centers for Medicare and Medicaid Services (CMS) are promoting continued eligibility for children and adults under the expansion of Medicaid under ACA, and PRI staff recommends that Connecticut adopt that strategy.

One of the ongoing problems in Medicaid has been the lack of access to specialists in the program. Medicaid rates for specialist visits have historically been only a fraction of what Medicare pays, and while Connecticut's payments are somewhat higher (79 percent) than the national average of Medicaid-to-Medicare ratio of 70 percent, the rates are still a problem in getting a Medicaid client in to see a specialist. Many states are facing the same problem and are developing strategies, like "telehealth" and "telemedicine", which use technology as a substitute for face-to-face client appointments to deal with access to specialists. The Connecticut legislature in 2012 statutorily authorized DSS to establish a demonstration project at federally qualified health centers to pilot this effort but the department has not yet done so, and thus that DSS effort should be legislatively mandated.

Increases in primary care management, enhanced patient-centered care, continuous Medicaid eligibility to promote enrollment stability, and expanding ways that Medicaid clients can access specialty care should help mitigate use of emergency departments for care that could be provided in a community setting. However, some Medicaid clients need even greater assistance managing their health care.

There are a number of programs operated by the various Medicaid administrative services organizations and other organizations to provide intensive case management (ICM) services to different Medicaid populations, depending on the population category and service needs. All the ICM programs showed positive outcomes to varying degrees. PRI staff concludes, however, the more successful initiatives, especially for frequent users of the ED who have behavioral health or substance abuse disorders, are associated with ICM programs that:

- have more face-to-face client interaction;
- involve emergency departments in the selection of clients, and in the development of a care plan;
- perform ongoing, and not episodic, monitoring of clients' stability and progress, including frequent meetings of providers involved in client care and services; and
- demonstrate a persistence in engaging the client and managing health and psycho-social needs.

The study report makes a number of recommendations to help achieve these components to intensive case management, including co-location of ICM staff at hospital EDs with high frequent user populations.

Finally, the study focused on another group who reportedly are frequent users of the ED, those seeking controlled prescription drugs, like OxyContin. While no hard data exists on the

extent of the problem in Connecticut or the degree to which it involves Medicaid clients, ED physicians indicate it is a persistent issue.

Connecticut has a prescription drug monitoring program for controlled substances maintained by the state Department of Consumer Protection. All licensed physicians and pharmacists, including ED physicians, can access this system to determine the extent of the presenting patient's use of controlled prescription drugs. The American College of Emergency Physicians has developed a set of guidelines that include, among other steps, the use of state monitoring programs by ED physicians. At this juncture, PRI staff proposes that ED physicians follow the ACEP guidelines rather than imposing strict practice regulations as a few other jurisdictions have done.

The committee staff make a total of 13 recommendations aimed at better educating Medicaid clients about alternate and more appropriate settings to get health care rather than visiting the emergency department is proposed, a more active approach to ASO-attribution or linking Medicaid clients to primary care providers, especially PCMHs. For clients who need intensive case management, more face-to-face client interaction by ICM staff, especially at the ED, and better coordination of ICM services is proposed. While committee staff acknowledge it should not be the responsibility of ED doctors and staff to ensure that frequent users of the ED are receiving adequate services in the community, it is important that ICM staff attempt to involve the ED staff in addressing the issues affecting client recidivism at the ED. The 13 recommendations are:

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.**

Introduction

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

There are 29 hospitals in Connecticut, and six satellite locations, each offering round-the-clock emergency care. The Medicaid population, although comprising about 17 percent of the state's population, accounted for approximately 36 percent of emergency department (ED) visits in 2012. But use of an ED by Medicaid clients is extremely varied, with more than half of Connecticut Medicaid recipients not visiting an ED at all during 2012. ED costs in the Medicaid program totaled $229 million in CY 12, about 4 percent of the approximate $6 billion Medicaid budget. However, program costs can range from $439 for individuals who visited an ED and were enrolled in HUSKY B to $1,519 for the HUSKY C population, the older and disabled Medicaid clients. In addition, some clients are considered frequent ED users – 4,671 clients had 10 or more visits in CY 12. Furthermore, during that year, there were 865 clients with 20 or more ED visits and 196 of them had visited five or more EDs.

Scope of Study

In June 2013, the PRI committee voted to authorize a study entitled Hospital Emergency Department Use (ED) and Its Impact on the State Medicaid Budget. The study was undertaken after discussions between PRI and leaders of the human services and appropriations committees. The study examined two areas of ED use among Medicaid clients:

- access to care for Medicaid clients because rates of utilization among various Medicaid populations are much higher compared to rates for individuals who have other sources of insurance or are self-pay; and
- use by individuals who need emergency care because of behavioral health or substance use disorders and frequently return to the ED for these reasons.

As the Medicaid population has grown, overall emergency department use in Connecticut has been rising among Connecticut's 29 acute care hospitals. In FY 12, there were approximately 1.76 million emergency room visits, an 18 percent increase from the 1.49 million visits in 2006. Concerns have been raised about ED usage, especially by Medicaid clients and how that may be contributing to increasing Medicaid costs.

While the study found that emergency department care is not a huge cost driver for overall Medicaid costs, continued efforts are underway through the Affordable Care Act to ensure Medicaid clients receive coordinated health care in the most appropriate setting. The study makes several recommendations to help reduce or prevent ED use by Medicaid clients in three areas. Some of the strategies recommended involve increasing access to community providers by better measuring adequacy of provider networks, which would impact all Medicaid clients – even those that have not visited an ED. Others are aimed at frequent ED use, defined by PRI staff as 10 or more visits within a calendar year. The goal of this group of recommendations is to better connect clients to more intensive care management in order to improve their health outcomes and reduce the cyclical nature of their behavior.

Methodology

Information about ED use by the general population and Medicaid clients was obtained from a variety of sources. PRI staff read research articles produced at the national level, examined other state information, and gathered information from reports produced by the Department of Public Health on patterns of ED utilization across time among various populations.

During the course of the study, PRI staff also conducted numerous interviews with state agency personnel and its contractors, including staff from the:

- Department of Social Services (DSS);
- Department of Mental Health and Addiction Services (DMHAS);
- Department of Public Health, including the Office of Health Care Access (DPH);
- Department of Consumer Protection (DCP); and
- Office of Healthcare Advocate (OHA).

As discussed in Chapter II of this report, Connecticut reimburses Medicaid providers using a fee-for-service system, but uses an administrative services organization (ASOs) structure to oversee and manage client services. The Department of Social Services contracts with two administrative service organizations. First, the Community Health Network of Connecticut oversees medical health care delivery and also provides data on all Medicaid services provided by any of the ASOs, including Benecare the ASO that manages dental services for clients and was not part of this study. The Behavioral Health Partnership, which includes DSS, the Department of Children and Families, and the Department of Mental Health and Addiction Services contracts with the third ASO, ValueOptions, the states' behavioral health ASO for most Medicaid clients. Finally, DMHAS also contracts directly with Advanced Behavioral Health, the ASO for certain programs exclusive to the HUSKY D population. To better understand the services provided by the three ASOs, PRI staff met with staff from each of these organizations, as well as attending several meetings at which ASO staff presented information about their efforts.

Committee staff also visited five emergency departments, interviewing the ED director, and in some cases, other staff and members as well – four visits were arranged by the Connecticut Hospital Association (CHA), and one by a representative of the Connecticut College of Emergency Physicians. In addition, PRI staff was invited to one of the monthly meetings of the emergency department directors held by CHA to gain their perspective and discuss the various issues associated with the study.

A two-page survey was mailed to the chief executive officers of each of the 28 acute care hospitals who are members of the Connecticut Hospital Association and to Essent-Sharon Hospital, which is not a member. The purpose of the survey was to identify how primary care providers are notified if a patient is seen in the ED; determine if the ED identifies and connects frequent users to community providers; ascertain how aware the ED was of the state's intensive case management programs; and gather their opinions on strategies the state should employ to

reduce the frequency of ED use. A total of 14 of 29 surveys were returned, for a response rate of 48 percent. A summary of the survey results is contained in Appendix A.

A separate survey was sent to each of Connecticut's 14 federally qualified health enters in the state. The survey asked a number of questions including availability of urgent care; wait times for regular appointments; and the centers' opinions about factors that may reduce ED utilization. PRI staff received 11 FQHC responses, for a response rate of 79 percent. Appendix B summarizes the results of that survey.

Overall data on ED utilization by all individuals was provided by the Department of Public Health. The Department of Social Services through its contractor for Medicaid administrative services, Community Health Network of Connecticut (CHNCT), provided PRI staff with extensive paid claim data about emergency department visits by Medicaid clients for CY 12. The data included information on the number of visits, the number of unduplicated clients receiving ED treatment, and the total cost of the visits by type of Medicaid program (i.e., HUSKY A, B, C, or D).

Report Organization

This report is organized into two chapters. Chapter I examines ED utilization data developed by the Department of Public Health and includes trend information on all visits to the emergency departments. This chapter then specifically looks at ED use and costs by Medicaid clients and whether certain populations within Medicaid have higher utilization patterns. It contains recommendations aimed at educating clients about alternatives to ED use and requires annual reporting of ED utilization by the Medicaid population. Chapter II examines what programs are being implemented to ensure other alternative care settings to EDs exist. The chapter discusses how well network adequacy is measured, how well Medicaid clients are being linked to primary care providers; and the success of intensive case management programs.

Chapter I

Profile of Emergency Department Use in Connecticut

When a person is sick or injured and believes the condition is an emergency, the individual may go to an emergency department independently or via ambulance. Emergency departments (EDs) have specially trained physicians, nurses, and other support staff that can often recognize and diagnose a variety of medical conditions that are severe and life-threatening. Furthermore, care is available around-the-clock and services provided are more comprehensive than those available in a regular physician's office. Other times, the focus of ED treatment is for conditions that are not life-threatening yet the individual believes that the ED will provide the care that is needed right away.

Emergency department obligation to provide medical screening. When a person seeks treatment at an emergency department, he or she is required to be screened. The federal Emergency Medical Treatment & Labor Act (EMTALA), signed into law in 1986, ensures public access to emergency services regardless of an individual's ability to pay. There are three basic obligations under EMTALA: 1) hospitals must provide any individual who requests treatment a medical screening examination to determine if an emergency medical condition exists; 2) if an emergency medical condition exists, treatment must be provided until it is resolved or stabilized; and 3) hospitals with specialized capabilities must accept transfers from hospitals that lack capability to treat unstable emergency medical conditions.

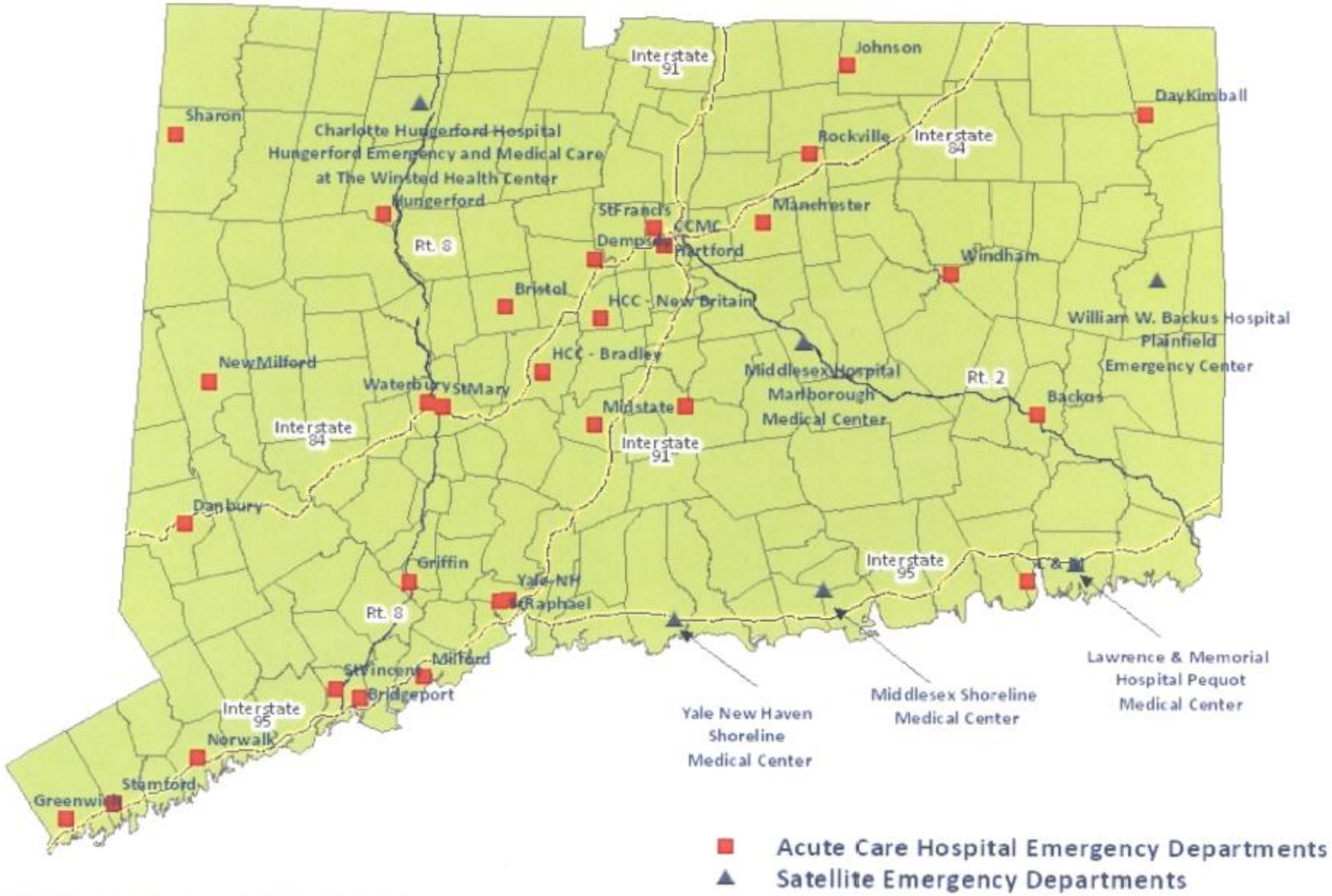
Use of Hospital Emergency Departments in Connecticut

State emergency departments. There are 29 hospitals in the state all with EDs, six of which also have satellite EDs (shown on Map in Figure I-1). Emergency departments are open year round, and care is available 24 hours a day/ 7 days a week. EDs are staffed by doctors and other medical personnel, and are able to provide specialized staff and sophisticated ancillary services, such as medical imaging scans, that would not be found in a primary care setting. In PRI staff interviews and at the committee's public hearing in September 2013, ED doctors noted that EDs serve as a safety net system for individuals who either cannot find medical care in the community or for whom care is not available when needed.

There are other factors that contribute to use of hospital EDs. Marketing and advertising of ED services due to increasing competition for health care business among hospitals has become more common. Some hospitals list ED wait times on websites and offer the ability to make ED appointments on-line or by phone. Also, other medical providers, including physicians and health care centers, often recommend patients seek ED care – either in off-hour phone answering messages or other communications.

Hospital reporting requirements. Each hospital is annually required to report financial and utilization data to the Department of Public Health's Office of Health Care Access (OHCA) that includes information about ED revenues and use. In addition, OHCA also has access to ChimeData, an information system maintained by the Connecticut Hospital Association (CHA) for its members that also contains information on ED utilization for each hospital.

Emergency Departments and Satellite EDs



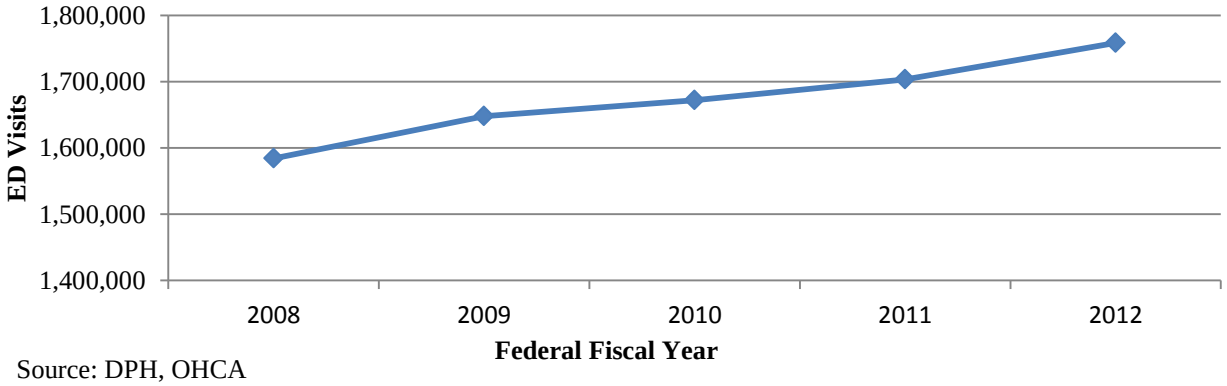
Source: DPH Licensure Division and OHCA CON Database
Prepared August 2012 OHCA

The office, located within the Department of Public Health (DPH), is required to conduct a statewide health care facility utilization study biennially (C.G.S. Sec. 19a-234) and report to the governor and the public health and human services committees on the study findings. As part of that study, the office examines utilization of all Connecticut hospital emergency departments, based on ChimeData and filings provided by individual hospitals.

The most recent OHCA report contains ED use data for a three-year period (FFY 10 – FFY 12).[1] The information in the report provides a broad snapshot of various trends associated with all ED visits regardless of payer source. In addition to the broad profile of Connecticut hospital ED use by all individuals contained in this OHCA report, the Department of Social Services (DSS) provided PRI staff with an extensive array of claims data on ED use specifically among the Medicaid population. Based on these reports and datasets, a profile of Connecticut hospital ED overall utilization is contained in this chapter as well as more detailed information about ED visits by Medicaid clients.

Utilization data for all individuals visiting Connecticut emergency departments. Figure I-2 shows total ED visits over the five-year period as reported by OHCA. There were 1,584,171 visits to hospital emergency departments in FY 08, rising to 1,758,515 visits in FFY 12, an increase of 11 percent. The number of ED visits for each of the 29 hospitals in FFY 12, along with the percent that were Medicaid visits, is provided in Appendix C.

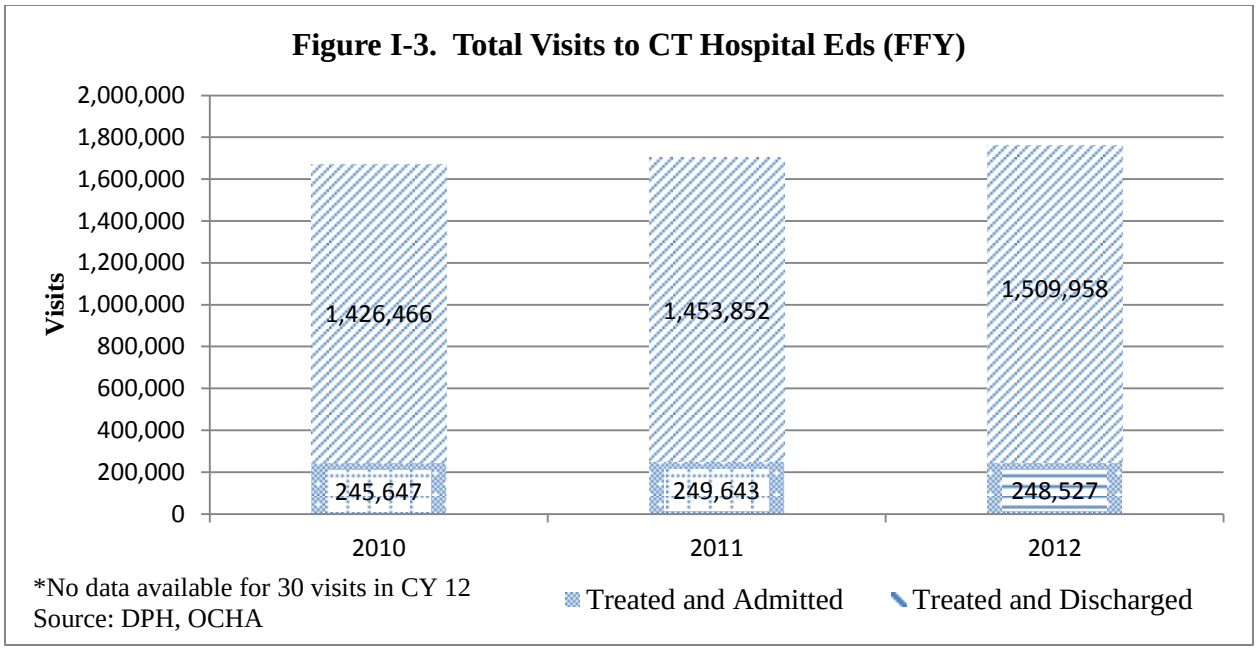
Figure I-2. Total ED Visits to CT Hospitals (including those leading to an inpatient admission)



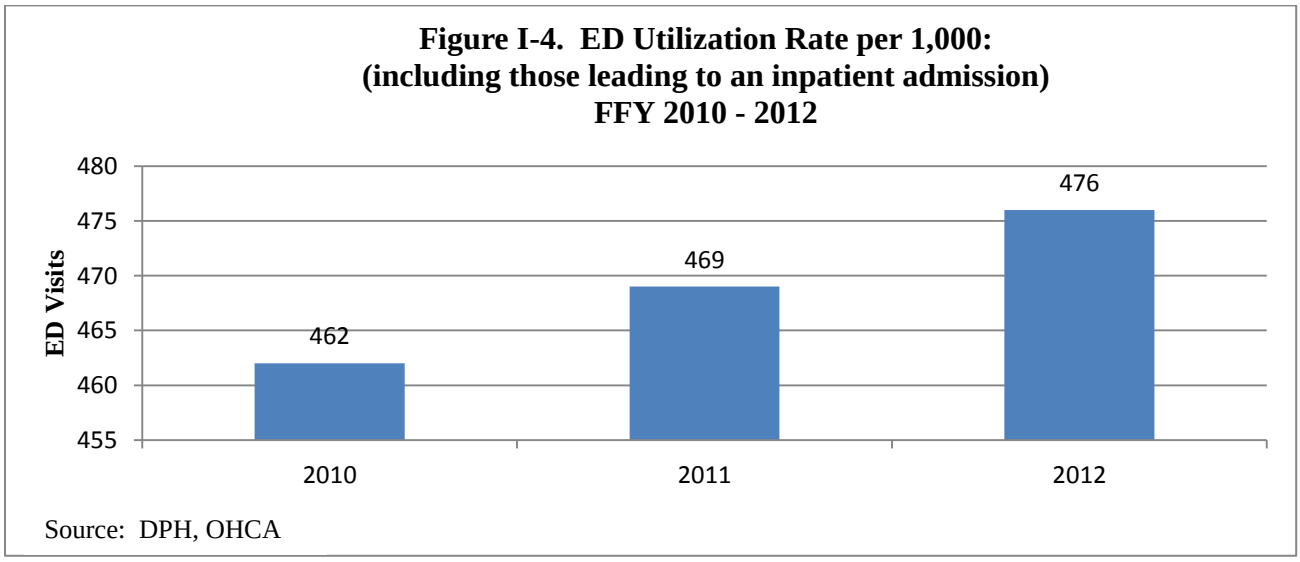
Source: DPH, OHCA

Although the number of ED vists to Connecticut hospitals has increased, the percent of inpatient admissions has remained unchanged. Figure I-3 shows that most ED visits do not result in an inpatient admission. In FFY 12, about 85 percent of visits to an ED ended up with the patient being treated and discharged, while 15 percent of visits resulted in the person being admitted to the hospital as an inpatient (or transferred to another hospital for admission). The Medicaid population, however, has a much lower inpatient admission rate, with only about seven percent of visits to an ED resulting in the client being admitted as an inpatient.

[1] Connecticut Department of Public Health Office of Health Care Access, *Health Care Utilization in Connecticut*, December 2013, 17-19.



