



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.

Medicaid clients 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 EDs.

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 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 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, PRI 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.

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