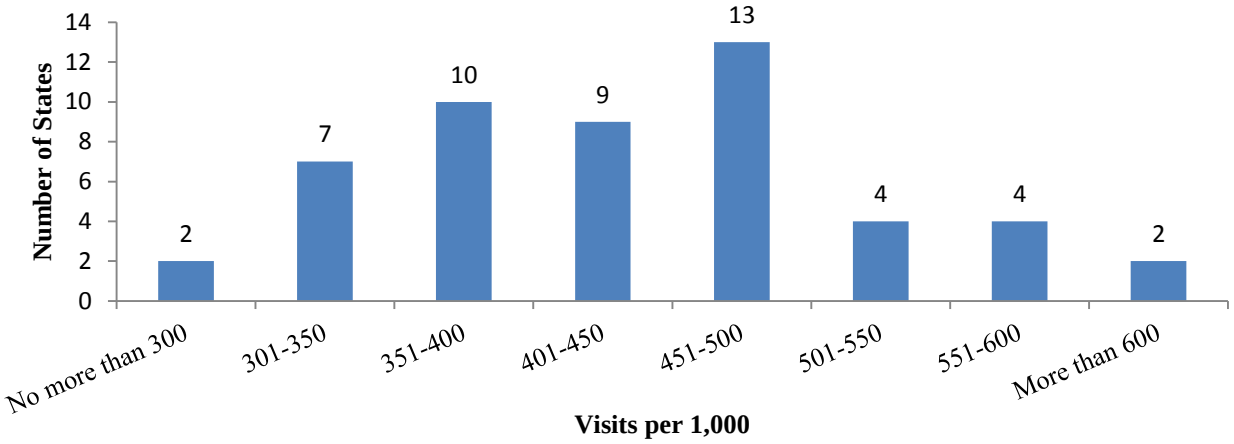
Emergency department utilization rate. The number of ED visits per 1,000 Connecticut residents has increased approximately one percent annually from FFY 10 to FFY 12. Figure I-4 measures the rate of ED visits per 1,000 state population and shows the growth rate over a three–year period. Although Connecticut's utilization rate is higher than the national average, it has the lowest utilization rate among the other six New England states. Based on data from 2011, Connecticut's rate of ED utilization was 469 per 1,000 population, which exceeds the national average of 415 per 1,000 population. (Appendix D contains a complete list of 2011 state-by-state ED utilization rates).



With 469 ED visits per 1,000 population in 2011, Connecticut ranks 23rd for the number of ED visits across the 50 states and District of Columbia. The District of Columbia is first with 736 visits per 1,000 and Hawaii is last with 266. The histogram in Figure I-5 illustrates that ED

visits per 1,000 are irregularly distributed, with nine states having fewer than 350, the majority of states (32), including Connecticut, having 351-500, and 10 states having more than 500.

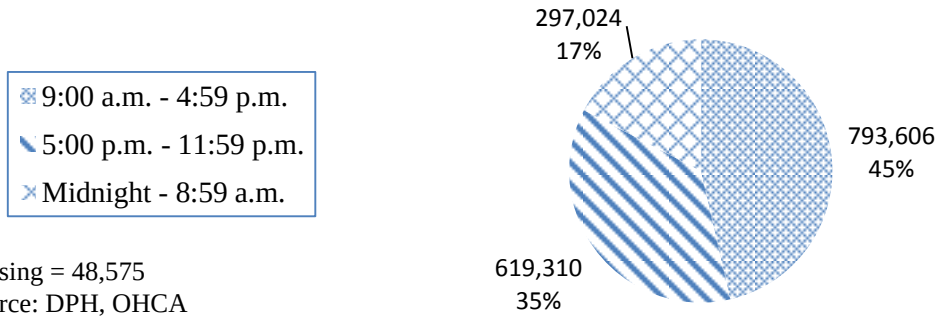
Figure I-5. Distribution of ED Visits Per 1,000 Population for 50 States and District of Columbia



Source: Kaiser State Health Facts (for 2011) Emergency Room Visits per 1,000 Population, 2011, Connecticut's rate presented in the Kaiser Health Facts is 458 per 1,000 population, slightly lower than presented in Figure 1-4 above.

Arrival time of ED visit. The utilization study also reports on the time of day that ED visits occur (shown in Figure I-6). It found that almost half (46 percent) of the 1,709,940 visits for which data were available occurred during daytime hours (9:00 a.m. to 4:59 p.m.), and 36 percent occurred between 5:00 – 11:59 p.m. According to the report, Medicaid clients, which at the time were about 18 percent of the population, accounted for more than one-third (36 percent) of the daytime ED visits. The data provided to OHCA by CHA, however, did not identify if the visit happened during the week, on weekends, or on holidays. Under new regulations, now under internal review, OHCA anticipates it will have access to complete ChimeData, which would include whether an ED visit occurred during the week or on a weekend.

Figure I-6. Timing of ED Visits to Connecticut Hospitals: FY 2012 (including those leading to an inpatient admission) (N = 1,709,940)



Missing = 48,575
Source: DPH, OHCA

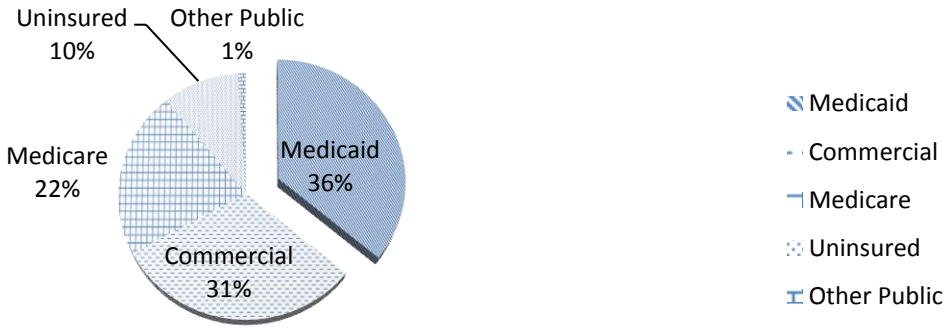
Total visits by payer source. Based on patient who self-report at the time of an ED visit, hospitals report the payer source for individuals who are treated and discharged from the emergency department as well as for those who are admitted to hospital inpatient care. This data, however, can only be used as a proxy for ED payer source since payer status may change when insurance coverage is verified by the insurer and an actual claim has been paid.

The use of hospital emergency departments by individuals with commercial insurance has been gradually declining. As reported in the PRI staff September update, the number has dropped by more than 30,000 visits (about 5 percent) from a high in 2007, although this trend has stabilized over the last three years. Factors contributing to the decrease are:

- the commercially insured population decreased while the number of persons covered by either Medicare or Medicaid has increased;
- the use of EDs by commercially insured has been discouraged by implementation of higher copays;
- employers are putting in place more programs for preventive care with penalties for nonparticipation; and
- the expanding number of urgent care centers, especially in suburban settings, has likely drawn many commercially insured patients there. Many urgent care centers do not accept individuals who have Medicaid.

Percent of visits by payer source. As shown in Figure I-7, Medicaid clients had the greatest percentage of ED visits (36 percent), followed by individuals with commercial insurance (31 percent). The percentage of commercially insured clients visiting the ED has decreased from 41.5 percent in 2006 to 31 percent in FY 12.

Figure I-7. ED Visits by Payer Source: FY 2012
(including those leading to an inpatient admission)



Source: DPH, OHCA.

The U.S. Census Bureau collects data on health insurance coverage. Its most recent publication utilizing this data was *Income, Poverty, and Health Insurance Coverage in the United States: 2012*. The Census Bureau reported that approximately 52 percent of the

population was covered exclusively by private health insurance (either employment-based or direct purchase), 16.5 percent of the population was covered by Medicaid, and 15.5 percent by Medicare at one or more times during 2012. An additional 15.4 percent was uninsured during 2012. Understanding that these numbers are approximations and do not include military health insurance or account for individuals who might have multiple types of insurance at the same time or at different times throughout the year, they still provide a useful point of contrast for viewing the figure, which depicts that the approximate 16.5 percent of the population enrolled in Medicaid accounted for 36 percent of all ED visits in 2012.

Utilization rate by payer source. Table I-1 shows the trend in the rate of ED utilization per 100 payer members by payer source.[2] As shown in the table, by far, Medicaid clients are the biggest users of the emergency department, but that population also had the largest drop in rate of use from 2010 to 2012, while rates for individuals who self-pay for ED services saw the greatest increase. As noted previously, although ED use had dropped from 2007 to 2010 for those with commercial insurance, the rate per 100 with commercial insurance has been relatively stable over the three-year period examined.

Table I-1. Utilization Trend in Connecticut: Rate per 100 Payer Population by Payer Source (treated and discharged from the ED)

Payer Source	***2010***	***2011***	***2012***
Commercial	18.5	18.1	18.5
Medicaid	116.4	112.7	106.8
Medicare	45.3	44.2	46.3
Self-Pay	37.5	45.8	49.0

Sources: DPH, OHCA: Individual Hospital Annual Report Filings: Report 165 – Hospital Gross Revenue, Net Revenue and Statistics by Payer Source (2011 and 2012), and U.S. Census Bureau, Health Insurance Historical Tables, HIB – Series, All Persons 1999-2012.

Frequent users of ED services. The Family Health Section (FH) within the Department of Public Health receives hospital revenue and statistical data each calendar year, including ED utilization data. In turn, FH provides this data to the Public Health Initiatives Unit (PHI) within DPH for state health planning purposes. Following development of a memorandum of agreement, DPH provided a data file to PRI staff for analysis. The file included information on individuals who were treated and discharged from the ED (i.e., not resulting in an inpatient admission).

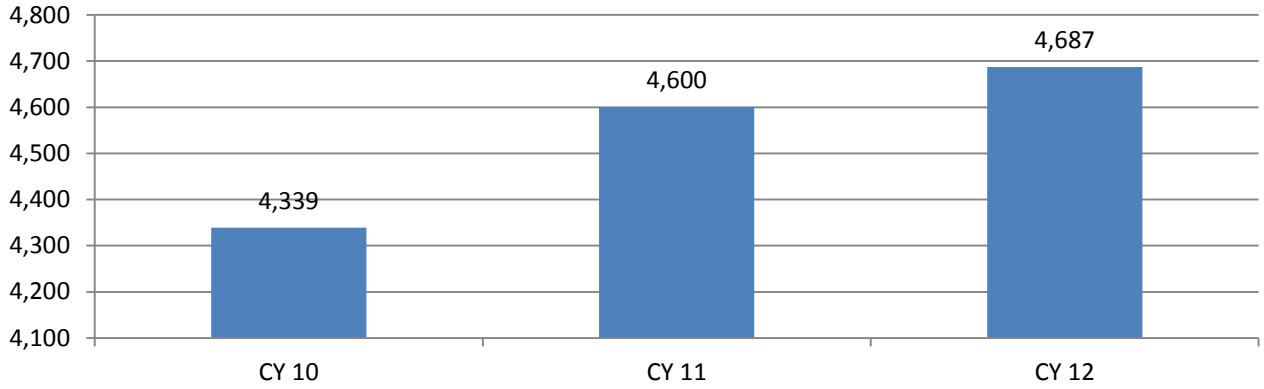
From this data, PRI staff was able to identify the number of individuals who could be considered frequent users of the emergency department (defined by PRI staff as 10 or more visits to an ED within a calendar year). However, from the data, PRI staff were only able to determine frequent ED users for individuals who had 10 or more visits to the ***same*** hospital and could not capture individuals who visited more than one hospital (i.e., had five visits at Hospital A and six visits at Hospital B). The data also do not capture individuals who had 10 or more visits within a

[2] The utilization rate is based on two separate data sources that encompass slightly different time periods. To calculate the rate, the number of individuals with ED visits was based on federal fiscal year filings by each hospital to OCHA, and the total number of individuals by type of insurance was based on census bureau data. While not a perfect measure, it may provide some overall insight into the utilization rate trend by each payer source.

12 month period that fell across parts of two calendar years. Thus, because of these two caveats, frequent users are under-represented in the information presented.

Figure I-8 shows the data, using as a broad aggregate measure, the number of individuals with 10 or more visits to the ED during CY 12. The figure provides some insight into the frequent use of ED services by all individuals, not just those enrolled in Medicaid. The number of frequent users was 4,339 persons in CY 10; that number grew to 4,687 visits by CY 12 – an increase of about 8 percent. While frequent users are not a large percentage of the population who visited the ED, accounting for only slightly more than one-quarter of one percent of individuals of the 1.5 million visitors that were treated and discharged, more analysis should be done so that individuals can be provided with resources to improve their health outcomes.

Figure I-8. Number of Individuals with 10 or More ED Visits in CY 12
All Payer Sources (treated and discharged from ED)



Source: DPH, Family Health Section

Number of individuals with ten or more visits by range. Table I-2 shows the number of individuals with 10 or more visits by range of visits over three calendar years. It is important to note again, however, these data do not include frequent users who visit more than one hospital emergency department – it only includes people with multiple visits to the ***same*** hospital. Given that individuals often seek care at more than one hospital ED throughout a year, the number of frequent users is likely higher than what is presented in the table.

Table I-2. Number Range of ED Visits For Unique Individuals with Ten or More Visits

Range	CY 10	CY 11	CY 12
10-19 Visits	3,704	3,935	3,969
20-30 Visits	441	459	504
31-50 Visits	141	147	164
50-74 Visits	31	43	36
75-99 Visits	12	9	10
100-150 Visits	17	6	3
151-199 Visits	1	-	1
200 or more	2	1	-
TOTAL	4,339	4,600	4,687

Source: PRI staff analysis of DPH data (Family Health Section).

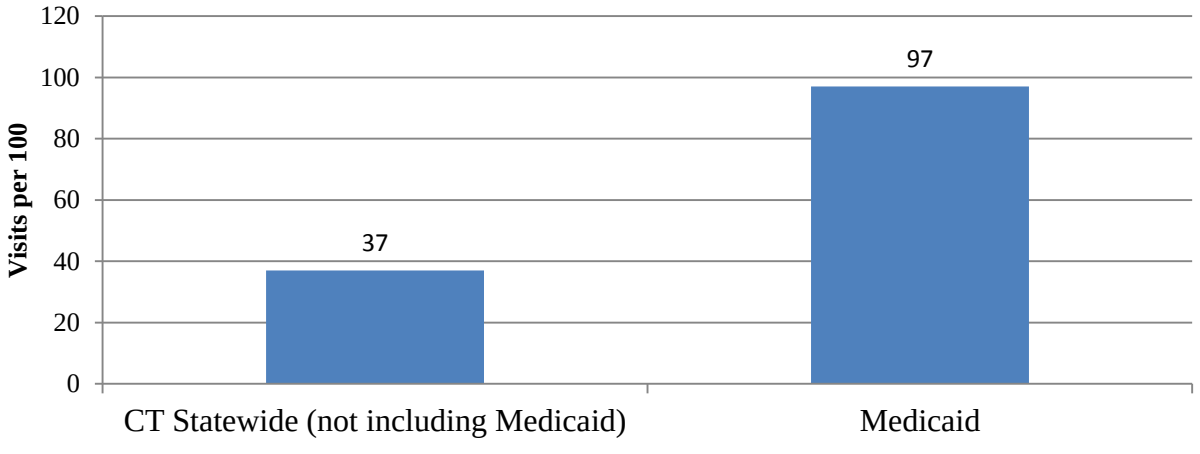
Use of Hospital Emergency Departments by the Medicaid Population

The DPH data show the overall trends in ED use in Connecticut hospitals by the general population. However, the focus of this study is to quantify the use of hospital emergency departments (EDs) by the Medicaid population and determine the impact that ED use has on the state's Medicaid budget. The study also examined use by individuals who need emergency care because of behavioral health or substance use disorders and frequently return to the ED for these reasons. Several recommendations are made in Chapter Two of this report addressing these two areas of focus.

It is widely accepted, both nationally and in Connecticut that Medicaid clients use the emergency department at much higher rates than individuals with other types of insurance or who self-pay for services. In interviews with hospital ED directors, PRI staff were told that EDs also function as a safety net for those who were unable to find community health care or other services in a timely manner, which can contribute to the higher rate of ED use by Medicaid clients.

Comparison of ED utilization rates statewide and by Medicaid clients. Figure I-9 shows the rate of ED visits per 100 persons by the Medicaid population compared to the rest of the state population. As shown in the figure, there were 97 visits made to the ED in CY 12 for every 100 Medicaid clients, or almost one visit per member, compared to 37 visits per 100 for the remainder of the state population (with the Medicaid population excluded).

Figure I-9. ED Visits Per 100 Population - CT Statewide and Medicaid (CY 12)



Source: PRI staff analysis of DSS data

Reasons for higher rate of use. In reviewing the national literature and in discussions with emergency department professionals, agency staff (DSS and the Department of Mental Health and Addiction Services), and advocates, several reasons are given as to why Medicaid clients use the emergency department at higher rates than the general population, even when compared to the Medicare rate. The reasons include:

- *the lack and location of urgent care facilities that accept Medicaid insurance;*
- *limited extended hours/weekend hours for primary care providers (PCPs) and federally qualified health centers which serve a large number of Medicaid clients ;*
- *the availability of PCPs in general, and those who accept Medicaid patients specifically;*
- *the need to educate patients around when to use an ED and when to seek care in the community;*
- *low copays for ED use;*
- *sicker population;*
- *the greater prevalence of behavioral health and substance abuse conditions;*
- *the desire to obtain narcotics; and*
- *incidents of public inebriation, with the inebriated person brought to the ED via ambulance.*

Medicaid enrollment and ED visits by program type. Table I-2 shows the number of individuals enrolled by HUSKY program in CY 12, a brief description of the program's population, the total ED visits for each group, and the rate of visits per 100 client population. As the table shows, the HUSKY D population used the ED at the highest rate, more than two times that of the HUSKY A population, the next biggest user which was HUSKY A.

The high rate of use among the HUSKY D population is not surprising. In 2010, Connecticut was the first state to expand Medicaid to previously ineligible low-income adults, as allowed under the Affordable Care Act (ACA). Many of this population had been served by the State Administered General Assistance (SAGA) program because of mental illness, substance abuse, or other behavioral health issues. Connecticut is not alone in this experience. Preliminary reports from states that initiated early Medicaid expansion are encountering greater than anticipated need for behavioral health services with the expansion population.[3]

The Department of Social Services through its contractor for Medicaid administrative services, Community Health Network of Connecticut (CHNCT), provided PRI staff with extensive paid claim data about emergency department visits by Medicaid clients for CY 12. The data included information on the number of visits, the number of unduplicated clients receiving ED treatment, and the total cost of the visits by type of Medicaid program (i.e., HUSKY A, B, C, or D). Although the number of clients enrolled in HUSKY C in the table captures individuals who are Medicare and Medicaid eligible, the number of ED visits does not include those who are eligible for *both* programs. The reason for this is that Medicare pays for an ED visit and thus is not captured in the Medicaid data, with Medicaid only responsible for co-pays and any other services not covered by Medicare.

[3] Sommers, B.D., Arntson, E., Kenney, G.M., Epstein, A.M, "Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials," *Medicare & Medicaid Research Review*. 3: 4 (2013): E1-E23.

Table I-2. Medicaid Programs by Eligible Populations[4]				
Program	***Description***	***Total Enrollment for CY 12***	***Total ED Visits***	***Visits per 100 Clients***
HUSKY A	Eligible children, parents, relative caregivers, elders, individuals with disabilities, low-income adults, and pregnant women	423,484	369,992	87
HUSKY B	Non-entitlement State Children's Health Program (SCHIP) for children under age 19 – copays and/or monthly premiums	13,965	6,068	44
HUSKY C	Available for low-income Aged, Blind and Disabled Connecticut residents who are aged 65 or older, blind or have a disability. Many are also eligible for Medicare	95,920	71,173	74
HUSKY D	Low-income individuals aged 19 through 64, who do not receive federal Supplemental Security Income or Medicare (used to be State Administered General Assistance (SAGA) program)	86,086	158,273	184
TOTAL		619,455	605,506	97
Source: DSS information provided to PRI staff.				

Analysis of Medicaid ED data with no inpatient admission provided by DSS. The data provided by DSS is for individuals who were treated and discharged from an ED visit, (i.e., the visit did not result in an inpatient admission). Connecticut's Medicaid reimbursement system is very complicated and there are several nuances surrounding ED reimbursement. These nuances depend on the model used by the hospital to staff its ED with emergency department physicians (i.e., direct hospital staff versus contracted) and whether a claim is coded for reimbursement as an "emergency visit" or a "non-emergency visit," according to DSS regulations.

DSS provided claim data to PRI staff separated by three broad cost categories associated with an ED visit:

- facility fees, which has two components:
  - the use of the ED and hospital overhead costs, and ED physicians directly employed by the hospital;
  - ancillary costs, which include labs, x-rays, scans, and in-house pharmaceuticals;

[4] An additional 1,724 clients were either enrolled in the Charter Oak Health Plan (1,390 clients); had a limited benefit (328 clients); or not identified by the program they were enrolled in (6 clients). These clients are not included in the analysis.

- professional fees, which include ED physicians not directly employed by the hospital (i.e., under contract) and the cost of specialty health care staff outside the ED attending the patient[5]; and
- ambulance costs (for those clients arriving by ambulance to the ED).

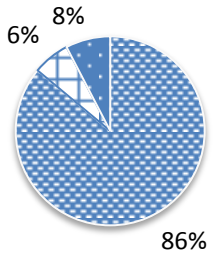
The data were also broken down based on a client's primary diagnosis classified by whether the visit was medical or behavioral-health related, with behavioral health further subdivided as to whether the visit was alcohol-related.

Total ED Medicaid reimbursement and visits. It is important to remember that not all Medicaid clients visit an ED each year, while some clients visit an ED multiple times within a year. In CY 12:

- *267,700 Medicaid clients (43 percent of all enrollees) visited an ED;*
- *ED visits numbered 605,506;*
- *Medicaid reimbursement for these visits was slightly more than $229 million, about four percent of the approximately $6 billion total Medicaid budget; and*
- *ED cost-per-visit was $350 -- less than half the per-client cost of $791.*

Costs by Medicaid reimbursement category. Figure I-10 shows the cost components of an ED visit broken down by facility fees, professional fees, and ambulance costs. As the figure shows, facility fees made up the largest portion of total ED costs in CY 12, accounting for 86 percent of all ED reimbursement or slightly more than $197 million. Professional and ambulance costs accounted for a much smaller share of overall costs – most likely because only a portion of clients visiting the ED receive services contained under the professional fee claim codes, or ambulance transport.

Figure I-10. Percentage of ED Costs by Reimbursent Category: CY 12



Source: DSS

Facility Professional Ambulance

[5] Although simplified for discussion purposes, the facility overhead portion of Medicaid reimbursement is dependent on primarily two factors. First, if ED physicians are directly employed by the hospital, reimbursement for services is usually contained in the facility fee. If ED physician services are contracted out, payment for their services is usually in the professional category. Second, whether the claim submitted is coded as an emergency or a non-emergency visit affects reimbursement.

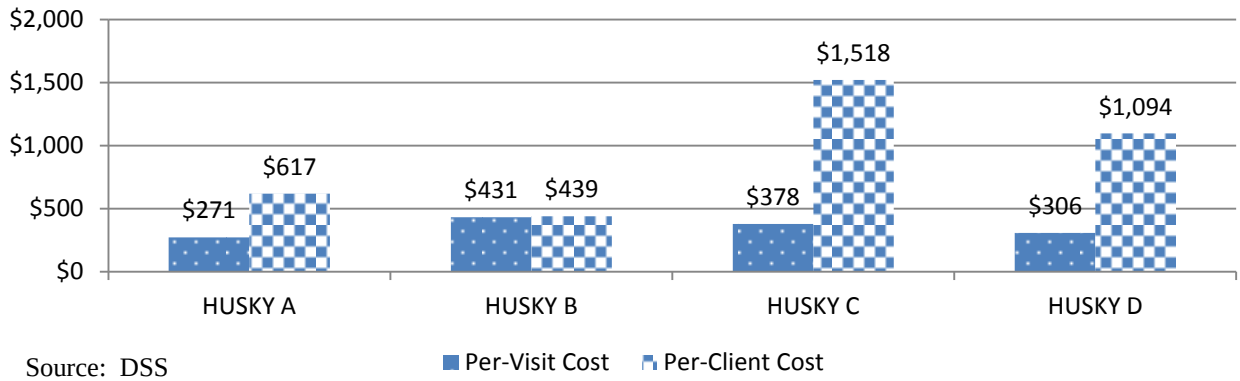
The department also broke down facility fees into two subcategories (referenced on page 10) - about 40 percent of facility reimbursement was for the visit (overhead and ED staff directly employed by the hospital) - while the remaining 60 percent was for facility ancillary costs (i.e, labs, scans, x-rays, and pharmaceuticals provided in the hospital). Professional costs can be also divided into two subcategories – professional services that are provided directly to the client in the ED by ED doctors under contract to the hospital, physician specialists providing direct patient services, and ancillary professional services such as a radiologist, not directly treating the patient but providing services, such as reading an x-ray.

Ambulance reimbursement. As noted above, not every Medicaid client who visited an emergency room in CY 12 arrived by ambulance, so PRI staff analyzed these costs separately. During that year, 42,361 Medicaid clients took an ambulance to the ED (or about 16 percent of the 267,700 unduplicated clients that visited an ED), costing a total of $17,527,108. There were a total of 77,260 ambulance trips; thus, each client using an ambulance took an average of 1.8 trips during the year. The average trip cost was $227 if calculated on a per-trip basis, but increasing almost 83 percent, to an average cost of $414, if calculated on a per-member basis.

Emergency department costs by HUSKY program. Figure I-11 shows per-visit and per-client costs by HUSKY program. The average cost of an ED visit, excluding ambulance costs, varied by HUSKY program and ranged from $271 for HUSKY A clients to $1,518 for clients enrolled in HUSKY C. Since some clients use the ED multiple times, costs rose significantly when examined on a per-client cost basis, with costs for HUSKY C clients exceeding $1,500 per-client and HUSKY D clients with costs more than $1,000.

The wide variation in the per-visit cost compared to the per-client cost, especially with clients enrolled in HUSKY C and D, indicates that these clients are more likely to have had multiple and costly ED visits. Thus, while the average per-visit cost is fairly inexpensive, the costs on a per-client basis increase greatly, more than tripling for HUSKY C and D clients. Again, this is not surprising since HUSKY C covers persons who are older or disabled, while the majority of those enrolled in HUSKY A and HUSKY B are low-income women who are pregnant and/or have children.

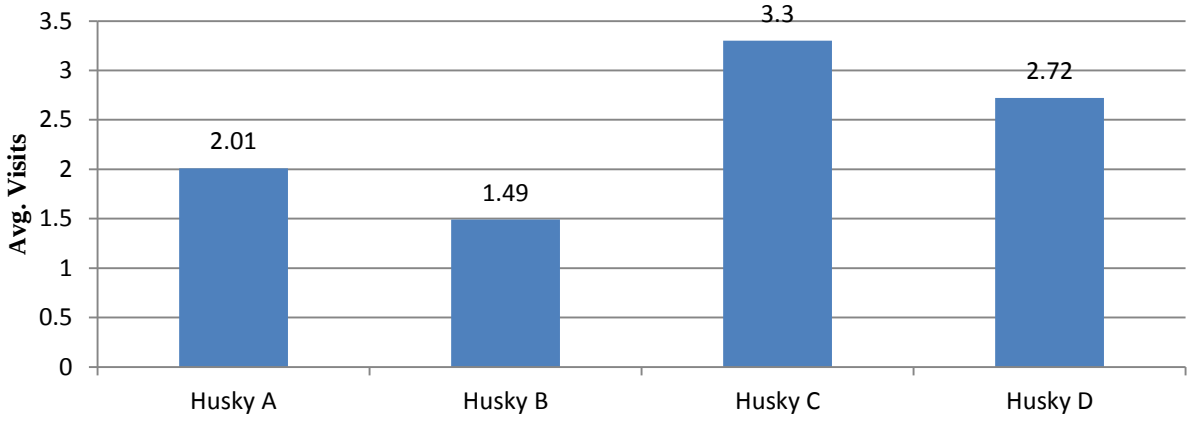
Figure I-11. Costs by HUSKY Program Per Visit and Per Client: CY 12 (excluding ambulance costs)



Source: DSS

Average number of ED visits by HUSKY program. Higher per-client costs are associated with higher numbers of ED visits. Program review committee staff examined the average number of ED visits by HUSKY program in CY 12. As shown in Figure I-12, individuals who were enrolled in HUSKY C and had visited an ED in CY 12 had an average of 3.30 ED visits, followed by those enrolled in Husky D with an average of 2.7 visits, the two HUSKY programs with the higher per-client costs.

Figure I-12. Average Number of ED Visits Per Member by Husky Program: CY 12



Ambulance costs. Committee staff examined ambulance costs separately because, as noted above, only 42,361 clients (16 percent) visiting an ED arrived by ambulance for a total cost of slightly more than $17.5 million. Table I-3 shows the number of clients taking an ambulance to the ED by HUSKY program, the number of trips taken, and the cost of the trip on a per-client and per-trip basis. Also shown is the percent of clients who took an ambulance compared to the total number of clients visiting an ED by HUSKY program. Again, HUSKY C and HUSKY D populations make up a much greater percent of those who arrive at the ED by ambulance, as those are individuals who are older and/or have a disability or previously lacked insurance and their health care was likely poor.

Table I-3. Number of Trips by Ambulance and Ambulance Costs

HUSKY Program	*# Clients Arriving by Ambulance (as percent of all clients visiting ED)*	*Avg. Cost per Client*	*# of Trips*	*Avg. Cost per Trip*
HUSKY A	20,324 (11%)	$329	29,247	$229
HUSKY B	360 (9%)	$325	490	$239
HUSKY C	8,264 (38%)	$585	22,069	$219
HUSKY D	13,413 (23%)	$438	25,454	$231
TOTAL	42,361 (16%)	$414	77,260	$227
Source: DSS				

Coding of primary ED diagnosis for claim submission. The department also provided detailed information on Medicaid costs for medical, behavioral health, and alcohol-related visits, based on the primary diagnosis for the visit, which is coded by ED personnel. About 92 percent of all Medicaid ED visits were coded with a primary diagnosis of medical; 6 percent were

classified as behavioral health; and an additional 2 percent were broken out separately from behavioral health and sub-categorized as alcohol-related. From discussions with ED physicians, DSS staff and its ASO, the behavioral health and alcohol-related reasons are likely under-represented as the *primary* diagnosis, as that is the one that is coded. While there can be a co-occurring medical and behavioral or alcohol reason for the visit, many physicians stated that they code the medical primary diagnosis first.

Emergency versus non-emergency visits. As noted earlier, the level of Medicaid reimbursement to hospitals is dependent on several factors, including whether a visit is coded for claim submission as an emergency or non-emergency visit by the hospital, as defined by regulation and in the DSS provider manual (see Table I-4). Although this factor affects only a portion of total reimbursement to the hospital for the visit, the reimbursement differs by almost $100. Medicaid reimburses $156.82 for an emergency visit compared to $57.23 for one coded as a non-emergency. Medicaid reimbursement rates for ED services are extremely complicated and are outside the focus of this study however, DSS did provide data on the cost and number of emergency versus non-emergency visits by HUSKY program.

Table I-4. Regulatory Definitions of Emergency and Non-Emergency ED Visit for Medicaid Payment.

Type of Visit	***Definition***
Emergency	"*Emergency visit" means an urgent encounter requiring the immediate decision-making and medically necessary action to prevent death or any further disability for patients in health crises (including labor and delivery).* Such medical conditions are manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In order to be considered urgent, the encounter must occur within seventy-two (72) hours from the onset of the presenting medical condition
Non-Emergency	*"Non-emergency visit" means a medically necessary non-urgent encounter presenting a medical condition which does not meet the requirements for an emergency visit as defined in this section but, rather, requires a routine level of ambulatory health care.* Such conditions may be characterized by the fact that they may also be treated in an alternate health care setting, such as: community-based physician's office, walk-in clinic, comprehensive health center, neighborhood health center and other free-standing primary health care clinics because such medical conditions do not require the skills, resources and equipment of a hospital emergency room. Such visits may include primary health care or the initial diagnosis and treatment of routine acute or chronic illnesses whether on a scheduled or unscheduled basis.
Source: RCSA. Sec. 17-134d-86	

Table I-5 and Table I-6 show information for ED visits coded by emergency and non-emergency visits, respectively. Added together, the expected number of 605,506 visits cited throughout this report is the result. However, the number of clients exceeds the 267,700 clients cited previously because those client who had multiple visits across the two code classifications, would be counted in each table.

Of the 605,506 visits for which data were available, 76 percent of ED visits were coded as an emergency. In Table I-5 there were 221,623 unique Medicaid clients who had 457,357 ED visits coded as an emergency in CY 12 or 76 percent of all visits. Total costs, excluding ambulance, were $198,240,987. Ambulance costs (not shown in the table) were $16,635,032, and there were 40,583 ambulance transports.

Table I-5. Medicaid Reimbursement for Visits Coded by Hospital as an Emergency Visit: CY 12 (excluding ambulance)

HUSKY Program	*# Clients Visiting ED*	*# ED Visits*	*Total Reimbursement*	*Avg. Cost per Client*	*Avg. Cost per Visit*
HUSKY A	147,771	267,943	$104,346,739	$706	$389
HUSKY B	3,125	4,306	$1,629,804	$522	$379
HUSKY C	19,530	59,393	$31,593,061	$1,618	$532
HUSKY D	51,197	125,895	$60,671,383	$1,185	$482
TOTAL	221,623	457,537	$198,240,987	$895	$433
Source: DSS					

Table I-6 shows there were 101,093 unique Medicaid clients who a total of 147,969 had ED visits coded as a non-emergency in CY 12, 24 percent of all visits. Total cost, excluding ambulance, for non-emergency care was almost $11.9 million. Ambulance costs were $16,635,032 and there were 40,583 ambulance transports. Costs for all HUSKY enrollees were very low, even for those clients enrolled in HUSKY C and HUSKY D.

Table 1-6. Medicaid Reimbursement for Visits Coded by Hospital as Non-Emergent: CY12 (excluding ambulance)

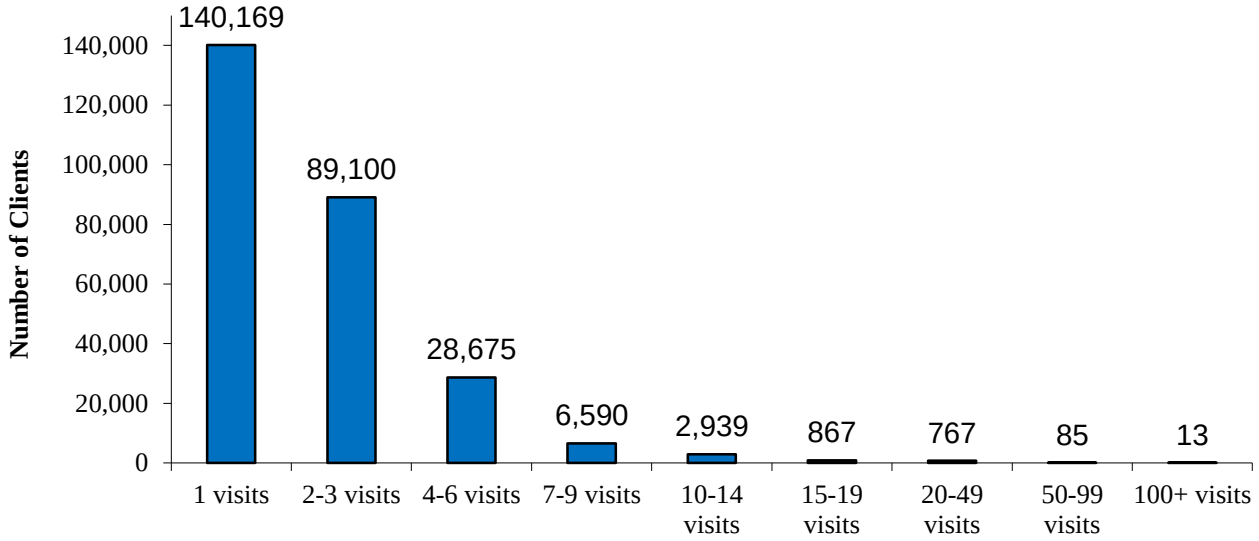
HUSKY Program	*# Clients Visiting ED*	*# ED Visits*	*Total Reimbursement*	*Avg. Cost per Client*	*Avg. Cost per Visit*
HUSKY A	72,669	102,049	$7,945,245	$109	$78
HUSKY B	1,429	1,762	$137,438	$96	$78
HUSKY C	6,880	11,780	$1,034,315	$150	$88
HUSKY D	20,115	32,378	$2,780,353	$138	$86
TOTAL	101,093	147,969	$11,897,351	$118	$80
Source: DSS					

Frequent Use of Emergency Departments by the Medicaid Population

A major focus of this study was to examine Medicaid clients who frequently use the emergency department. While no single definition exists of what constitutes “frequent use”,

DSS provided data, separated into ranges, on ED usage patterns among Medicaid clients (shown in Figure I-13). As noted previously, 267,700 Medicaid clients visited an ED in CY 12. While the majority of clients who went to an ED (52 percent) had only one visit to the ED, a small number of clients (4,671) had 10 or more ED visits. Although these frequent users represent only 1.7 percent of Medicaid clients who had an ED visit during the year and less than 1 percent of all clients enrolled in Medicaid, in interviews with PRI staff, ED physicians noted it was important to identify frequent users of emergency services so that both hospitals and community organizations could better meet their needs by providing preventative care and improving health outcomes.

Figure I-13. ED Users -Frequency of Visits - CY 12



Source: DSS presentation to the Medical Assistance Program Oversight Council, October 11, 2013

One of the strategies that may reduce ED use, especially frequent visits, is better client education. When an individual becomes eligible for Medicaid, he or she receives a packet of materials including a 41-page member handbook that explains all of the health benefits covered under Medicaid. Enrollees also receive a four-page summary outlining the benefits. In addition, DSS maintains a website specifically dedicated to Medicaid clients. On the website's homepage, there is a headline that states, "not sure if you should see your doctor or go to the emergency room" along with a graphic depicting confused individuals, and a 24-hour phone number to phone for the "Nurse Helpline." The nurse can advise individuals who have medical symptoms and provide advice on whether or not to seek ED care, along with answering any questions about follow up that a client forgot to ask at a recent appointment. While PRI staff believes the website is a beneficial method by which to assist clients who have questions about medical conditions requiring visits to an ED, additional educational efforts need to be made by the department.

As noted above, the utilization rates per 100 Medicaid members are more than two and one/half times higher than those of the rest of the Connecticut population, and almost five times higher for HUSKY D clients. Strategies need to be developed to educate clients in myriad ways

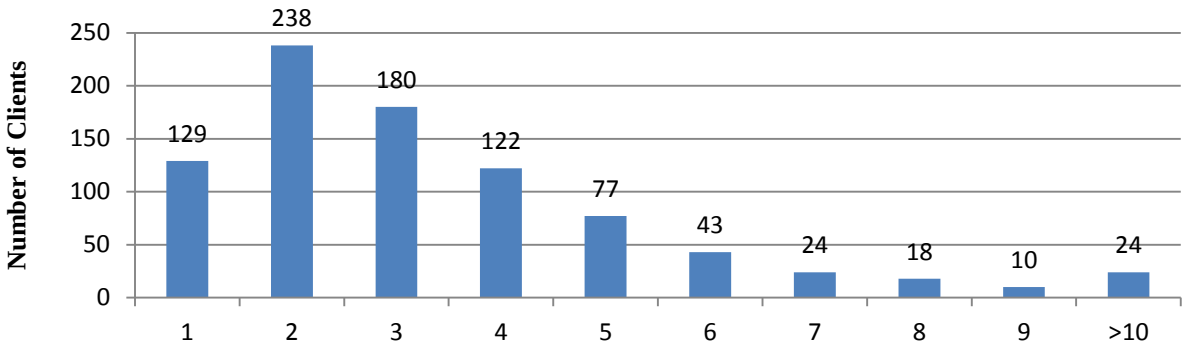
to reduce these high rates of utilization. One simple method would be to develop written brochures that reiterate the information contained in the summary of covered benefits as an effective way to reach clients who do not have ready access to on-line information. Therefore PRI staff recommends:

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.**

Number of different hospital emergency departments visited by clients. The department provided more detailed information on 865 Medicaid clients with 20 or more visits to an emergency department in CY 12, arrayed by the number of hospital EDs the client had visited in CY 12. Figure 1-14 shows that the greatest number of clients – 238 - with 20 or more visits to an ED, visited two different hospital EDs, followed by 180 clients who visited 3 EDs, and 129 clients, 1 ED. There were 196 clients who had visited five or more hospitals.

It is important to note that the DSS had to request its medical ASO to perform special data analysis to identify frequent Medicaid ED users, and only reported information on use and costs for those clients who had 20 or more visits within a calendar year. The ASO, CHNCT has access to complete client claim adjudication history from CY 12 forward. Furthermore, while there may be legitimate reasons for high ED use or visiting multiple hospitals, PRI staff was also told that this may be an indication of drug-seeking behavior.

Figure I-14. Number of Different EDs Visited by Medicaid Clients with 20 or more ED Visits in CY 12



Source: DSS

In much of the literature dealing with frequent use of the ED and Medicaid, the first step in formulating programs that can reduce the frequency of visits is to identify the population and determine the reasons for their visits. Therefore PRI staff recommends:

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 room 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

If DSS had more developed information on the frequent users of hospital emergency departments it would be better equipped to recognize where gaps in services are located, whether these frequent users are already receiving other Medicaid services and if so, what obstacles are occurring in service delivery that brings clients back to the EDs.

Chapter II

Alternatives to Emergency Departments

There is no clear agreement among medical providers and others about what constitutes "inappropriate use" of hospital emergency departments. In fact, most emergency department physicians PRI staff interviewed maintain there is no inappropriate use. However, another way to consider the question about ED use by people insured by Medicaid, this study's focus, is whether by seeking care at the ED in all the various [reported] circumstances, these patients are getting the most effective care in terms of both client health and costs in the context of the entire health care delivery system.

The "prudent layperson" definition[6] typically guides payment for clients with commercial insurance, but those insurers have instituted measures like higher co-pays for emergency department use, to discourage people from getting their care in an ED if alternatives exist. Most people with commercial insurance also have access to alternatives like urgent care centers or walk-in clinics. These centers are not licensed as health care facilities in Connecticut, but rather the individual practitioners are licensed, much like a private doctor's office or practice. The number of these centers has increased rapidly, and there now are at least 100 throughout the state, primarily in suburban areas. These centers offer medical care, often without an appointment, and the co-pays required are generally between $20 and $30, substantially less than a typical co-pay of $75 at an ED.[7] Further, emergency department co-pays can be as high as $150, the upper limit placed on insurers by the Connecticut Insurance Department in 2002.

Another setting where people can go for minor health issues like colds, sore throats or for flu shots are retail health clinics or "minute clinics". These are located at many pharmacies like CVS and Walmart. Again, because the facility is not licensed by DPH, but only the medical practitioners who work there, it is difficult to determine the exact number. And while many of these clinics do accept Medicaid, most are not located in urban areas that would be convenient to Medicaid clients.

Connecticut's medical practitioner supply. A basic prerequisite to keeping people out of EDs is an adequate supply of medical providers in the community. Connecticut compares well with other states in the number and ratio of physicians relative to the general population. According to the American Association of Medical Schools data on physician workforce supply, Connecticut had 332.8 *actively practicing physicians* per 10,000 civilian population, placing the state 6th highest nationwide, and much higher than the national average of 260.5 or the statewide median of 244.5.[8]

[6] The American College of Emergency Physicians "prudent layperson" is defined as "one who possesses an average knowledge of health and medicine, and the prudent layperson standard establishes the criteria on which insurance coverage is based – not on ultimate diagnosis, but on whether a prudent layperson might anticipate serious impairment to his or her health in an emergency situation."

[7] Based on information from Connecticut Anthem Blue Cross Blue Shield website, and according to the Connecticut Association of Health Plans, which represents other health maintenance organizations.

[8] For a breakdown of Connecticut's Physician Workforce Profile see the 2013 State Physician Workforce Data book at the AAMC website.

Similarly, the supply of physician assistants (PAs) in Connecticut is 9th highest per population in the country. Connecticut has approximately 1,900 licensed PAs, about 47 per 100,000 people, and about 75 percent higher than the national average of 27 per 100,000. Connecticut is also among the 40 states that allow PAs to diagnose, treat, and dispense medication, as long as this is done under the supervision of a licensed physician.

Another area where Connecticut ranks high – 5th nationwide -- is in the supply of advanced practice registered nurses (APRNs). With 3,665 APRNs licensed in Connecticut, or 96 per 100,000, the state has almost two-thirds more APRNs than the national average of 58 per 100,000. Connecticut is among 27 states that limit the scope of practice of APRNs. While APRNs in Connecticut are permitted to write prescriptions, the law requires that they directly or indirectly be supervised by a physician. Very rural states, with many fewer physicians, are more likely to allow APRNs to practice without physician supervision.

Provider Adequacy for Medicaid Population

Measuring the supply of medical practitioners available to treat the general population is not the same as assessing adequacy of supply for Medicaid clients. As shown in Chapter One, Medicaid clients are the biggest users of hospital emergency departments in Connecticut, and preventing or reducing this use is the main focus of this study. Thus, ensuring there are adequate numbers of providers to serve this population is crucial in mitigating use of the emergency department for care that could and should be provided in other settings.

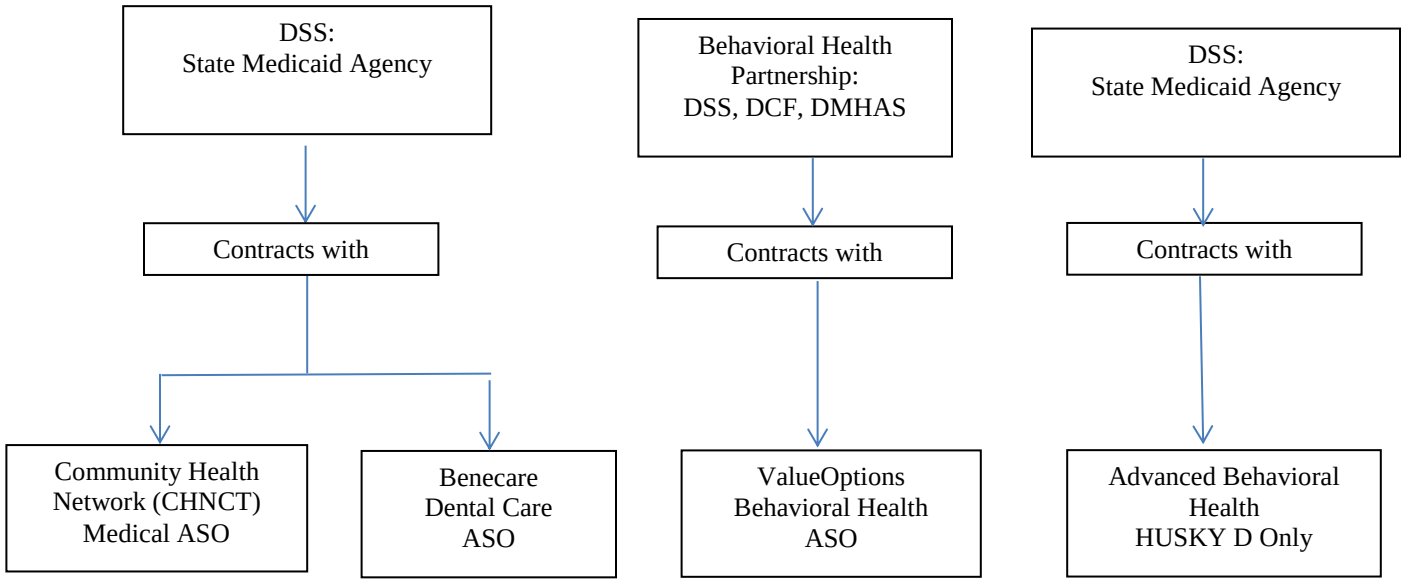
It is also important that we ensure adequacy as the state gets ready to meet the needs of the expanded Medicaid population. As of mid-January 2014, approximately 41,000 additional Medicaid clients had enrolled through ACCESS Health CT, the state's health exchange. It is likely that many of these newly added recipients will be low-income adults who were not eligible for the first round of Medicaid expansion in 2010 that limited eligibility to extremely low-income individuals (56 percent of federal poverty level).

Unlike many other states, Connecticut employs a fee-for-service (FFS) payment model for its Medicaid program. Most states provide Medicaid services through managed care organizations (MCO), with the states usually paying a capitated per member per month premium to the MCO, which then assumes the risk for paying medical claims for that client. According to the Centers for Medicare and Medicaid Services (CMS), in 2011 about 75 percent of Medicaid clients nationwide were in managed care, for at least part of their Medicaid services. That percentage is likely to increase as most states are using the MCO model for their Medicaid expansion under the federal Affordable Care Act.

Connecticut had covered medical services for family Medicaid, HUSKY A and B, through MCOs until January 2012. Behavioral health was "carved out" of the services provided under the MCO model, and those services were delivered under the auspices of the Behavioral Health Partnership. Other Medicaid populations, aged, blind, and disabled (HUSKY C), and Medicaid low-income adults (LIA), now renamed HUSKY D, were always under a FFS reimbursement system, and remain so under the current model.

However, because of legal issues around disclosure of rates and payments by the Medicaid MCOs, Connecticut abandoned the MCO model in favor of an administrative services organization (ASO) structure in January 2012. Under this model, the state is self-insured, and assumes all the financial risk for Medicaid clients, but the state contracts with four different organizations to provide administrative and other services. Figure II-1 shows the Connecticut ASO model.

Figure II-1. Administrative Services Organizations (ASOs)



The two major ASOs – Community Health Network of Connecticut (CHNCT) for medical services and ValueOptions (VOI) for behavioral health services -- are contracted to provide services such as:

- provider recruitment and enrollment;
- referral assistance and appointment scheduling;
- utilization management, including authorizing prior approvals for certain procedures;
- case management, including intensive case management (ICM);
- quality management; and
- health data analytics and reporting.

It is important to note that none of the ASOs is responsible for member eligibility determination or enrollment, which remains a DSS responsibility, nor are they responsible for claims payment, which is performed by HP (Hewlett Packard) under contract to DSS.

PRI staff reviewed the relevant contracts for each of the ASOs and Table II-1 below shows some key provisions of the contracting entity's payment and duration. (It should be noted that some of the contract were amended multiple times, primarily to extend duration). While the study was not a review of these contracts or the performance of these entities per se, PRI staff believes it is important to identify what services the state has delegated to these organizations and how well these services are performed. The ASO structure is the one the state has chosen to link Medicaid clients to the most appropriate care in the most appropriate setting, oversee the services they receive and where, and the attendant costs. How well these services are delivered no doubt has an impact on Medicaid clients' use of hospital EDs.

Table II-1. State Contracts with Administrative Services Organizations

Organization	***Primary Contracting Agency or Entity***	***Contract Duration***	***Paid Amt. for FY 13***
CHNCT	DSS	1/1/16 - 12/31/16	$105.7 million
ValueOptions	CT Behavioral Health Partnership	01/01/11 - 12/31/13	$26.6 million
BeneCare	DSS	9/30/11 – 12/31/13	$6.6 million
Advanced Behavioral Health	DMHAS	7/1/11- 6/30/16	$29.7 million

Source: PRI staff review of contracts and payment information from the CT Transparency website, maintained by the Office of Fiscal Analysis.

PRI staff focused on the services furnished by three of the ASOs --- Community Health Network, which serves as the medical ASO for all Medicaid clients; ValueOptions, which serves as the behavioral health ASO for all Medicaid clients; and Advanced Behavioral Health, whose services are limited to HUSKY D and DMHAS clients who seek treatment for substance abuse disorders. Benecare (the dental ASO) services were not examined.

Medicaid Administrative Services Organizations

Figure II-2 below depicts some of the major services performed by the various ASOs to ensure that Medicaid clients receive health care in the most appropriate setting.

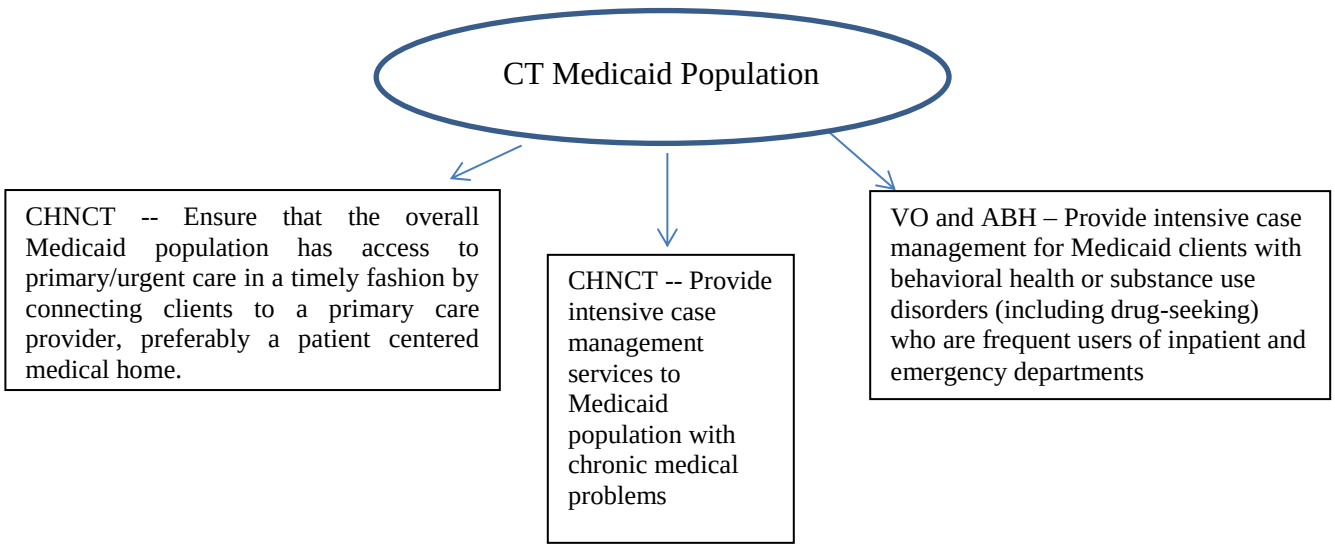
Provider Enrollment and Measuring Network Adequacy

As noted earlier, one of the roles of the ASOs is to assist with provider recruitment and enrollment in order to ensure network adequacy for the Medicaid population. As noted in the PRI September update, the medical ASO measures the network adequacy for primary care using Geo Access, a tool that gauges proximity of clients to providers, with one primary care provider within 15 miles of each Medicaid client as the standard. As reported by CHNCT, there were 3,302 primary care providers (i.e., MDs, PAs, and APRNs) enrolled at 6,129 locations throughout the state, which met the 15-mile threshold for almost 100 percent of all Medicaid clients.

As noted in the PRI September 2013 update, there are a number of limitations with measuring access by mileage proximity alone. For example, issues such as the length of wait

time for an appointment, closed panels (i.e., the provider is not accepting new Medicaid clients), and access to specialists are not measured.

Figure II-2. ASO Services to Connecticut Medicaid Population



Anticipating the expansion of Medicaid under the federal Affordable Care Act, and the issues around adequacy of access for this population, the legislature passed Special Act 13-07, requiring the Council on Medicaid Assistance Program Oversight (MAPOC) to study obstacles to achieving an adequate healthcare network for Medicaid recipients and recommend strategies to improve access and ultimately health outcomes. That report is due in January 2014.

In the fall of 2013, MAPOC requested that CHNCT provide information regarding network adequacy of specialists enrolled in Medicaid, as well as what the trend in provider enrollment has been for primary care physicians. CHNCT reported that primary care physician enrollment has increased from 1,362 to 2,441 over the past two years. The number of other primary care practitioners, like physician assistants and nurse practitioners, has almost tripled during the same period, from 260 such providers enrolled in January 2012 to 777 in November 2013.

The increase in the number of primary care providers (PCPs) available to Medicaid clients has been helped by the dramatic increase in Medicaid rates to these providers under ACA. Effective January 1, 2013, rates paid for Medicaid primary care services are equal to those paid by Medicare, and are 100 percent federally reimbursable for two years. This almost doubled the amount paid for some Medicaid services – for example, an outpatient primary care office visit increased from the prior Medicaid rate of $67 to $123.53.

In December 2013, CHNCT submitted only Geo Access statistics related to network adequacy of specialists for Medicaid clients to MAPOC, using both 10-mile and 20-mile

standards. Both measures yielded high adequacy results, exceeding 95 percent. However, as noted above, there are significant issues with the geo-access standard. Further, specialists are not included in the ACA-enhanced Medicaid reimbursement rate, thus expansion of that network may not produce similar results compared to those achieved in the primary care area.

Both CHNCT and ValueOptions are required by contract to conduct mystery shopper surveys as another measure of access. Staff of the ASOs, (posing as a client), would survey enrolled providers to ascertain whether they are in fact accepting new Medicaid patients, and if so, how long a wait before an appointment can be scheduled PRI staff asked DSS for the latest results of these surveys but the department responded that none had been done recently.

PRI staff did determine that ValueOptions in 2010 had conducted such a mystery shopper survey of 35 enhanced care centers, all of which were receiving added payments to furnish enhanced behavioral health services to children. The results of the survey found that 12 of the centers had deficiencies in service delivery and had to submit corrective action plans; the 12 passed the second round of the survey.

PRI staff believes using the Geo Access measure alone to gauge adequate access to care for any category is fraught with limitations, and can produce very misleading results. Further, the mystery shopper survey can prove useful both for measuring access and improving quality, as the VOI one conducted in 2010 demonstrated. Therefore, PRI staff recommends that:

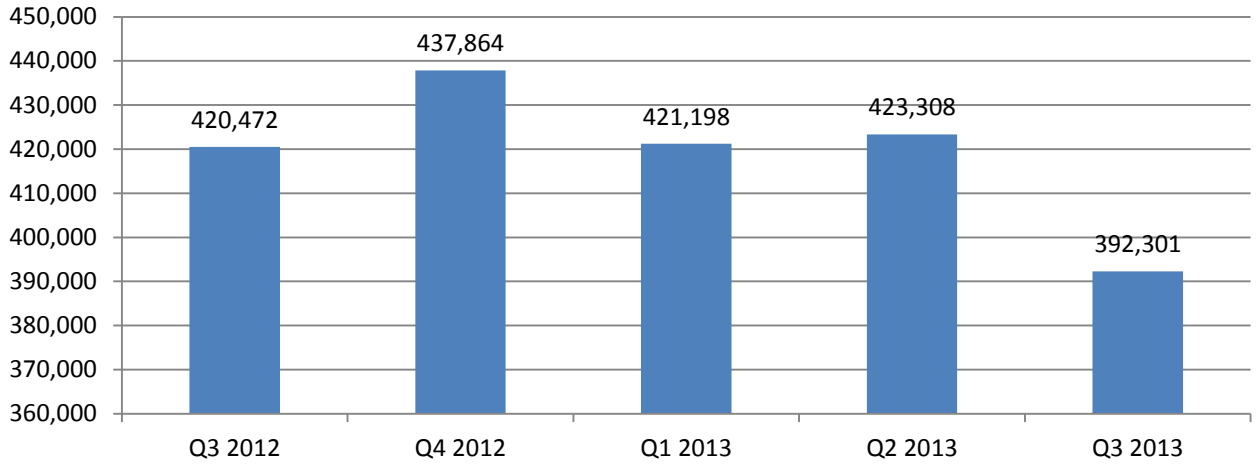
3. **The Department of Social Services shall require the administrative services organizations to conduct the mystery shopper survey of primary care providers and specialists, including whether the providers are accepting new patients, and wait times for appointments for new and existing clients to measure ease of access, as required in the administrative service organization contracts.**

If these surveys were being conducted and reported (along with other network adequacy measures) as contractually required, MAPOC would not have needed to requested special data analysis and reports to be provided in order to meet its statutory charge. Further, if the surveys were conducted, they would provide a clearer picture of -- 1) geographic areas in which Medicaid clients' access to care is problematic; and 2) the extent of specialty care statewide and by type of specialists -- and the ASO could develop strategies for improving capacity. The need to conduct mystery shopper surveys will also become more critical to ensure that providers that are given enhanced payments to manage client care are in fact doing so.

Attribution. Under a managed care model, Medicaid clients can choose, or, by default are assigned to, a managed care organization and the MCOs are then paid on a per member per month basis to "manage" their care and ensure provision of all covered services required by the client. MCOs are then required to report on certain health and quality measures for their enrolled members to ensure they are receiving adequate services. Under the ASO model, a Medicaid client is not "assigned" but the ASO attributes the client to a primary care provider based on either: a client choosing a PCP; or through a review of claims of that client's primary care usage.

In the PRI September update, attribution rates of Medicaid clients as of May 2013 were provided. Those results showed that 80 percent of children were attributed to a primary care provider, but only 50 percent of adult Medicaid recipients were, for an overall rate of 64 percent. Figure II-3 shows the trend in overall Medicaid clients attributed, and indicates a decline in the number and percentage in the third quarter of 2013.

Figure II-3. Number and Percent of Medicaid Clients Attributed to Primary Care Provider



Source: DSS December 2013 Presentation to MAPOC

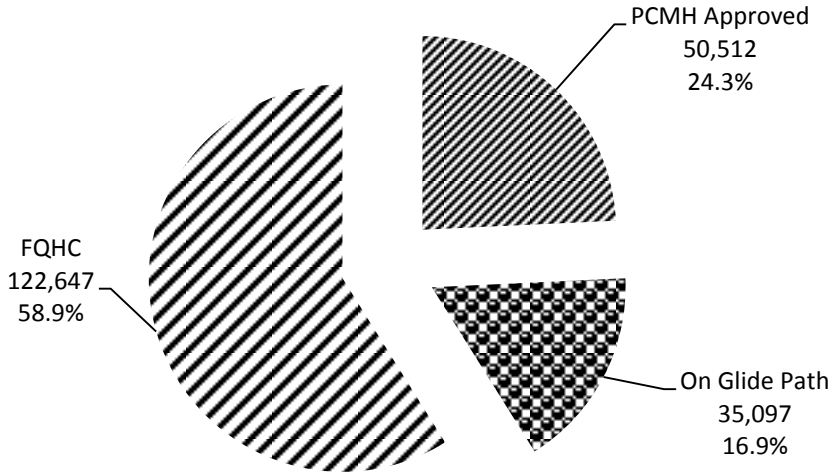
PRI staff believes that the low attribution rate, especially for adults, is an indication that about half of Medicaid adult clients are not being seen by a primary care provider. The linkage of clients to a primary care provider is the first step in managing and coordinating that patient's care and a major tenet of the ACA.

Another effort advanced by the Affordable Care Act to help manage and coordinate patient care is to have primary care practices accredited as person centered medical homes (PCMHs). Under the ACA, these PCMHs receive enhanced payments -- varying amounts depending on the type of practice and accreditation level -- if they agree to:

- increase individual attention on the patient and focus on preventative care;
- improve availability of hours to patients;
- use electronic health records; and
- use and analyze data to improve performance and health outcomes.

Figure II-4 shows the status of the PCMH program, in terms of both provider status and member attribution, as of December 2013. There were almost 1,100 practitioners already approved, or in "glide path" – in the process of acquiring accreditation; all 14 of the states federally qualified health centers, with 352 providers, are approved as PCMH. Thus, it appears that about one-third of the 3,302 Medicaid providers are PCMH-approved.

Figure II-4. PCMH Program Attributed Members by Program Type as of 12/5/2013



Source: December 2013 Presentation to MAPOC Care Management Committee

The figure also indicates that 208,196 Medicaid members were attributed to a PCMH as of December 2013, less than one-third of the Medicaid population. PRI staff recognizes it is early in the PCMH program, but the low Medicaid participation rate combined with the overall low attribution rate to any primary care provider indicates that more aggressive linkage of Medicaid enrollees to a primary care provider, especially those who are PCMHs, needs to occur. Therefore, PRI staff recommends that:

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. **Further, 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.**

PRI staff believes that the low attribution rates are an indication that these Medicaid clients are not affiliated with a primary care provider, and even fewer with a PCMH. If the concept of coordinated, preventive care through a "patient home" model is to be realized, it must be implemented at the earliest stages – as soon as eligibility occurs. If Medicaid clients are informed and are offered assistance in making the connections with a primary care provider, and

preferably a PCMH, it will help ensure that care is provided in a coordinated fashion in the most appropriate setting, and mitigate visits to the emergency department.

As indicated above, in order to become PCMH-accredited providers must agree to use electronic health records (EHR). All the federal qualified health centers (FQHCs) in Connecticut are approved in the PCMH program, and thus use EHR. However, the exchange of information between hospital ED use and primary care providers, including the FQHCs, varied. In responses to a PRI survey of FQHCs, eight of the 11 (72.7 percent) responded a hospital's ED or records department would typically send notice if one of the center's patients visited the ED. Of those eight, four health centers reported typically receiving such notice within 24 hours, three reported receiving such notice within seven days, but the remaining health center reported that it could take up to 30 days to receive such notice from the hospital. However, three health centers reported that they did not receive notice when a patient was seen in an ED. Each of these centers indicated that patients were asked to notify them if they were seen in an ED and/or that patients were routinely asked about whether they had recently visited an ED when they presented for a health center appointment.

Ultimately the goal of health information technology is that all patient information will be available through secure electronic systems that can be accessed by and communicated to relevant providers in real time. However, that goal is still a number of years away, at least in Connecticut. The Health Information Technology Exchange of Connecticut (HITE-CT) a non-profit, quasi-public organization charged with overseeing this effort has faced significant challenges. The state's filing of its plan update to the national oversight agency in June 2013 indicates it is significantly behind schedule and is likely to adopt a more regional than statewide approach to information sharing.[9] As indicated in that filing, this is partially due to the fact that many hospitals (and health networks) have adopted their own exchanges.

Thus, while statewide exchange of health information does not appear attainable, at least in the foreseeable future, it is important that other efforts to share information that will assist in coordinated and managed care for Medicaid recipients be adopted. Important first steps to that are attributing Medicaid providers to a primary care provider, and putting that information on the client's Medicaid card. With that information, a hospital's emergency department or records department will at least know who to contact about the visit so that follow-up care can be coordinated.

Continuous Eligibility

An ongoing issue with Medicaid clients is instability in eligibility. This can be for a number of reasons, including:

[9] . The June 2013 CT DPH Submission to the Office of National Coordination of Health Information Technology states: *HITE-CT was intended to play a major role in Connecticut's healthcare reform efforts. Due to vendor contract issues, much of the work that was supposed to have been completed by now is still pending. (HITE-CT) Connecticut's healthcare landscape is undergoing rapid changes due to organizational consolidations and evolving federal and state regulations. Many hospitals within the state either have HIE projects in production or are planning them. But currently there is no sharing happening between the exchanges. Clearly this does not meet our objective for statewide exchange. The full filing can be accessed at www/ct.gov/DPH/lib/dph/state_health_planning/HIT/movingfromphase1tophase_2statetemplate_combinedreport06262013/pdf*

- a client may seem eligible for Medicaid at the time the person appears for medical services but never produce the documentation necessary for eligibility to be determined;
- a client may be determined eligible for Medicaid, but become ineligible later because of (usually minor) changes in income;
- because DSS cannot locate the Medicaid client for redetermination; or
- more recently, some Connecticut Medicaid recipients have had their eligibility terminated because of glitches in DSS' eligibility system as the department transitions to more modern technology.

CMS reports that as of January 2013, 32 states have adopted 12-month continuous eligibility for either Medicaid or CHIP for children, and 23 states have implemented it for both. Connecticut had continuous eligibility for children before 2003, but discontinued that option because of budget issues, and it has not been reinstituted.

Connecticut expanded its Medicaid state plan in 2010, providing eligibility to childless adults with very low incomes (56 percent of federal poverty level), many of whom had been previously covered under state-administered general assistance (SAGA). Under the ACA, effective January 1, 2014 Medicaid coverage in Connecticut has been expanded further to those with incomes up to 138 percent of FPL. The state will receive 100 percent reimbursement for services to the Medicaid population for two years, decreasing to 90 percent after that.

It is important, given the expansion and the increased demands on eligibility determination workers and supporting systems, that predictability and stability of Medicaid eligibility be achieved. National studies have shown that the average monthly Medicaid cost for adults falls when they are enrolled for more months of the year.[10] This occurs for two reasons – first, the longer someone is on Medicaid, the more likely that person is to receive primary and preventative care to keep healthy and reduce the risk of needing more expensive specialty, inpatient, or emergency care. Second, Medicaid enrollment often takes place when a person is sick and seeking care, and therefore has higher utilization and costs just after enrollment.

The same study cites the importance of stable Medicaid eligibility for providers who have Medicaid clients, especially PCPs. Primary care providers prefer to maintain ongoing long-term relationships with their patients. If the system shows the client's Medicaid eligibility is in question, the provider is faced with the dilemma of treating and risking non-payment, or refusing to treat. In addition to the potentially negative impact on the patient/provider relationship, this off-and-on eligibility, frequent enrollment, and re-enrollment, or "churning", can be administratively time-consuming for the Medicaid agency as well.

Connecticut appears to do better than the national average in terms of enrollment continuity ratios for its state Medicaid programs, with an overall ratio of 85.3 percent eligible compared to a national average of 81.7 percent. Nevertheless, in the face of the ACA expansion every effort should be made to ensure that this ratio is maintained or increased. (See Appendix G for a state-by-state comparison).

[10] Bridging the Gap: Continuity and Quality of Coverage in Medicaid, George Washington University, September 2013.

In a guidance bulletin issued in May 2013, CMS suggests five strategies to assist states with Medicaid and CHIP enrollment given the anticipated expansion of those rolls under the ACA. The five approaches are:

1) Implementing the early adoption of the new income rules for eligibility based on modified adjusted gross income;
2) Extending the Medicaid renewal period so that renewals that would normally occur at during the first quarter of calendar year 2014 -- the same time as the expansion populations are enrolled – occur later;
3) Enrolling persons into Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility;
4) Enrolling parents into Medicaid based on children's income eligibility; and
5) Adopting 12-month continuous eligibility for parents and other adults.

Connecticut, along with 22 other states, has received approval from CMS for implementation of the second policy and will be allowed to extend Medicaid renewals that would otherwise occur in the first quarter of 2014, when coverage for the newly eligible population would begin.

Another CMS-suggested strategy is implementing 12-month continuous eligibility for parents and other adults. States can unilaterally adopt 12-month continuous eligibility for children. CMS cites adopting this option for adults also can mitigate the problems associated with churning (cited above), and improve continuity of care for families and other Medicaid recipients. CMS indicates that states need to have demonstration authority to do this, and those states with what are called 1115 waivers, which Connecticut has, will need to seek an amendment to implement 12-month continuous eligibility. Given that CMS is advocating the strategy in a published guideline, citing its benefits, and indicating that the agency will works with states interested in the approach, PRI staff believes that CMS will be likely to approve such an amendment. For these reasons, PRI staff recommends that:

6. **the legislature 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.**

Access to Specialists

As noted earlier in the chapter, no clear figures exist on the extent of access to healthcare specialists for Medicaid clients. The geo-access measure used by CHNCT for the MAPOC study group produced results based on mileage proximity only. At the committee's September 26, 2013 public hearing held on this topic, the lack of specialists available to Medicaid clients was cited as a reason that brings people to the emergency department. Two of the three emergency department doctors, representatives from a Hartford FQHC, and the commissioner of DPH all testified that access to medical specialists is a problem. One physician indicated that a Medicaid patient may have to wait five or six months to see a university-sponsored gastroenterologist who

would not charge. Most specialists are very reluctant to see Medicaid clients at the rates Medicaid pays.

The ACA is fully reimbursing primary care physicians and other primary care providers at the Medicare rate for two years. That provision, which covered rates beginning in January 2013, does not apply to specialists. The Kaiser Family Foundation researches, analyzes, and reports on various aspects of both Medicare and Medicaid programs. One measure the foundation calculates and reports on is the state ratio of Medicaid-to-Medicare reimbursement. Using that measure, Connecticut's reimbursement for Medicaid "other" services – excluding primary and obstetric care, but including specialty care -- is about 79 percent of what Medicare pays. This is higher than the national average of 70 percent, but, for specialists in Connecticut, the low reimbursement is a deterrent to accepting Medicaid clients. (See state comparison ratios in Appendix E).

Data from all federally qualified health centers nationwide on patients, visits, and services are reported in a uniform data system maintained by the federal Department of Health and Human Services. Data from the Connecticut centers indicate that eight percent of the more than 332,000 patients in Connecticut received supportive services, like assistance with getting an appointment with a specialist. Further, a 2008 report issued by the Connecticut Health Policy Project entitled *Fixing Medicaid* cited that the Fair Haven Community Health Center "employ[ed] four full-time staff who have the sole task of getting patients appointments with specialists." The PCMH model is offering enhanced payments to primary care providers to help manage all aspects of a patient's care, including assisting clients with appointments with specialists. However, if the pool of specialists willing to accept Medicaid is so small that getting an appointment is virtually impossible even with assistance, or if the wait for a visit is exceedingly long, then other strategies must be employed.

In 2012, P.A. 12-109 authorized DSS to implement a demonstration project for FQHCs to develop telemedicine at FQHCs. DSS indicates that this has not been implemented but that the department is working with UConn to analyze the benefits, cost, safety, and other factors associated with a telemedicine pilot. The results of that analysis are due in March 2014.

Many other states are authorizing some Medicaid services to be provided through telemedicine, which is two-way real time *interactive* communication between the patient and specialist, or through broader "telehealth" services. The latter includes telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices that are used to collect and transmit patient data for monitoring and interpretation. Both types of services may be covered and reimbursed as part of a coverable service. According to information on CMS' website, a state plan amendment would not be required if the state reimburses in the same way and in the same amounts as a face-to-face service or consultation. A state plan amendment would be required if the state chose to reimburse differently than a face-to face, or if only certain services or specialties were covered under telehealth.

The Community Health Center (CHC), a FQHC located in Middletown, has begun a pilot of its own, with no Medicaid reimbursement. The CHC electronically sends patient health records to specialists at the UConn Health Center. The specialists review the records for a small fee and make treatment recommendations based on the review, rather than having a face-to-face.

While this may not be a strategy that would work in all cases, DSS ought to be examining how strategies like this could be implemented and reimbursed. In light of the fact that DSS has not yet implemented the pilot as authorized, PRI staff believes the department should be mandated to do so. Therefore PRI staff recommends that:

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.**

Intensive Case Management

Increases in primary care reimbursement, enhanced patient-centered care, continuous Medicaid eligibility to promote enrollment stability, and expanding ways that Medicaid clients can access specialty care may help to mitigate use of hospital emergency departments for care that could be provide in a community setting. However, some Medicaid clients need even greater assistance managing their health care.

In Connecticut, the ASOs described previously in this chapter are contractually required to provide intensive case management (ICM) services to certain clients. The ICM services are eligible for Medicaid reimbursement from CMS. Currently the services provided by two of the ASOs -- CHNCT and ValueOptions -- are Medicaid-reimbursed, but not those of ABH.

Intensive case management services are split among the three ASOs, depending on the Medicaid population involved and services required:

- Community Health Network-CT, the primary ASO and the one mainly responsible for overall case management, offers intensive case management for clients with *high-risk medical needs.*
- ValueOptions, which is the ASO for Medicaid behavioral health, provides ICM for mental health and substance abuse for all Medicaid clients, except for those clients in Husky D who are in need of substance abuse treatment.
- Advanced Behavioral Health, which managed the behavioral health care of SAGA and DMHAS populations prior to Medicaid HUSKY D, remains the contracted provider of intensive case management services for the HUSKY D population, but now primarily for substance abuse.

Community Health Network - CT. CHNCT has multidisciplinary regional care teams comprised of 131 staff in total performing intensive case management. The staff include: RNs, APRNS, registered dieticians, social workers, pharmacists and human services specialists, along with a medical director, who is a physician.

- The model of ICM employed by both CHNCT and Value Options is primarily a "broker model", where the client's case is managed through telephone contact, with attempts to address a client's needs and obstacles to care access remotely rather than face-to-face. Also, it appears that clients targeted for ICM by CHNCT are primarily selected based on medical conditions and upon frequency of inpatient admissions, with no significant attention to emergency department use. The top five medical conditions cited by CHNCT that initiate client contact and potential enrollment in its ICM program are:
- diabetes;
- cardiac;
- behavioral-health sensitive;
- gastrointestinal; and
- respiratory.

Just because a Medicaid client is identified by the ASO as someone who could benefit from intensive case management, does not mean the client is required to enroll. CHNCT reported on its ICM activities for FY 13, and are shown in Table II-2 below.

Table II-2 Community Health Network – Intensive Case Management Outreach – FY 13	
# of Members Outreached for ICM	43,074
# of Members Who Agreed to/ are Enrolled in ICM	16,836
Age of Member Enrolled	
0-18	2,227
19 and older	14,609
Source: DSS October 11, 2013 Presentation to MAPOC	

Thus, a little less than 40 percent of the Medicaid clients identified for intensive case management actually choose to enroll, as the program is not mandatory. Strategies that CHNCT indicates it offers to assist patients with while still receiving inpatient care are:

- collaboration with providers and the CT Behavioral Health Partnership;
- visits to the client while still an inpatient;
- discharge planning;
- transitional care outreach within seven days of discharge; and
- medication adherence management.

CNHCT indicates it also helps clients address some of their basic living needs. Human service specialist assistance, which CHN considers an extension of intensive case management, coordinate referrals for housing information, food pantries, utility assistance, DSS benefit information, or legal services. The ICM program also assists with interventions to effectively manage a range of behavioral health needs, and also offers help to clients who want to quit smoking.

CHNCT outcomes. Intensive case management for clients with medical needs is having a positive impact if measured by Medicaid use overall. Although there are no data for targeted ICM populations or specific reasons for hospital or ED use, the data show that overall inpatient hospital use by Medicaid clients declined for the five quarters from January 2012 through March 2013. CHN reported that for that period:

- inpatient admissions per 100 member months declined by 3.2 percent (despite a rise in one quarter);
- inpatient days per 100 member months declined by 8.1 percent;
- the average length of inpatient stay decreased from 5.42 days to 5.16 days (5 percent);
- cost per inpatient admission decreased from $7,545 from the first quarter of 2012 to $7,345 per inpatient admission (2.7 percent reduction) in the first quarter of 2013; and
- while the overall number of emergency department visits per 100 member months declined 3.2 percent during the period, emergency department costs rose 8.5 percent.

ValueOptions. The above outcomes reported by CHNCT are broad measures of hospital and emergency department use. However, outcome measures around Medicaid clients with behavioral health needs, especially adults, are not well-reported. ValueOptions, the lead ASO for behavioral health, employs 30 staff dedicated to intensive case management, which includes social workers, certified addiction counselors, psychologists, certified family and individual peer staff, and a psychiatrist. As noted in Chapter One, the vast majority of ED visits by Medicaid clients are coded for claims submission purposes as medical for the primary diagnosis, even though many of these visits may also involve a behavioral or substance abuse component In its 2011 ED Provider Analysis Report,[11] Value Options reported that 41,049 Medicaid enrollees over the age of 18 had ED visits with a behavioral health primary diagnosis. More than 12 percent of these patients (4,975) had readmissions to the ED within seven days, and almost 28 percent had readmission within 30 days of a prior ED visit. Also, almost 38 percent had no follow-up outpatient care following the ED visit.

The Provider Analysis Report on emergency department use for 2011 was the last one conducted; DSS indicates ValueOptions did not issue one for 2012. Given the lack of more recent data on follow-up outpatient care after an ED behavioral health visit, it is unknown whether there has been an improvement in this area. PRI staff believes the information in the ED Provider Analysis Report offers very useful information. Further, the report is one that ValueOptions is contractually obligated to produce. Therefore, PRI staff recommends that:

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.**

[11] . One of the required reports by VOI in its contract with DSS is on provider analysis of hospital emergency department use for behavioral health reasons. VOI is to examine claims around behavioral health including inpatient admissions, readmissions to ED, and follow-up outpatient visits by these clients.

ValueOptions outcomes. ValueOptions in December 2013 reported to MAPOC outcome measures on 149 Medicaid members who had received combined ICM services during 2012. Measurement criteria were a comparison of services provided to clients in the 6 months prior to receiving ICM and in the 6 months after. The results showed that ED visits dropped 15 percent and inpatient hospitalizations decreased by 50 percent following six months of ICM. Value Options reported more detailed outcomes for 123 of the 149 clients as shown in the Table below:

Table II-3. Value Options Outcome Measures for Clients in ICM for CY 2012			
Measure	***6 months prior***	***6 months after***	***% Change***
Total ICM assignments	123	123	
Total possible days in community	22,509	22,509	
Total days in combined setting	2,839	776	-72.7%
Inpatient psych days	2,300	610	-73.5%
Inpatient detox days	539	166	-69.2%
Total days in community	19,470	21,733	+10.5%
Percent of days in community	87.4%	96.6%	+10.5%
Source: Value Options Presentation to MAPOC, December 13, 2013			

While the outcomes are positive, *PRI staff finds the number of clients – 149 – identified and engaged in ICM with ValueOptions is very low, especially given:*

- the number of Medicaid clients -- 4,671 – who had been to an ED 10 or more times during 2012;
- the 4,975 adult Medicaid clients with a behavioral health diagnosis who were readmitted to the ED within seven days of an initial visit in 2011; and
- 38 percent of Medicaid clients had no follow-up outpatient visit after an ED visit with a behavioral health primary diagnosis in 2011.

Further, as reported by ValueOptions, there is no indication whether these clients were Tier 1 or Tier 2 clients (as described on next page), or whether these clients were also served by Advanced Behavioral Health, the ASO for Husky D with primarily substance abuse concerns.

Coordination of Intensive Case Management

CHNCT and VOI indicate that intensive case management is coordinated to avoid duplication of services and improve care. Table II-4 below illustrates how members with complex needs are assigned for intensive case management. Both CHN and Value Options indicate they coordinate ICM care for two categories of clients in two tiers.

Tier 1. The ASOs coordinate ICM services targeting the medical and behavioral health needs for clients with less chronic needs. The two ASOs indicate that services include care coordination while a client is still an inpatient and include: combined discharge planning; discussion of medication adherence; and assigning appropriate ICM/peer contacts.

Table II-4. Assignment of Members for Intensive Case Management	
Client Needs	***Assignment***
Complex Medical with Behavioral Health (not serious and persistent mental illness)	Co-managed by CHNCT and ValueOptions (CT Behavioral Health Partnership)
Complex Medical with serious and persistent mental illness	Co-located CNHCT and VOI specialized team of ICM behavioral health RNs at CHNCT
Behavioral Health with no Complex Medical needs	ValueOptions (CT Behavioral Health Partnership)
Source: DSS Presentation to MAPOC, November 2013	

The community level services include regional ICM monthly case discussions, with focused "case rounds" of high ED users and members with pain management issues. The two ASOs' regional ICM staff also identify individuals who are receiving home care who may benefit from ICM services. ValueOptions also indicates that it coordinates with CHNCT on crisis intervention for individuals with behavioral health issues and coordinates with the CT Behavioral Health Partnership and DMHAS for clients needing substance abuse treatment.

Tier 2. This level of care coordination is targeted for those clients who have one or more chronic medical conditions but who also have serious and persistent mental illness, and have had at least one inpatient or ED visit in the prior 12 months. The ICM team for these Tier 2 clients is a combination of CHNCT and ValueOptions staff co-located at CHN's office in Wallingford, and combines telephone and face-to-face management of client care. The ICM services are stratified according to whether the client's needs are determined to be low, medium or high risk. According to Value Options, clients identified as high risk get face-to-face visits.

Table II-4 above does not specifically address the issue of coordination of care for HUSKY D clients who have substance abuse disorders. Further, it seems unlikely that clients always fall neatly into one category or another, and therefore their ICM needs not be coordinated. PRI staff recognizes there may be reasons to address certain needs and populations in different ways. However, the ASO intensive case management delivery structure regarding what services are being provided and to whom are not always clear.

Advanced Behavioral Health. ABH is the administrative services organization under contract with DMHAS to provide intensive case management to HUSKY D clients needing services because of substance abuse disorders. Perhaps because ABH has provided ICM services for some time, its services are better known to hospital ED staff. In a PRI survey of hospitals, 70 percent of hospital ED respondents indicated awareness of the intensive case management programs implemented by Advanced Behavioral Health. In contrast, fewer than half of the respondents indicated they were aware of any ICM programs operated by either CHNCT or VO. *PRI staff believes that the greater recognition of the ABH programs by ED staff is also because the ABH staff work more closely with hospital ED staff to assist clients, whereas the two major ASOs focus primarily on inpatient use.*

The programs implemented by ABH were begun a number of years ago when many of the DMHAS clients were under SAGA and their behavioral healthcare was being managed by Advanced Behavioral Health. Now, ABH -- along with the Eastern Region Services Center

(ERSC) in one of the five human services regions -- delivers client outreach and engagement activities for individuals who meet high utilization and other designated criteria. ABH and ERSC have approximately 41full-time staff who work with clients, and the model employed is primarily a face-to-face encounter model rather than the broker focus (e.g., telephone) employed by CHNCT and ValueOptions. During FY 13, staff had approximately 24 sessions with each client. The average time that a client is in intensive case management is about six months (183 days).

The ICM activities performed by ABH focus on assisting people in their recovery, including: help with housing and employment; coordination of clinical issues; development and monitoring of individuals' comprehensive recovery plans; and working with other community organizations and advocacy groups to implement the programs.

Table II-5 describes the criteria for enrollment in the ABH and ERSC intensive case management along with three more targeted programs designed to provide a more appropriate level of care and treatment other than through hospital ED or inpatient admissions. More than 1,800 individuals have been served by one or more of the programs during FY 13.

Table II-5. Criteria for Enrollment:
ABH Intensive Case Management and Related Programs

Program	***Criteria for Enrollment***
Intensive Case Management	Individuals with: • 4 or more acute care admissions within 6 months; • those previously assigned to ICM that have re-emerged with readmissions to acute care; • 2 acute admissions in 30 days; • 3 residential treatment admissions in 12 months; or • first time residential treatment admission for individuals age 23 or younger
Acute Care Initiative	Individuals who have had three or more inpatient mental health admissions within a 90-day period, or one admission lasting 30 days or longer.
Opioid Agonist Treatment Protocol (OATP):	Individuals who have had either four or more acute care admissions within six months or three or more acute care admissions within the 90-day period for the primary diagnosis of opioid dependence.
Alternatives to Hospitalization	Individuals who have a primary or dual diagnosis of substance abuse/dependence and who frequently use the ED
Source: ABH Quality Report Submission to DMHAS	

ABH outcomes. According to ABH reports to DMHAS, 51 percent of clients met their recovery goals while in ICM and an additional 33 percent had partially met them. More than half (56 percent) had stable or transitional housing and 19 percent had full- or part-time employment, when they were discharged from ICM. Another six percent had received a disability determination offering them some financial support.

Late in 2011, ABH also began implementing strategies to reduce the number clients who discontinued ICM because the staff were "unable to locate". Staff received training in ways to collecting additional contact information at intake and retraining on client re-engagement techniques. After these interventions were executed, there was a 38 percent reduction in the number of clients who discontinued ICM and a 60 percent increase in the number of clients who left ICM with meeting some or all of the recovery goals.

ABH also examined Medicaid claims data to look at other outcome measures six months before and six months after the client was engaged in ICM. ABH reported to DMHAS that clients enrolled in ICM had a 57 percent reduction in inpatient episodes with $4.5 million less in treatment dollars spent, a 46 percent cost reduction. There also was a reduction of 19 percent in outpatient episodes, with a decrease in treatment spending of about $370,000 or 21 percent less than before the intensive case management.

ABH also reported that there were 612 fewer emergency room visits (18 percent decrease) for these clients in the six months after ICM enrollment, with a reduction in ED costs of 21 percent (or $83,000 saved) and ancillary costs associated with ED visits were reduced by 33 percent or $135,000. Not surprisingly other outpatient medical service costs increased, as ICM staff helped clients address previously neglected medical issues. Outpatient costs for clients in ICM rose $42,000 or 45 percent in the six months after. The size of the increase relative to the amount is an indication of the lack of outpatient medical attention sought by these clients prior to ICM, and how effective outpatient services can reduce the need for more expensive treatment on an emergency basis.

Alternative to hospitalization program. Perhaps the most intensive program implemented by ABH is the alternative to hospitalization (ATH) program where the ICM staff attempt to decrease the number of inpatient admissions to acute mental health services through collaboration with hospital emergency departments and mobile crisis teams. The staff attempt to arrange alternative levels of care, when appropriate. As the table shows, 78 percent of clients were able to be diverted to alternate care, while the program did not make connections with about 19 percent of clients. This program is being implemented at eight hospitals listed in Table II-6, and most of them are located in the cities.

ABH reports to DMHAS show that since the ATH program was begun in 2006, inpatient admissions were reduced from 44 percent of clients who presented at the ED to only 13 percent. At the same, clients who diverted from inpatient admissions (to alternative programs) increased from 47 percent to 78 percent, as shown in the table above. The number of emergency department visits has not dropped, however.

Table II-6 Activity in the ATH Program by Hospital in FY 13								
Hospital	***Region***	***Admissions***		***Diversions***		***Non-Connections***		***Total***
Hartford	IV	5	2%	120	39%	29	9%	154
St Francis	IV	0	0%	32	10%	8	3%	40
Manchester	IV	0	0%	7	2%	2	1%	9
Bridgeport	I	0	0%	18	6%	5	2%	23
St Vincent's	I	1	0%	7	2%	1	0%	9
Middlesex	II	4	1%	43	14%	11	4%	58
St Mary's	V	0	0%	1	0%	0	0%	1
Waterbury	V	1	0%	12	4%	1	0%	14
Total		11	4%	240	78%	57	19%	308
Source: ABH Quality Improvement Report to DMHAS								

As was discussed in Chapter One, while it may not always be indicated in the primary diagnosis, many frequent users of hospital emergency departments are clients who have mental health, substance abuse conditions, or both. Of the 2,236 visits (not unique clients) to one of emergency departments participating in the ATH program, fully 76 percent had a primary or dual diagnosis of substance abuse/dependence. The breakdown of the diagnoses is presented in Table II-7.

Table II-7. Visits to the Emergency Departments (in ATH) by Diagnosis										
Action	***All***		***MH Only***		***Dual MH***		***SA Only***		***Dual SA***	
Admission	285	12.75%	27	1.21%	216	9.66%	12	0.54%	30	1.34%
Diversion	1,478	66.10%	14	0.63%	176	7.87%	777	34.75%	508	22.72%
Non-connection	473	21.15%	3	0.13%	97	4.34%	231	10.33%	141	6.31%
All Presentations	2,236	100%	44	1.97%	489	21.87%	1,020	45.62%	679	30.37%
Source: ABH Quality Improvement Report to DMHAS										

The goal of the ATH program is to divert the client to a more appropriate level of care rather than an inpatient hospital admission, and 78 percent of clients were diverted in FY 13; thus, the outcomes appear positive.

Reimbursement for ICM provided by ABH. As noted earlier, Medicaid reimburses for intensive case management services, and DSS indicated to PRI staff that Connecticut is receiving federal matching payments for all the services provided by CHNCT and VOI. Because the ICM services provided by ABH had been previously offered only to state–funded SAGA or DMHAS clients, they had not been reimbursed by Medicaid. However, now that these services are provided to enrolled Medicaid clients, they are eligible for Medicaid reimbursement.

DMHAS staff indicates that steps are being taken to begin billing Medicaid for these services. But Connecticut began Medicaid coverage for HUSKY D in 2010, more than three years ago, and PRI staff believes this reimbursement effort should become a priority. The annual cost to the state for the ABH-contracted ICM services is approximately $4.4 million. If the 50 per cent federal Medicaid match were captured, it would mean about $2.2 million in reimbursement.

Therefore, PRI staff recommends that:

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.**

Middlesex Hospital model. Another model of intensive case management is one exclusive to Middlesex Hospital in Middletown. The director of emergency services at Middlesex Hospital, Dr. Michael Saxe, described the model and its outcomes in interviews with PRI staff, as well as in testimony and materials presented to the PRI committee at its public hearing on September 26, 2013.

Recognizing that the population of frequent users of emergency departments does not get better with the traditional model of episodic care delivery, Middlesex Hospital began an intensive care coordination model in 2010. The program, known as the Community Care Team (CCT), was activated by the hospital's ED director, and initially involved the hospital and four community agencies. The program expanded in 2012 to include five additional providers, including the local FQHC and representatives from the three Medicaid administrative services organizations. The CCT operates with the understanding that community collaboration is necessary to improve health outcomes and that psycho-social problems, like homelessness and a lack of social network, are community problems.

Criteria. Since the program began, 117 clients have engaged in the CCT program. A key tenet is that once a client has agreed to participate they are in the program long–term. While participation is voluntary, once a client agrees, he or she must sign a Release of Information (ROI), a HIPAA requirement in order that medical records and other information on a client can be shared. Clients also agree to an ED care plan that is developed by the director of emergency services at Middlesex Hospital.

Of the 52 individuals who have been in the Middlesex Hospital CCT for six months or more, 58 percent are male and 42 percent female, and 36 (69%) are between 40 and 59 years old. The vast majority of CCT clients are covered by public health insurance -- 50 percent of clients are Medicaid recipients, while 40 percent are on Medicare. Another six percent had no insurance and four percent were commercially insured.

Clients are selected because they have frequent ED visits; clients had a range of 12 to 80 visits over a 12-month period. These frequent users have complex conditions – 36 percent had a diagnosis of chronic alcoholism; 28 percent had a serious mental illness; 22 percent were diagnosed with coexisting severe mental illness and substance abuse disorders (primarily alcohol); and 14 percent had other drug dependence like opioids or cocaine.

Program operation. The CCT created a position entitled "Health Promotion Advocate", which is state grant-funded and serves as the link between the patient, the emergency department, the CCT, and community service providers. The person is located primarily in the ED at Middlesex Hospital and works during times determined to be when people experience a

crisis that brings them to the ED. The person also does "check-in" calls for those clients in the community who are stabilized or working on recovery.

The CCT meets weekly and collaboratively develop a customized care plan for each client with goals for:

- treatment and/or stabilization;
- stable housing;
- health insurance;
- linkage to primary care, psychiatrists, specialists, and outpatient services;
- wrap-around services and supports post active treatment; and
- after care planning.

The CCT periodically reviews each client's progress, and revises the care plan if a client needs other services or additional supports.

CCT outcomes. Middlesex Hospital provided data at the public hearing showing outcomes for the 52 individuals who have received CCT interventions for 6 months or longer. Comparing the 6 to 11 month prior to CCT involvement with the 6 to 11 months post-CCT involvement, results indicated inpatient hospitalizations were reduced from 75 to 31, a 59 percent decrease. Further, ED visits for that population declined from 849 visits to 415, 51 percent fewer.

Financial outcomes for the hospital were also positive as a result of the CCT program, as shown in Table II-8.

Table II-8.. Hospital Financial Outcomes Pre-and Post- CCT Intervention (52 Clients)			
Total	***Pre-CCT***	***Post-CCT***	***Difference***
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			

Findings Related to Intensive Case Management

Looking at outcomes of the various intensive case management programs, especially those aimed at frequent ED users, PRI staff concludes that the more positive outcomes appear to be associated with:

- programs that have more face-to-face client interaction;
- hospital emergency department involvement in selection of clients;

- hospital emergency department involvement in development of care plans;
- ongoing monitoring of client's community care and progress (not episodic);
- frequent meetings of community providers involved in care; and
- persistence in engaging the client and in managing care, including psycho-social needs.

To improve outcomes for frequent ED users, PRI staff believes that the approach taken with The Middlesex Hospital Community Care Team model be replicated in hospitals where Medicaid clients are frequent users of the emergency department. To implement that approach, PRI staff recommends that:

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.**

One of the ongoing issues from a community provider and case management perspective is involving hospital emergency departments in community programs. In the survey responses from FQHCs, 5 of the 11 respondents indicated hospital EDs' reluctance to participate in programs that help in ED prevention and diversion was an obstacle. Further, eight of 11 (73%) FQHC respondents indicated that "more involvement of hospital EDs in community healthcare systems" would help reduce ED utilization.

Respondents to both the survey of hospital EDs and the FQHC identified better intensive case management as a strategy that would help in preventing and diverting clients from ED use, with fully 90 percent of FQHCs indicating this strategy would help. More than 70 percent of hospital ED respondents indicated that co-locating case management staff in the ED would help reduce ED utilization. Thus, PRI staff believes this recommended model will involve hospital emergency departments much more in community care. At the same time, adopting this ICM model offers an ongoing and less episodic approach to client care, especially with chronic frequent users of the emergency departments. Placing ICM staff at hospital EDs where there is high frequent user utilization should also help with implementation, and provide the link between the hospital ED and community care.

In late May 2013, ValueOptions began a model of intensive case management at St. Francis Hospital for Medicaid clients with behavioral health or substance abuse disorders, but it is targeted to inpatient clients only. As seen in the statistics in Chapter One, only a small percentage of clients are admitted for inpatient services, so intensive case management should also focus on meeting clients where they present and begin addressing their care then.

Another reason individuals may frequent emergency departments is because they do not comply with the medical or behavioral health treatment already identified, including taking medications already prescribed. While intensive case management certainly makes efforts in helping clients with medication management, one way to try and prevent or reduce the number of ED visits is through what is called "outpatient commitment", which essentially removes the need for the individual's consent for certain outpatient care. Appendix F provides further information on this topic, including what other states are doing and Connecticut's most recent history with the issue.

Alcohol Abuse and Visits to Emergency Departments

The profile of clients in the Middlesex Hospital Community Care Team Program suggests that chronic alcoholism is common among frequent users of that hospital's ED. Broader data provided by CHN-CT on diagnosis of adult Medicaid clients who presented at the ED during 2012 show this as well. While alcohol abuse did not show up on the *primary* diagnosis, two codes -- alcohol abuse unspecified or acute alcohol intoxication were listed as the *secondary* diagnosis for over 9,000 visits or 10 percent of the total adult visits where both diagnoses were captured. (In fact, the top five secondary diagnoses were all behavioral-health related, making up 20 percent of the ED visits for that population.)

Given that alcohol abuse is common among people who visit the ED, and even more prevalent among the clients who present at hospitals participating in the alternative to hospitalization program, including Middlesex Hospital, it is not surprising that fully 78 percent of hospital EDs that responded to the PRI survey indicated that alternative settings to the ED for persons who are intoxicated would reduce ED utilization. Doctors who testified at the public hearing also suggested this.

Medical triage. State statutes allow police to take intoxicated persons into protective custody and bring them to their home, an emergency room or a treatment center that provides "medical triage" rather than to arrest the person or take the person to jail. Medical triage is

statutorily defined as *a service which provides immediate assessment of symptoms of substance abuse, the immediate care and treatment of these symptoms as necessary, a determination of the need for treatment of these symptoms as necessary, a determination of need for treatment, and assistance in attaining appropriate continued treatment (C.G.S. Sec. 17a-683).*

PRI staff verified with the Department of Public Health licensing staff that there are no treatment centers currently licensed to provide "medical triage". Staff of one alcohol and drug treatment program in Hartford informed program review staff that to be licensed for "medical triage" requires a medical doctor on staff 24 hours a day. That provider, the Alcohol and Drug Recovery Center (ADRC), as well as The Rushford Center, had both been licensed to provide "medical triage" but could no longer afford to meet the licensing requirements for that service, especially given that Medicaid clients make up a large percentage of those in substance abuse treatment and the rates Medicaid pays are low. Both centers were granted a certificate of need by OHCA in 2007 to terminate that level of care.

Further, even if medical triage centers were operational, bringing intoxicated persons to such centers if no treatment beds are available would not address the problem. It might only tie up police or add confusion to emergency medical service personnel about where to transport intoxicated persons. Others have mentioned "sobering centers", with only minimal medical personnel on staff, as a possible alternative to emergency departments as places to bring intoxicated persons. There would be little in the way of medical attention given the person, but rather they would provide a safe place for the person to sober up. Both of these options would mean ambulance personnel or police would have to make a judgment on where to bring the person, both of which pose potential liability.

Substance Abuse Treatment Enhancement. There may be a more appropriate strategy that should be implemented. When a person, especially a frequent user, presents at the ED with a diagnosis of alcoholism, and wants to detox and begin recovery, every attempt should be made to locate a detox bed at that time. If the person begins a treatment program and is assisted with long-term recovery, as the CCT model provides, there is a better chance the individual will not be chronic recidivist of the ED than if the individual is treated for intoxication and discharged. PRI staff believes that ED doctors are too busy and are not the appropriate staff to engage the client in beginning treatment. Instead, PRI staff believes that this should be a role for the intensive case management team assigned to be co-located in a hospital emergency department as recommended above.

There are programs in place that are geared to assist with this. The Substance Abuse Treatment Enhancement Project (SATEP) is one. The project is a partnership of ADRC, Advanced Behavioral Health and other providers to help eligible individuals receive substance abuse treatment in the North Central Region, especially Hartford. The initiative, which is funded by DMHAS, increases access and provides coordinated treatment services, including case management, housing, and transportation. One of the functions of ABH in the project is to operate a dedicated toll-free access line available 24 hours a day, 365 days a year. Trained staff use an assessment tool that screens and refers callers to appropriate levels of care through conference calling with providers, locates available openings for treatment, and arranges for transportation when necessary.

SATEP-eligible clients include those who present at an ED or DMHAS-funded provider agency within the North Central Region requiring medically monitored detoxification. However, emergency department physicians cannot be a primary navigator of services like SATEP; in fact they may not even be aware of the program's existence. Instead, intensive case management staff, with knowledge of SATEP and other treatment programs, should be co-located at hospital EDs as recommended. If ICM staff are located in the EDs, where clients with chronic and/or acute alcoholism are likely to present, this would increase the likelihood of these patients getting into detox and a long-term treatment program.

Another program targeted to serve high-cost Medicaid clients is being implemented jointly by the Corporation for Supportive Housing, the Partnership for Strong Communities, and the CT Aids Project, with a federal Social Innovations grant. The Connecticut Integrated Healthcare and Housing Neighborhoods project is a pilot initiative begun in 2012 that identifies high-cost Medicaid utilizers who are homeless. The project matched homeless data with state Medicaid data and found that that the top 10 percent of homeless high-cost users (419 people) had annual Medicaid costs of almost $68,000 each, almost nine times more expensive than the average Medicaid beneficiary costs.[12] One of the top expenditures was for ED visits. The project indicates that research shows that supportive housing is able to reduce Medicaid costs by 41 percent among homeless high medical users, through a reduction of inpatient hospitalizations and ED use.

The project is a collaborative effort of FQHCs, local mental health authorities, supportive housing/ public housing providers, homeless service/outreach programs, and the state's Medicaid Medical ASO. The project works with local hospitals to assist in identifying clients and to ensure effective transitions from care. As of December 2013, the project had assisted 35 people in four regions, with a goal of housing 160 persons. This demonstrates that the linkages between hospital EDs and community care providers are already being established, but PRI staff believes they need to be strengthened. A first step to doing this is better informing hospital ED staff about these care management programs.

While improved awareness by ED staff of community programs should help, PRI staff believes that ED staff should be engaged in community care teams and ongoing intensive case management of clients who have a care plan. However, it should not be the responsibility of the hospital ED doctor or hospital staff to make the connections to, or arrange for, the client's services in the community. Those connections should be made by the intensive case management staff that are co-located at the hospitals, and who have knowledge about the client's psycho-social needs and what programs or providers are available to address them.

Drug-seeking Patients and Emergency Departments

Another group of persons who frequently use hospital emergency departments are those patients seeking controlled prescription drugs, primarily opioid pain relievers, such as oxycodone (OxyContin) and hydrocodone combinations (e.g., Vicodin, Lorcet) Prescription drug abuse continues to be the nation's fastest growing drug problem. Many of the controlled substances –

[12]. Website material on the Connecticut Integrated Healthcare and Housing Neighborhoods from 2012 through December 2013.

are highly addictive and patients seek prescriptions from various sources as they need higher dosages to treat their pain.

Demand and treatment data indicate that abuse of controlled prescription drugs, particularly painkillers, is a rapidly growing threat. According to the National Survey on Drug Use and Health (NSDUH), pain relievers are the most common type of controlled prescription drugs taken illicitly and are the prescription drugs most commonly involved in overdose incidents. Still others may seek these drugs to distribute or sell. Nationwide, treatment admissions related to controlled prescription drugs rose 68 percent between 2007 and 2010 and prescription opiate/opioid-related emergency department visits rose 91.4 percent between 2006 and 2010.

While no hard data exists for Connecticut on the number of Medicaid clients who visit EDs seeking controlled prescription drugs, ED physicians and others interviewed by PRI staff indicate it is a persistent problem. Patients who visit the ED to obtain these substances may believe that in the busy emergency department setting, they will have an easier chance of obtaining a prescription than they would from a physician or other prescriber in a more controlled office setting.

Further, patients may be going to hospital emergency departments seeking controlled prescription drugs because other medical providers in the area may have instituted policies severely limiting the prescribing of these medicines. For example, seven of the 11 FQHCs who responded to a PRI survey indicated they have a policy for prescribing narcotics and another two are currently developing a policy. The policy typically requires the patient to sign a pain management agreement, which limits the supply of medicines to 14 days or less. Further, the patient agrees not to seek the medications from another source, and to have the prescription filled at a particular pharmacy. Seven of the 11 FQHCs also thought implementing a statewide policy on prescribing narcotics would lessen or prevent unnecessary use of the emergency departments.

Currently, the state Department of Consumer Protection collects prescription data for controlled substances into a central database which then can be accessed by medical providers and pharmacists. Known as the prescription drug monitoring program (PDMP), all pharmacies (with a few exceptions) that dispense, mail or ship prescriptions into the state and other dispensing practitioners are required to report weekly on the prescribing of these substances to DCP. Legislation passed in 2013 (P.A. 13-175) requires all practitioners to register with DCP in order to access the prescription monitoring program. The purpose of the program is to present a complete picture of a patient's controlled substance use, including prescriptions written by other providers. This may assist practitioners in properly managing a patient's treatment, including the referral of a patient to services for treatment for drug abuse or addiction when appropriate.

Through the drug monitoring program, patient information on all previous prescriptions for pain medication is available currently to ED physicians. Some emergency room physicians cite issues around ease of accessing the automated system, (e.g., frequency of password changes) and the time it takes away from providing medical care to retrieve the information, as obstacles to using the program. However, given the sensitivity of the information contained in the database, security and access protection is an appropriately high priority.

This prescription monitoring program can provide valuable information about a patient, and could be a helpful tool in treating the person. The American College of Emergency Physicians (ACEP) recognizes that the diversion of controlled substances from medical to non-medical purposes has become a significant public health problem. ACEP acknowledges that prescription drug monitoring programs can assist in identifying these clients as well as those who have become addicted. Its Board of Directors voted in 2011 to support the use of electronic prescription monitoring by its members, but does not support mandating their use, as some states require.

Efforts among other states to address this issue have included the development of statewide opioid prescribing guidelines, such as those developed by the Utah Department of Health or the ED opioid prescribing guidelines developed in Washington State by the Washington chapter of the American College of Emergency Physicians (ACEP) working with other state organizations.(See Appendix G for guidelines) In New York City, Mayor Bloomberg issued a policy in January 2013 restricting prescribing of narcotics at emergency departments at public hospitals. The policy limits prescriptions of narcotic painkillers like Vicodin and Percocet to a three-day supply. Long-acting painkillers, including OxyContin, as well as Fentanyl patches and methadone, are prohibited from being dispensed at all. Further, lost, stolen or destroyed prescriptions are not to be refilled.

Some of these policies implemented in states like Washington also deal with the necessity of patient education about the safe use and proper disposal of opioid medications. According to ACEP, early data indicate that, in some cases, these guidelines may decrease prescription opioid overdose. Anecdotal experience suggests that public policies such as these may change patient perceptions of appropriate prescribing and mitigate complaints arising from more stringent prescribing practices. ACEP has approved related policy statements about optimizing the treatment of pain in patients with acute presentations and the implementation and use of electronic prescription drug monitoring programs.

In December 2013, the American College of Physicians (ACP) also published a policy paper including 10 guidelines that the organization supports around the issue of prescribing of controlled substances.[13] These recommendations are similar to those outlined by the ACEP including the use of state prescription drug monitoring databases, but the ACP advocates for the development of a national monitoring system.

According to staff at the Connecticut Department of Public Health, the agency does not endorse the development of regulations or policies that restrict the prescribing practices of physicians, including those in the emergency department. DPH indicates that practitioners should use professional judgment in prescribing controlled prescription drugs, as they would in other areas in the practice of medicine. The department has indicated that emergency department physicians in the state, as part of an effort guided by the Connecticut Hospital Association, are working on developing their own guidelines in this area. In light of this, PRI staff recommends

12. that emergency department physicians as a first step follow ACEP guidelines, which includes checking the state's prescription drug

[13] The guidelines are contained in a policy paper "Prescription Drug Abuse: A policy Option Paper from the American college of Physicians", published in the Annals of Internal Medicine, December 10, 2013.

monitoring program prior to prescribing controlled prescription drugs to a patient in the ED.

PRI staff believes that Connecticut emergency department physicians should be given an opportunity to first develop and implement their own guidelines regarding prescribing opioids and determine if they have an impact, before any state policies or regulations are mandated. These policies could include some of the measures that Washington State has developed around education and development of pain management plans. The effective implementation of the guidelines will require hospital emergency departments to recognize that, as with many of the issues explored in this study, EDs are part of the community's healthcare network, and that treatment of the patient should not be done in isolation.

While the abuse of these controlled prescription drugs is not limited to any segment of the population or payer source, and there are no hard data about the scope of the problem among Connecticut's Medicaid population. Its impact on Medicaid nationwide is significant enough that CMS released a policy paper in January 2012 addressing the issue. The brief, entitled *Drug Diversion in the Medicaid Program: State Strategies for Reducing Prescription Drug Diversion in Medicaid.*

These strategies are not limited to prescribing controlled substances in the ED, but among the strategies suggested is that Program Integrity Units within state Medicaid programs utilize the data in the prescription drug monitoring programs in order "identify outliers and reduce the time and cost involved in drug diversion investigations." Connecticut's Medicaid program integrity function is located in DSS' Office of Quality Assurance (OQA). It has access to the prescription drug monitoring program, but it is not clear how the system is used in investigations, as the division's emphasis has historically been on auditing for provider overpayments, and provider fraud and abuse, rather than on potential client fraud and abuse.

Connecticut has employed another strategy CMS recommends, which is the client "lock-in" or pharmacy restriction, which limits Medicaid clients to one pharmacy via a three step letter process (initial letter, warning letter, and actual restriction) performed by DSS' federally required Drug Utilization Review vendor, Health Information Designs. There is a three-month interval between each step in order to allow the recipient time to change behavior. There are no set guidelines on drug use that lead to a client being restricted; rather a review of the entire clinical picture by a five-member Medical Review Team determines if a patient will be restricted.

A number of criteria are taken into account when reviewing a recipient's claims to see if they support restriction, which include, but are not limited to:

- number of physicians prescribing;
- number of pharmacies used;
- therapeutic duplication; and
- number of early refills.

Federal law also stipulates that a client may ask for a Fair Hearing after any letter (adverse action) is sent if that person does not agree with the decision.

Clients may come off the pharmacy restriction list. The manner in which clients are removed from a pharmacy restriction is also determined by HID's five-member Medical Review Team. Statutorily, recipients within the pharmacy restriction program must be reviewed annually to determine if they should remain restricted to a single pharmacy, or if their behavior over the past year warrants an "unlock". The same criteria that are evaluated when determining if a recipient will be restricted are also revisited during the required annual reviews, resulting in either a renewed one-year restriction or removal from the restriction program. Again, set guidelines do not exist for removal; rather the entire clinical picture is taken into account, and whether the recipient will be unrestricted, is decided on a case-by-case basis.

If DSS finds a client has been recently arrested and the arrest involves selling of controlled prescription drugs, the client is put into an immediate pharmacy restriction for one year. DSS notes that every pharmacy restriction is meant to protect the individual and is not meant to be punitive.

Table II-9 below shows the number of Connecticut Medicaid clients placed on pharmacy restriction each year since 2009. As the table shows, the number of has tripled since 2009, although it is still a very small percentage (less than one-half of one percent) of the state's total Medicaid population).

Table II-9. Medicaid Clients on Pharmacy Restriction List	
Year	***Number***
2009	89
2010	128
2011	206
2012	240
2013	289
Source: DSS	

Program review staff believes that rigorous implementation of these CMS-recommended strategies should be implemented by DSS, and therefore, PRI staff recommends

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 for determination whether these clients should be placed on the Medicaid prescription restriction program.**

APPENDICES

Appendix A

Survey of Connecticut's Hospital Emergency Departments (EDs)

A two-page survey was mailed to the Chief Executive Officers of each of the 28 Acute Care Hospitals who are members of the Connecticut Hospital Association and to Sharon Hospital, which is not a member. Personnel at 14 of the 29 hospitals completed the survey and returned it to PRI staff, for a response rate of 48.3 percent. Table 1 lists the responding hospitals by the size of the municipality in which they are located. Three of the responding hospitals (21.4 percent) were located in two of the largest Connecticut cities with populations of over 120,000. Another three (21.4 percent) were located in communities ranging in size from 45,000 to 65,000. Five (35.7 percent) were located in cities with populations ranging from 25,000 to 40,000. The remaining three (21.4 percent) were located in cities/towns with populations under 15,000.

Table 1. Hospitals Responding to ED Survey by Community Size

Hospital Name	***Community***	***Population of Home Municipality***
St. Francis Hospital	Hartford	124,775
Hartford Hospital	Hartford	124,775
Stamford Hospital	Stamford	122,643
Greenwich Hospital	Greenwich	61,171
Bristol Hospital	Bristol	60,477
Manchester Hospital	Manchester	56,385
Middlesex Hospital	Middletown	48,030
Backus Hospital	Norwich	36,388
Rockville Hospital	Vernon	29,839
New Milford Hospital	New Milford	28,388
Lawrence & Memorial Hospital	New London	25,891
Johnson Hospital	Stafford	11,773
Day Kimball Hospital	Putnam	9,307
Sharon Hospital	Sharon	3,014

ED Notification to Primary Care Provider

Each responding hospital routinely notified an identified primary care provider (PCP) if their patient had been seen in the ED, most doing so in more than one way. Not all ED patients have a PCP, and even those that do sometimes do not provide the PCP name to a hospital ED. Only one of the fourteen hospitals (7.1 percent) reported using a single method of notifying the PCP, which was via email. Thirteen EDs (92.9 percent) would make a phone call to an ED patient's PCP and twelve (85.7 percent) would either: mail, fax or send notification by email. Three hospitals (21.4 percent) specifically mentioned using electronic medical records (EMR) to notify PCPs when one of their patients had been seen in the ED, and these three hospitals included both of the hospitals not otherwise indicating that emails, letters or faxes were sent. Table 2 summarizes the methods used by the responding hospitals.

Table 2. Methods through which Hospital EDs Inform Identified PCP when Patient is Seen						
	Email	***Letter***	***Fax***	***Phone***	***EMR***	***Total Methods***
Hospital A	1					1
Hospital B				1	1	2
Hospital C			1	1		2
Hospital D			1	1		2
Hospital E			1	1		2
Hospital F		1		1		2
Hospital G			1	1		2
Hospital H			1	1		2
Hospital I			1	1		2
Hospital J			1	1		2
Hospital K			1	1		2
Hospital L				1	1	2
Hospital M		1	1	1		3
Hospital N			1	1	1	3

Policies Concerning Frequent ED Utilization

Only four hospitals (28.6 percent) had adopted a specific definition of what constituted frequent ED utilization and this ranged from 6 to 10 visits within a calendar year. Two hospitals (14.2 percent) specified that 6 visits within a year constituted frequent utilization; and one each specified 7-9 visits (7.1 percent) and 10 visits (7.1 percent), respectively. One of the two hospitals defining frequent use as 6 visits per year also included 3 or more visits within 6 months in its definition of frequent utilization.

Nine hospitals (64.3 percent) had dedicated staff to assist frequent utilizers of the ED with arranging for intensive follow-up care, which at 8 of the 9 hospitals could be either medical or behavioral health related. At the remaining hospital, dedicated staff persons were available only to assist frequent utilizers with behavioral health conditions. Six hospitals (42.9 percent) had also specifically adopted policies or programs to try to reduce ED use. These policies or programs are summarized in Table 3.

The policies at three hospitals called for the development of individualized care plans for frequent utilizers, either in consultation with the patient's PCP or with the hospital's care management department. One hospital reported having been involved in two different trial programs to reduce visits by frequent utilizers. The first trial was to treat the patient and then refer to a PCP, the second trial was to assign a case manager to make referrals to local agencies. One hospital had adopted a policy of developing treatment plans for patients with chronic pain to limit the use of opiates and the remaining hospital had developed a weekly team meeting to discuss individuals with high ED utilization and in need of community based mental health services after those individuals had provided appropriate signed releases.

Table 3. Hospitals with Policies or Programs Targeting Frequent ED Utilizers		
	Has Policy or Program	*Brief Summary of Policy or Program*
Hospital A	--	
Hospital B	--	
Hospital C	✓	Develops treatment plans for patients with chronic pain to limit use of opiates
Hospital D	✓	Develops individualized care plans for frequent utilizers in consultation with PCP and/or an ED based provider
Hospital E	--	
Hospital F	--	
Hospital G	✓	Has had trial programs: (1) treat and assign to PCP; (2) provide case management and refer to community agencies
Hospital H	--	
Hospital I	--	
Hospital J	✓	Creates a uniform care plan in consultation with hospital care management department
Hospital K	--	
Hospital L	✓	Hospital has participated in development of a community care team, which meets weekly for one hour to discuss on-going community treatment for frequent ED utilizers following execution of appropriate patient releases
Hospital M	--	
Hospital N	✓	Case manager arranges outpatient care for subsequent visits

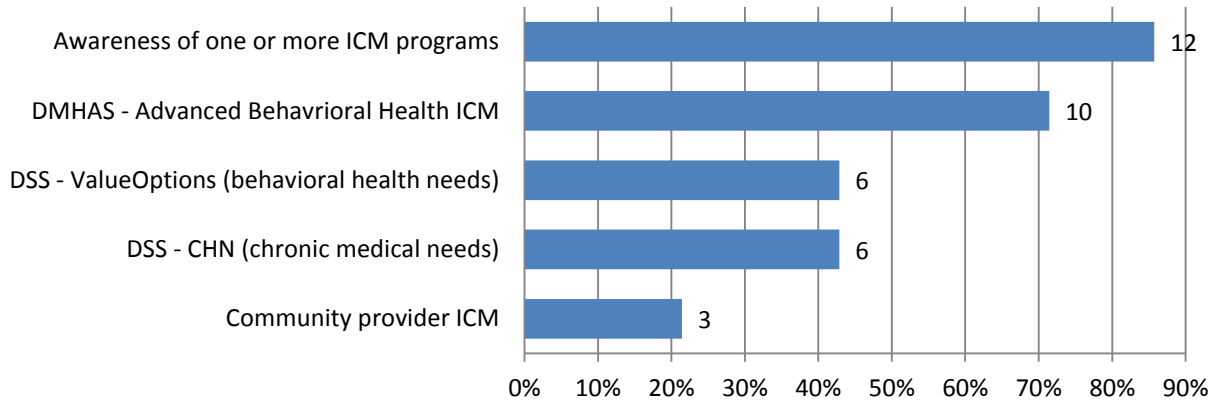
Intensive Case Management for Frequent ED Utilizers

In addition to the six hospitals that were implementing their own programs to reduce visits by frequent ED utilizers, personnel at twelve of the responding hospitals (85.7 percent), were aware of one or more avenues through which frequent ED utilizers might be able to access intensive case management (ICM) services from other sources. These ICM programs are listed in Figure 1, as well as the percentage of responding EDs that were familiar with each type of program.

Interestingly, there was no correspondence between the size of the community in which a hospital was located and the familiarity of ED staff with ICMs. At least one hospital in a large community (over 100,000), a mid-sized community (between 40,000 and 60,000), and a small

community (less than 20,000) were aware of all both DSS ICM programs as well as the DMHAS ICM program. Similarly, at least one hospital in each of these size categories was unaware of DMHAS ICM Program, which was the program with which the most hospitals statewide were familiar.

Figure 1. ED Survey Respondent Awareness of ICMs for Frequent ED Utilizers (N=14)



At ten hospitals (71.4 percent) this included at least some awareness of DMHAS' intensive case management services through Advanced Behavioral Health. At six hospitals (42.9 percent) it included awareness of the DSS Community Health Network case management program for those with chronic medical needs, and at six hospitals (42.9 percent) it included awareness of the DSS ValueOptions case management program for those with behavioral health needs. Seven of the fourteen responding hospitals (50 percent) were aware of having been contacted by one or more of the programs providing such ICM services, but this did not include either of the hospitals that reported having no awareness of any of the ICM programs.

Only three responding hospitals were aware of community provider based programs that helped to prevent/divert frequent users of the ED within their service area, and each of these hospitals did make referrals to the available program.

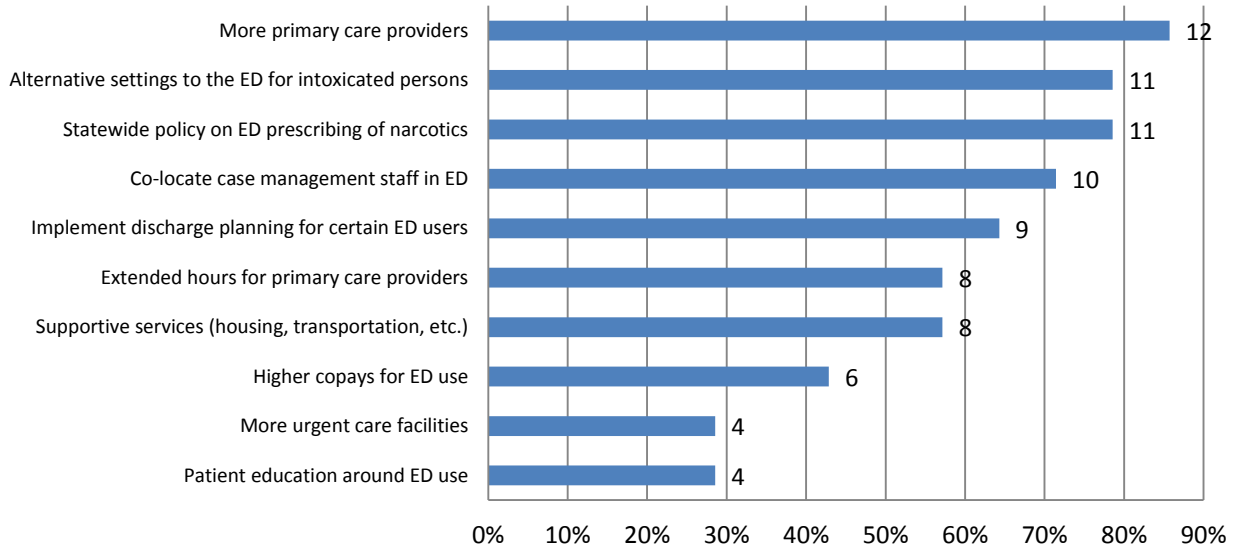
Endorsement of Strategies to Reduce or Prevent Non-Emergent Use of the ED

Responding hospital personnel were asked to identify strategies that they believed would be effective in reducing the frequency with which patients were using the ED for non-emergent and/or non-urgent care. The survey listed 10 possible strategies, and responding personnel were invited to circle all strategies that they believed would be effective. It was apparent that no respondent believed a single strategy would be effective as each respondent selected at least 4 strategies. One respondent (7.1 percent) endorsed 9 of the suggested strategies, and another (7.1 percent) endorsed 8. Five respondents (35.7 percent) endorsed 6 or 7 of the strategies. The remaining 7 respondents (50 percent) endorsed either 4 or 5.

As depicted in Figure 2, four strategies were endorsed by 10 or more (71.4 percent or more) of the 14 respondents. These strategies were:

- ensuring a greater availability of PCPs to see patients;
- providing an alternative setting the ED for intoxicated persons;
- adopting a statewide policy on ED prescribing of narcotics; and
- co-locating case management staff in emergency departments to provide better connection from the hospital ED to community based care.

Figure 2. Percentage of ED Survey Respondents in Agreement with Listed Strategies to Reduce ED Utilization (N=14)



Three strategies were endorsed by either 8 or 9 (57.1-64.3 percent) respondents. These strategies were:

- extending hours or providing weekend hours for PCPs;
- providing supportive services such as housing and transportation; and
- implementing discharge planning for certain ED users.

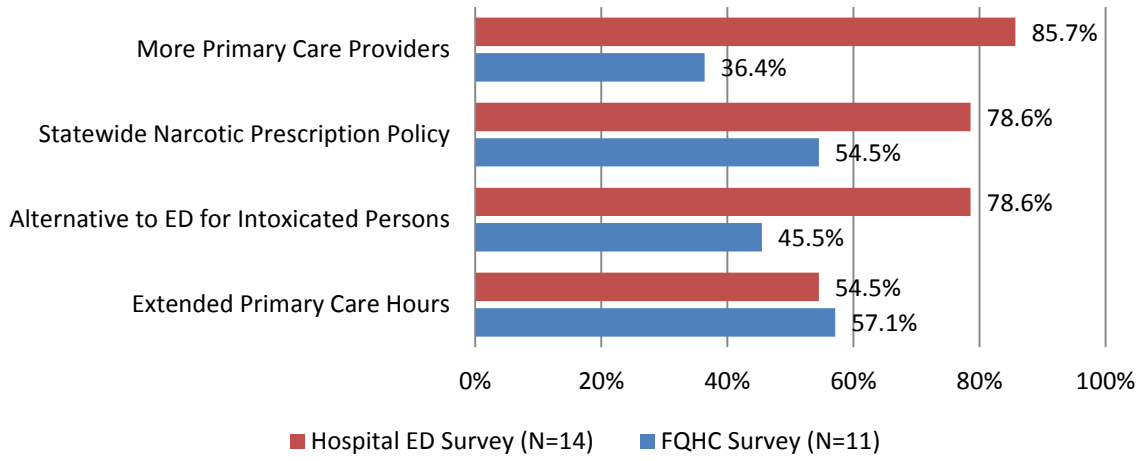
The three strategies that were endorsed least frequently were adopting higher co-payments for ED use (endorsed 6 times), ensuring the availability of more urgent care facilities (endorsed 4 times) and providing patient education around ED use (endorsed 4 times).

Comparison of ED and FQHC Survey Responses

As a point of comparison, four of the strategies listed on the ED survey paralleled factors to reduce ED use listed on a survey distributed to Connecticut's FQHCs. Figure 3 reflects the one strategy identified by respondents to both surveys as likely to reduce ED utilization was that of offering extended hours for primary care providers. The remaining four strategies: increasing the number of primary care providers, providing an alternative to the ED

for intoxicated persons, and adopting a statewide policy on the prescription of narcotics were each endorsed much more frequently by respondents to the ED survey.

Figure 3. Percentage of Survey Respoondents Identifying Strategies to Reduce ED Utilization



Survey Respondents' Other Comments

Finally, respondents were provided with the opportunity to make any other comments in regard to the survey albeit not responsive to any particular question. Personnel at two different EDs, both in communities with populations between 20,000 and 80,000, noted that community providers often declined to treat the uninsured and/or those who were particularly difficult to work with, and these providers instead referred individuals needing behavioral health care to the ED.

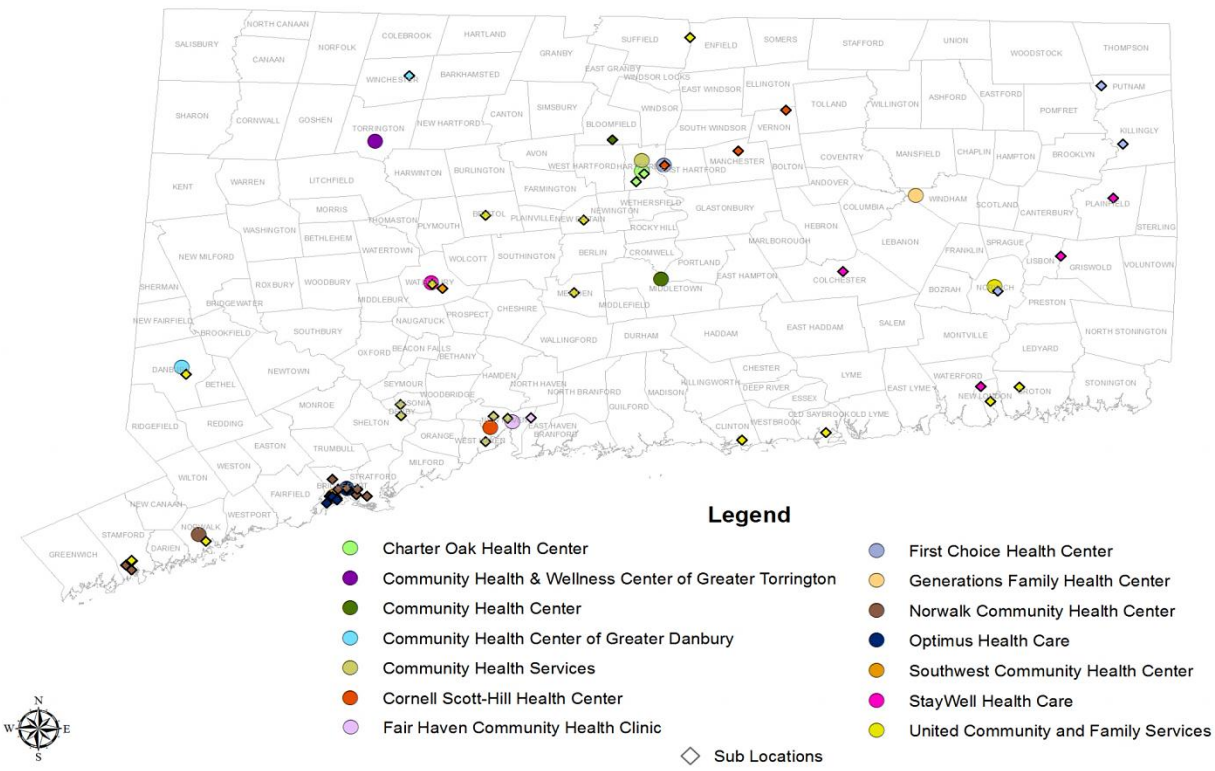
APPENDIX B

Survey of Connecticut's Federally Qualified Health Centers (FQHCs)

Brief surveys were mailed to each of Connecticut's14 Federally Qualified Health Centers (FQHCs). Figure 1 shows the location of these 14 health centers, and their satellite locations. Personnel at 11 of the FQHCs completed the survey and returned it to Program Review and Investigations staff, for a response rate of 78.6 percent. The responding health centers represent virtually all communities served by FQHCs throughout the state, with the two non-responding health centers being located in the Hartford and New Haven areas, which, as shown in Figure 1, are each served by more than one FQHC.

Figure 1.

Federally Qualified Health Centers and Sub Locations



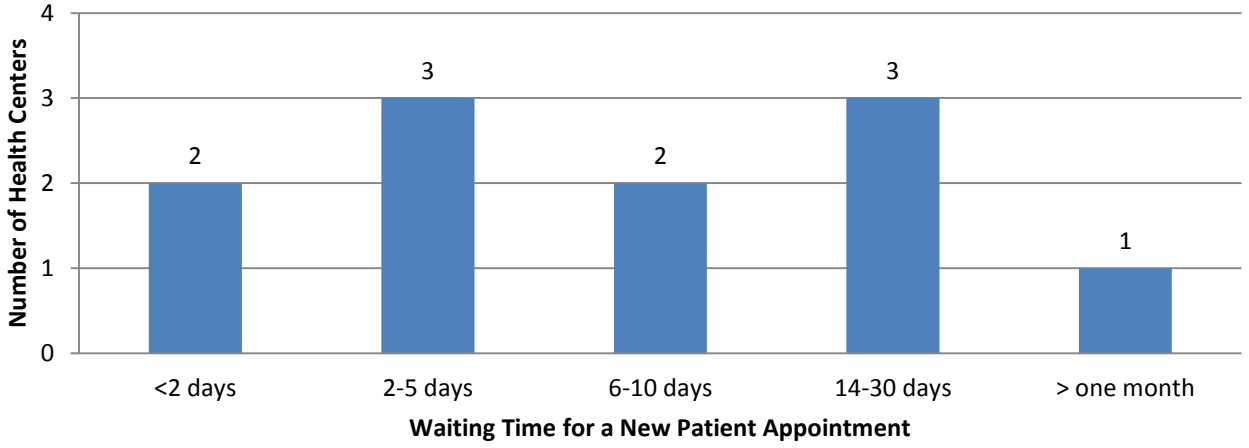
Availability of Urgent Care at FQHCs

All of the FQHCs offered walk-in or urgent care appointments. Nine of the health centers reported the percentage of daily appointments that were used for walk-in or urgent care. Of these nine, two (22.2 percent) reported approximately half of their appointments each day were walk-in or urgent care. Two additional health centers (22.2 percent) reported that between one-quarter to one-third of all appointments were for walk-in or urgent care. For three health centers (33.3 percent) no more than 1 in 10 appointments each day were used for walk-in or

urgent care, and the remaining two health centers (22.2 percent) reported approximately 15-20 percent of their daily appointments were used for walk-in or urgent care.

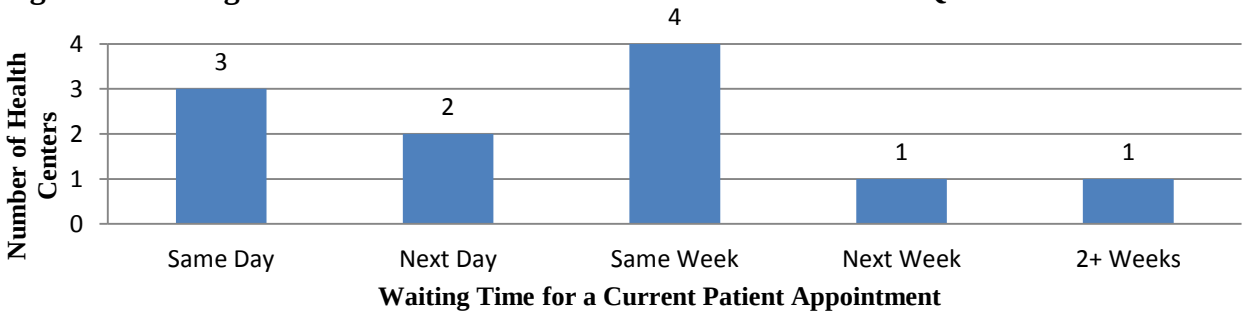
According to survey responses, the ability of an individual to obtain an urgent care appointment at an FQHC does depend on whether the individual is a new or established patient at the health center. All 11 responding health centers provided average wait times for both new and established patients. Although all responding FQHCs had the ability to accept new patients, the waiting time for a new patient appointment ranged from same day appointment availability at two health centers (18.2 percent) to 6-8 weeks at one health center (9.1 percent). Figure 2 depicts the reported waiting times for a new patients at the 11 responding FQHCs. Probably not surprising, the four health centers (36.4 percent) reporting waiting times of 2 or more weeks for new patient appointments were located in cities – Hartford, New Haven, Norwalk and Waterbury.

Figure 2. Waiting Time for New Patients at Connecticut's FQHCs



The average wait times reported for an established patient to schedule an appointment ranged from same-day to two or more weeks, as shown in Figure 3. Five of the responding FQHCs (45.5 percent) reported typical availability of appointments for the same or the next day for established patients, as compared to only 2 (18.2 percent) reporting an average wait time of less than 2 days for new patients.

Figure 3. Waiting Time for Esatablished Patients at Connecticut's FQHCs



From the survey responses, it appears that waits for appointments are longer for new patients than established clients. Four centers reported waits of 2 weeks or longer for new patients, while only one center indicated that lengthy a wait for an established patient.

Availability of On-Call Services at FQHCs

Each of the FQHCs also had an established on-call system for patients to call after hours and on weekends and holidays. These on-call systems would result in a physician from the health center speaking with the patient in order to determine whether their emergent health care needs could be managed by phone and by scheduling an appointment for the next business day or whether they required immediate attention from a hospital ED.

ED Utilization by FQHC Patients

Eight of the FQHCs were able to report the estimated percentage of patients typically referred to a local ED, either during regular office hours or by the on-call physician. Six of the eight FQHCs (75 percent) reported referring 5 percent or fewer of their patients to the ED, and the remaining two (25 percent) reported that 10-15 percent of patients were referred to the ED.

Six health centers also provided estimates of the percentage of health center patients presenting at the ED without first accessing the health center's urgent care or on-call services. Three (50 percent) reported approximately 5 percent of patients would do so; two (33.3 percent) reported 8-10 percent would do so, and the remaining health center (16.7 percent) reported that about 15 percent of its patients would present at the ED without first accessing the on-call system. One FQHC volunteered the observation that, among patients presenting directly to the ED without first calling the health center, slightly fewer than half, probably about 40 percent, actually sought ED care appropriately while the other 60 percent should have come to the health center for treatment.

After-Hour Prescription Refills

Six of the eleven responding FQHCs (54.5 percent) reported that the on-call physician could handle requests for prescription refills, with one additional health center (9 percent) reporting that the on-call physician could do so "in an emergency." The four remaining health centers (36.4 percent) required that refill requests be handled during business hours, with two centers (18.2 percent) indicating that patients should contact their pharmacy to submit the refill request and the other two (18.2 percent) simply indicating that refills were processed only during regular hours.

Narcotic Prescription Policy

Eight of the eleven (72.7 percent) responding FQHCs had adopted narcotic prescription policies, and one other respondent reported that it was in the process of developing such a policy. Two centers reported that their policy was to prescribe no more than 14 days of narcotics at a time, and one center reported that an initial narcotic prescription would only be written for 7-10 days but did not specify the duration of subsequent prescriptions. Two centers attached their written policies regarding pain management. For one FQHC this policy was in the form of a contract to be signed by the patient and the prescribing physician and at the other health center it

was in the form of two protocols to be followed by the provider/prescriber. One protocol was for the management of acute pain (pain expected to last for no more than six weeks) and one for management of chronic pain.

Notification and Action When FQHC Patient is Seen in ED

In responding to the question: "Is your FQHC notified if one of your center's patients has been in an ED?" eight of the eleven (72.7 percent) responded affirmatively and indicated that the hospital's ED or records department would typically send notice. Four health centers (36.4 percent) reported typically receiving such notice within 24 hours, three (27.3 percent) reported receiving such notice within 7 days, and the remaining health center (9.1 percent) reported that it could take up to 30 days to receive such notice from the hospital. Three health centers (27.3 percent) reported that they did not receive notice when a patient was seen in an ED. Each of these centers indicated that patients were asked to notify them if they were seen in an ED and/or that patients were routinely asked about whether they had recently visited an ED when they presented for a health center appointment.

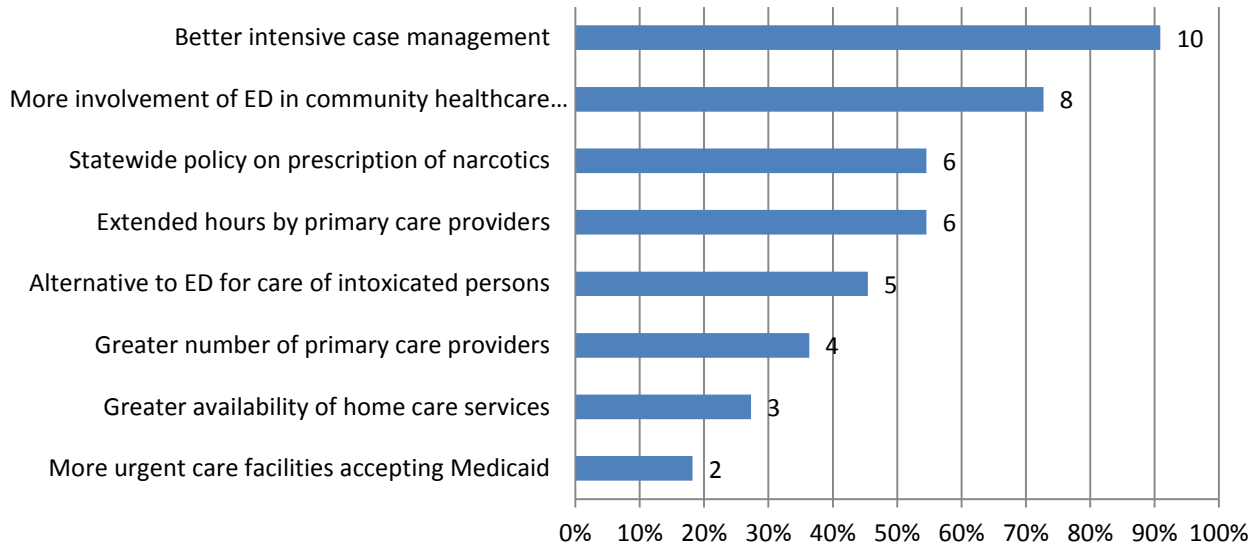
Nine of the health centers responded to a question about what actions were taken after receiving notice that a patient had been seen in an ED. Six of the nine (66.7 percent) reported that the health center would contact the patient to schedule a follow-up, with one of those respondents reporting that they would do so "if necessary." Two on the nine (22.2 percent) reported that they would contact the hospital for additional information. The remaining health center (11.1 percent) reported taking no action after receiving notice of a patient having been seen at an ED.

Endorsement of Factors to Reduce or Prevent Unnecessary ED Utilization

The FQHC survey provided an opportunity for respondents to indicate whether they believed that any of eight listed factors would reduce or prevent unnecessary utilization of EDs. These factors are listed in Figure 4, as well as the percentage of respondents that endorsed each one.

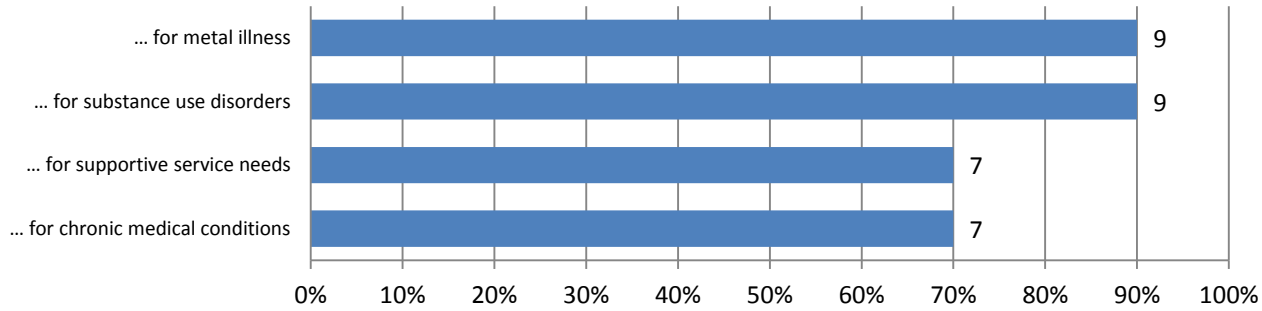
The four factors which the majority of the eleven FQHC respondents believed could decrease ED utilization were: better intensive case management (10 respondents, 90.9 percent); more involvement of hospital ED in community healthcare system (8 respondents, 72.7 percent); extended hours for primary care providers (6 respondents, 54.5 percent) and a statewide policy on the prescription of narcotics (6 respondents, 54.5 percent). Five responding FQHCs (45.5 percent) believed that an alternative to the ED for the care of intoxicated persons would decrease ED utilization. The factors that could decrease ED utilization that were endorsed by the fewest FQHC respondents were increasing the number of primary care providers (4 respondents, 36.4 percent), a greater availability of home care services (3 respondents, 27.3 percent) and having more urgent care facilities that accept Medicaid clients located close to hospitals (2 respondents, 18.2 percent).

Figure 4. Percentage of FQHC Survey Respondents in Agreement with Factors to Reduce ED Utilization



The most commonly identified factors that might reduce ED utilization was better intensive case management, and the survey also gave respondents the choice of four types of health care needs meriting better intensive case management. One respondent endorsed only the overarching category and no subcategories. The 10 respondents that identified one or more of the four possible sub-areas are reflected in Figure 5. Nine of these FQHCs (90 percent) felt better intensive case management was needed for individuals with mental illness and substance use disorders, and seven (70 percent) identified the need for better case management for those with chronic medical conditions and supportive service needs.

Figure 5. Percentage of FQHC survey respondents identifying specific health needs meriting better intensive case management

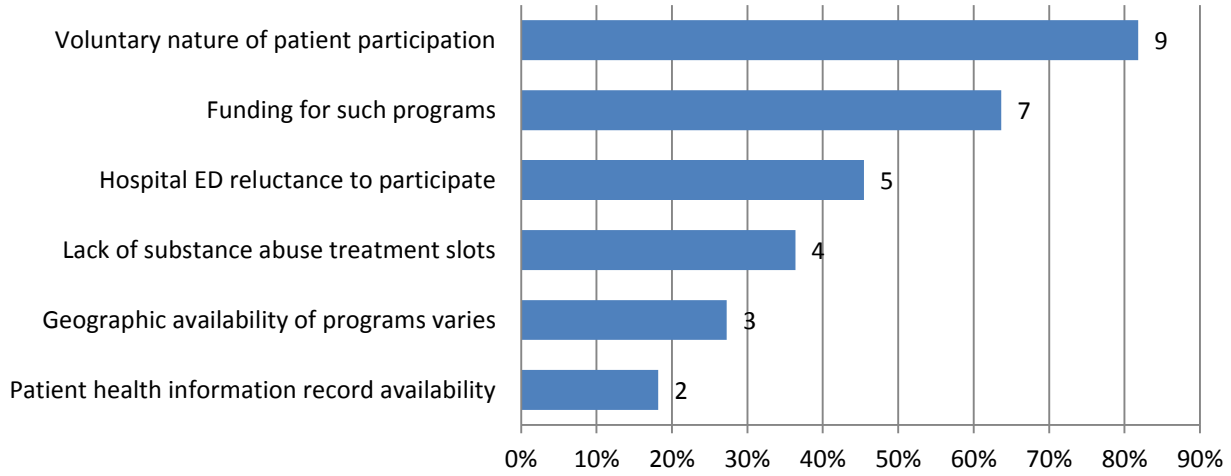


Identification of Obstacles to ED Prevention and Diversion Programs

The final question on the survey distributed to FQHCs asked respondents to endorse one or more of six obstacles to ED prevention and diversion programs, or to identify other obstacles in narrative format. The reasons and the percentages of respondents endorsing each one are

depicted in Figure 6. Over half of the FQHC respondents identified the voluntary nature of patient participation as a significant obstacle (9 respondents, 81.8 percent), and the lack of funding for such programs (7 respondents, 63.6 percent). Almost half (5 respondents, 45.5 percent) identified the reluctance of hospital EDs to participate in such prevention and diversion programs. The three obstacles endorsed by the fewest respondents were the lack of substance abuse treatment slots (4 respondents, 36.4 percent), the fact that not all programs were available in all regions (3 respondents, 27.3percent), and the limited availability of patient health information records (2 respondents, 18.2 percent).

Figure 6. Obstacles to ED prevention and diversion programs endorsed by FQHC survey respondents



Three respondents identified "other" obstacles. These obstacles were: lack of patient education; ED access being too easy; the lack of good management programs in specialties; and, generally "other incentives and disincentives."

Survey Respondents' Other Comments

Respondents were also provided with space to add other narrative comments relevant to the survey. Four FQHC respondents chose to do so. Two of these respondents expressed the belief that "hospitals want the [ED] revenue, so no incentive not to see clients." One respondent explained that there was a need for "more time to implement patient centered medical homes and time to change patient health seeking behaviors" and querying whether there were "consequences if a patient is seen during the day when [a health center is] open" or "if there was some way to control the ER use for patients who could wait to be seen in primary care." Similarly, another respondent noted that limits could be placed on the number of ED visits and/or that co-pays be implemented for Medicaid client use of the ED. This respondent also suggested a prohibition on the marketing of ED services and trying to stop the proliferation of ED and urgent care facilities while investing in primary care development

Appendix C

Hospital	Number of ED Visits in FY 12 Treated and Discharged	Percent of Total that are Medicaid Visits 2012
Backus	60,738	38%
Bridgeport	67,791	52%
Bristol	32,242	41%
Charlotte Hungerford	35,812	32%
CT Children's Medical Ctr	52,613	66%
Danbury	56,362	31%
Day Kimball	24,726	36%
Essent – Sharon	15,856	8%
Greenwich	35,924	12%
Griffin	12,373	34%
Hartford	79,223	46%
Hospital of Central CT	96,434	51%
John Dempsey	24,430	26%
Johnson Memorial	18,145	28%
Lawrence & Memorial	76,140	35%
Manchester Memorial	41,475	37%
Middlesex Memorial	85,082	24%
MidState Medical	84,907	40%
Milford	33,427	25%
New Milford	16,366	21%
Norwalk	39,550	23%
Rockville General	24,278	35%
St. Francis	62,547	44%
St. Mary's	62,968	53%
St. Raphael	43,564	48%
St. Vincent's	64,398	41%
Stamford	43,189	31%
Waterbury	47,677	44%
Windham Community	33,618	43%
Yale New Haven	114,396	42%

Hospital ED Visits per 1,000 Population: 2011	
Location	***ED Visits per 1,000 Population***
United States	**415**
Alabama	479
Alaska	435
Arizona	339
Arkansas	474
California	294
Colorado	338
Connecticut	***458***
Delaware	460
District of Columbia	736
Florida	397
Georgia	411
Hawaii	266
Idaho	327
Illinois	421
Indiana	483
Iowa	416
Kansas	363
Kentucky	538
Louisiana	535
Maine	***576***
Maryland	423
Massachusetts	***468***
Michigan	473
Minnesota	361
Mississippi	592
Missouri	491
Montana	370
Nebraska	389
Nevada	302
New Hampshire	***514***
New Jersey	393
New Mexico	411
New York	432
North Carolina	461
North Dakota	597
Ohio	564
Oklahoma	488
Oregon	363

Location	***ED Visits per 1,000 Population***
Pennsylvania	488
Rhode Island	***516***
South Carolina	361
South Dakota	306
Tennessee	486
Texas	386
Utah	304
Vermont	***473***
Virginia	420
Washington	340
West Virginia	656
Wisconsin	373
Wyoming	402
Source: Kaiser Family Foundation (http://kff.org/other/state-indicator/emergency-room-visits/).	

Appendix E

Medicaid-to-Medicare Reimbursement Ratios: A State Comparison

Location	All Services	Primary Care	Obstetric Care	Other Services
United States	0.66	0.59	0.78	0.70
Alabama	0.78	0.70	1.01	0.71
Alaska	1.24	1.27	1.14	1.28
Arizona	0.82	0.75	0.92	0.84
Arkansas	0.79	0.70	0.74	1.11
California	0.51	0.43	0.54	0.67
Colorado	0.71	0.74	0.68	0.69
Connecticut	0.87	0.71	1.23	0.79
Delaware	0.97	0.98	0.94	0.96
District of Columbia	0.80	0.80	0.80	0.80
Florida	0.57	0.49	0.90	0.55
Georgia	0.75	0.70	0.81	0.83
Hawaii	0.62	0.57	0.66	0.68
Idaho	0.88	0.89	0.82	0.92
Illinois	0.62	0.54	0.86	0.64
Indiana	0.62	0.55	0.78	0.69
Iowa	0.82	0.77	0.86	0.90
Kansas	0.78	0.82	0.73	0.78
Kentucky	0.77	0.72	0.97	0.76
Louisiana	0.76	0.75	0.73	0.76
Maine	0.65	0.63	0.68	0.65
Maryland	0.73	0.70	0.89	0.70
Massachusetts	0.77	0.68	0.97	0.72
Michigan	0.51	0.46	0.61	0.50
Minnesota	0.71	0.73	0.66	0.72
Mississippi	0.90	0.90	0.90	0.90
Missouri	0.59	0.57	0.57	0.68
Montana	0.97	0.94	1.05	0.96
Nebraska	0.87	0.76	1.01	0.96
Nevada	0.74	0.68	0.80	0.83
New Hampshire	0.58	0.60	0.61	0.51
New Jersey	0.45	0.50	0.37	0.46
New Mexico	0.92	0.85	1.00	1.00
New York	0.55	0.42	0.80	0.58
North Carolina	0.82	0.85	0.72	0.87
North Dakota	1.34	1.35	1.24	1.39
Ohio	0.61	0.59	0.65	0.63
Oklahoma	0.97	0.97	0.97	0.96
Oregon	0.81	0.72	1.04	0.71
Pennsylvania	0.70	0.56	1.15	0.49
Rhode Island	0.37	0.33	0.39	0.46
South Carolina	0.81	0.74	1.39	0.79
South Dakota	0.76	0.69	0.84	0.82
Tennessee	NA	NA	NA	NA
Texas	0.65	0.61	0.68	0.75
Utah	0.74	0.74	0.74	0.74
Vermont	0.80	0.81	0.82	0.77
Virginia	0.80	0.74	0.91	0.82
Washington	0.76	0.66	1.07	0.59
West Virginia	0.80	0.74	1.08	0.75
Wisconsin	0.77	0.60	0.93	1.01
Wyoming	1.16	0.96	1.74	0.89

Appendix F

Assisted Outpatient Treatment (Involuntary Outpatient Treatment)

Assisted outpatient treatment (AOT) (also called "involuntary outpatient treatment," "involuntary outpatient commitment" (IOC) or simply "outpatient commitment (OPC)) is court-ordered, community-based treatment for people with untreated severe mental illness, such as schizophrenia, bipolar disorder, or major depression, who meet strict legal criteria.[1] Generally, these individuals are too ill to recognize they need medical care and have a history of medication and treatment noncompliance. The basic goal of AOT is to provide treatment to these individuals so that they do not require repeated psychiatric hospitalizations.

According to the Treatment Advocacy Center, 45 states and the District of Columbia allow courts to order involuntary outpatient treatment for people with severe untreated mental illness. Connecticut is one of five states (along with Maryland, Massachusetts, New Mexico, and Tennessee[2]) that do not have such a law.[3] Even in states that do have AOT laws on the books, however, there is frequently limited implementation, based on economic constraints, resource barriers, and stakeholder resistance.[4]

Proponents of AOT laws believe they reduce psychiatric hospital admissions, homelessness, and criminal justice involvement, and also improve treatment compliance and quality of life for individuals with psychiatric disabilities.[5] Those opposed feel such laws remove an individual's civil right to choose where and how to receive treatment and, also, that AOT is an inappropriate mechanism for service provision in the absence of a mental health system that provides comprehensive infrastructure to meet the treatment needs of all individuals with mental health needs, including those with serious mental illness.[6] Currently, there seems to be a growing consensus that in a limited number of circumstances, and accompanied by adequate procedural safeguards, AOT may in fact be an appropriate option for a very small population of individuals

[1] Parts of this appendix are based on the Connecticut General Assembly's Office of Legislative Research reports (e.g., Csere, M., Office of Legislative Research. Updated Report: Involuntary Outpatient Mental Health Treatment Laws. 2013-R-0105. Online at http://cgalites/2013/rpt/pdf/2013-R-0105.pdf. Accessed on January 14, 2014.

[2] Tennessee is, however, currently running a two-year pilot AOT program in one county. See Tennessee Code Annotated § 33-6-624, effective July 1, 2012.

[3] Treatment Advocacy Center. Assisted Outpatient Treatment Laws. Online at http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws. Accessed on January 14, 2013.

[4] Swanson, JW, Van Dorn, RA, Swartz, MS, Robbins, PC, Steadman, HJ, McGuire, TG, Monahan, J. The cost of assisted outpatient treatment: Can it save states money? *American Journal of Psychiatry*. 170:1423-1432. doi:10.1176/appi.ajp.2013.12091152.

[5] Geller, J.A. The evolution of outpatient commitment in the USA: From conundrum to quagmire, p. 236. *International Journal of Law and Psychiatry*, 29: 234-248 (2006).

[6] National Alliance on Mental Illness (NAMI). Involuntary Treatment and Court-Ordered Treatment. Online at http://www.nami.org/Content/ContentGroups/Policy/Updates/Involuntary_Commitment_And_Court-Ordered_Treatment.htm. Accessed on December 16, 2013.
Mental Health America (MHA). Position Statement 22: Involuntary Mental Health Treatment. Online at http://www.nmha.org/positions/involuntary-treatment. Accessed on January 14, 2014.

with serious mental illness, with two of the largest national mental health consumer and family advocacy organizations having issued position statements to this effect.[7]

State Variation in AOT

States vary somewhat in terms of eligibility requirements, processes, and who can apply to the court to admit an individual to AOT. For example, some states such as Florida, California, and New York limit AOT to adults, whereas other states such as Georgia, Maine, and North Carolina also allow minors to receive such treatment. Some states require an individual to be involuntarily hospitalized at the time of the court application for AOT, while others allow an application to be initiated when an individual still lives in the community. In a January 2013 report, the Office of Legislative Research (OLR) provided summaries of AOT laws in four states, including New York, which has the most extensively implemented and studied AOT law in the country.[8] That OLR report also linked interested readers to the Treatment Advocacy Center's summary of the AOT laws in each of the 45 states and the District of Columbia.[9]

Research Supporting AOT

In the middle of the last decade, one observer noted that discussion of outpatient commitment in the United States "has been characterized by considerably more opinion than fact."[10] Unfortunately, this remains largely the case, with the exception of evaluations of the specific AOT systems in North Carolina and New York.

In North Carolina, a research team at Duke University reported statistically significant reductions in hospital admissions, length of hospitalization, episodes of violent conduct, and frequency of being criminally victimized for those individuals receiving services pursuant to AOT.[11] The most recently published peer-reviewed research article concerning New York's AOT statute – Kendra's Law – included findings that overall service costs for individuals with serious mental illness can be reduced through the use of AOT.[12] These savings were realized primarily through a decrease in frequency and length of hospitalization and increased utilization of outpatient behavioral and medical health services.

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[7] National Alliance on Mental Illness (NAMI). Involuntary Treatment and Court-Ordered Treatment. Online at http://www.nami.org/Content/ContentGroups/Policy/Updates/Involuntary_Commitment_And_Court-Ordered_Treatment.htm. Accessed on December 16, 2013.
Mental Health America (MHA). Position Statement 22: Involuntary Mental Health Treatment. Online at http://www.nmha.org/positions/involuntary-treatment. Accessed on January 14, 2014.

[8] Csere, Office of Legislative Research. Updated Report: Involuntary Outpatient Mental Health Treatment Laws. 2013-R-0105.

[9] Treatment Advocacy Center. Assisted Outpatient Treatment Laws. January 2013. Online at http://www.treatmentadvocacycenter.org/storage/documents/Standards_-_The_Text-_June_2011.pdf. Accessed on January 14, 2014.

[10] Geller, J.L. The evaluation of outpatient commitment in the USA: From conundrum to quagmire, p. 235. *International Journal of Law and Psychiatry*. 29: 234-248 (2006).

[11] Reported in Geller (2006) at p. 239.

[12] Swanson, JW, Van Dorn, RA, Swartz, MS, Robbins, PC, Steadman, HJ, McGuire, TG, Monahan, J. The cost of assisted outpatient treatment: Can it save states money? *American Journal of Psychiatry.* 170:1423-1432. doi:10.1176/appi.ajp.2013.12091152.

This study of Kendra's Law included a comparison of costs with those expended to serve a group of individuals with similar diagnoses (primarily schizophrenia, but including major depression, bipolar disorder, and other serious mental illness) who were not eligible for AOT but participated voluntarily in assertive community treatment (ACT) or intensive case management (ICM). In New York City, the voluntary service recipients saw significant net declines in overall service costs, but such decreases were not as large as for the AOT group. In a group of participants from other New York counties there was no significant difference in overall cost before and after receipt of voluntary services.[13]

Proposed Legislation for Outpatient Civil Commitment in Connecticut

Connecticut has recently considered a legislative proposal to establish AOT. During the 2012 legislative session, Senate Bill 452 included a provision that would have allowed directors of both inpatient and outpatient psychiatric facilities to apply to probate court for the appointment of a conservator solely to consent to the administration of psychiatric medication for individuals who were determined, by two qualified physicians, to:

(1) be capable of giving informed consent but refusing to take psychiatric medication or have a history of failing to take such medications;
(2) have a condition for which there is no less intrusive beneficial treatment; and
(3) have a condition which is likely to continue unabated and place the individual or others in direct threat of harm.

This proposed legislation is described in detail in a report issued by the Office of Legislative Research in January 2013.[14]

The model of AOT articulated in Section 5 of SB 452 is unique in comparison to the models described in the statutes of other states, in large part because it is limited to the involuntary administration of psychiatric medication. In addition, although SB 452 included the procedural safeguard of requiring that involuntary administration of medication be the least restrictive treatment option, only one other state relies on a finding that AOT is the least restrictive option as the sole procedural safeguard against misapplication of its AOT statute.

Following a public hearing at which only one witness testified in favor of the AOT proposal contained in SB 452, the bill was never voted out of committee.

In 2013, P.A. 13-3, An Act Concerning Gun Violence Prevention and Children's Safety, established a taskforce to study the provision of behavioral services for young adults. One of the 13 areas the task force is to make recommendations in is "employing the use of assisted outpatient behavioral health services and involuntary outpatient commitment as treatment options." The task force's report is due February 1, 2014.

Procedural Safeguards in Other States' AOT Statutes

[13] Id.
[14] Price, S.., Office of Legislative Research. OLR Backgrounder: 2012 Outpatient Civil Commitment Bill. 2013-R-0026. Online at http://cgalites/2013/rpt/pdf/2013-R-0026.pdf. Accessed on January 14, 2014.

Figure 1 depicts the distribution of the 50 states and District of Columbia across the categories of: no AOT statute, AOT with no procedural safeguards, and AOT with one, two or three or more procedural safeguards.

Figure 1. Percentages of States With Various Forms of Statutory AOT Safeguards

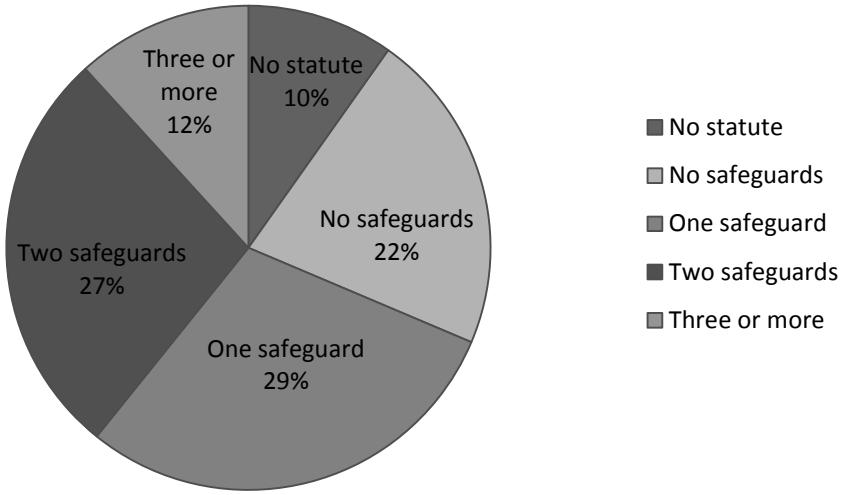
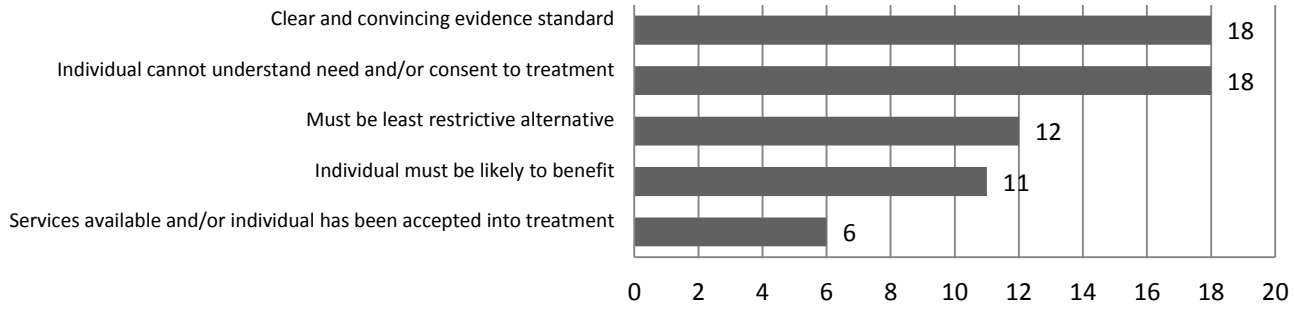


Figure 2 lists the most common safeguards contained in the AOT statutes of other states and illustrates the frequency with which each safeguard is employed by states.

Figure 2. Frequency With Which Selected Procedural Safeguards are Included in State Statutes



The two most common procedural safeguards are the imposition of a higher standard of proof – that of clear and convincing evidence – than other civil proceedings, and the requirement that the individual to be subject to the order be unable to appreciate the need for and/or to consent to treatment. Each of these safeguards is in place in 18 of the 35 states with AOT statutes (51.4

percent). As noted in the discussion of Connecticut's 2012 proposed legislation, another common safeguard is that AOT be the least restrictive treatment option, with 12 of the 35 states (34.3 percent) requiring this showing. Eleven states (31.4 percent) require a showing that AOT is likely to benefit the individual being ordered into it. Finally, 6 of the 35 states with AOT statutes (17.1 percent) require that there be a showing either that the services the individual needs are available in the community and/or that the individual has been accepted into an appropriate treatment program.

Appendix G

American College of Emergency Physicians Guidelines for Prescribing of Opioids

Opioid Prescribing [Adult]

Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department (June 2012)

Complete Clinical Policy on Opioid Prescribing (PDF)

Scope of Application. This guideline is intended for physicians working in hospital-based EDs.

Inclusion Criteria. This guideline is intended for adult patients presenting to the ED with acute noncancer pain or an acute exacerbation of chronic noncancer pain.

Exclusion Criteria. This guideline is not intended to address the long-term care of patients with cancer or
chronic noncancer pain.

Critical Questions

1. In the adult ED patient with noncancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse?

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. The use of a state prescription monitoring program may help identify patients who are at high risk for prescription opioid diversion or doctor shopping.

2. In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications?

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations.
(1) For the patient being discharged from the ED with acute low back pain, the emergency physician should ascertain whether nonopioid analgesics and nonpharmacologic therapies will be adequate for initial pain management.

(2) Given a lack of demonstrated evidence of superior efficacy of either opioid or nonopioid analgesics and the individual and community risks associated with opioid use, misuse, and abuse, opioids should be reserved for more severe pain or pain refractory to other analgesics rather than routinely prescribed.

(3) If opioids are indicated, the prescription should be for the lowest practical dose for a limited duration (eg, <1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

3. In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids?

Level A recommendations. None specified.

may prescribe short-acting opioids such as oxycodone or hydrocodone products while considering the benefits and risks for the individual patient.

Level C recommendations. Research evidence to support superior pain relief for short-acting schedule II over schedule III opioids is inadequate.

4. In the adult ED patient with an acute exacerbation of noncancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations.

(1) Physicians should avoid the routine prescribing of outpatient opioids for a patient with an acute exacerbation of chronic noncancer pain seen in the ED.
(2) If opioids are prescribed on discharge, the prescription should be for the lowest practical dose for a limited duration (eg, <1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.
(3) The clinician should, if practicable, honor existing patient-physician pain contracts/treatment agreements and consider past prescription patterns from information sources such as prescription drug monitoring programs.