December 7, 2022
Study packet contents

Reducing Unnecessary Emergency Department Utilization

- Report in brief
- Policy options
- Staff follow-up memo

Reducing Unnecessary Emergency Department Utilization

POLICY OPTIONS IN BRIEF

There are 6 policy options in the report for Member consideration.

Option: Direct DMAS to collect and report on claim denials from MCOs by provider type
(Option 1, page 20)

Option: Direct a study of primary care practice scheduling processes for Medicaid enrollees, including whether Medicaid enrollees are able to get appointments in compliance with MCO contracts
(Option 2, page 22)

Option: Establish two grant programs for hospital and ambulance-based care management
(Options 3 and 4, pages 25, 27)

Option: Require hospitals to submit ESI codes, reason codes, and social determinant of health Z-codes on claims and require them to be submitted to the APCD
(Option 5, page 27)

Option: Require free standing emergency departments to better identify themselves to patients
(Option 6, page 30)

FINDINGS IN BRIEF

Number of ED visits remained steady prior to COVID-19 pandemic, but severity of visits and costs increased from 2016-2020

The number of ED visits in Virginia remained steady from 2016-2019 before declining in 2020, reflecting the impact of the COVID-19 pandemic. The intensity of services for patients increased during this time, and the average cost of an ED visit increased by 41.5%. An increasing number of visits for mental health and substance abuse issues were a contributing factor to these trends.

Alternatives to an ED visit need to be available and accessible

People go to the ED for many reasons, some include the inability to get an appointment with a physician or limited hours and locations for urgent care centers. A bad experience in an alternative care setting often leads to ED use. Medicaid enrollees often have the most difficult time finding alternative settings. Additionally, primary care provider acceptance of Medicaid enrollees and scheduling practices are often barriers to access.

Some ED visits for patients with chronic conditions and frequent ED users can be prevented

Patients with chronic conditions that go unmanaged in the community present in the ED with an emergency, but those emergencies could have been prevented. Conditions such as diabetes, hypertension, and asthma can be treated and managed, but often result in ED visits if patients don't get the care they need. Additionally, the vast majority of high utilizers of the ED have mental health or substance abuse diagnoses. Hospital-based and ambulance-based care management programs can be effective at better managing these conditions in the community.

Freestanding EDs should be easily identified to consumers

Freestanding EDs generally serve a similar patient mix to hospital-based EDs, but consumers can confuse them for urgent care centers or hospitals. Improved awareness by consumers can ensure they seek care in the most appropriate setting and avoid surprise medical bills.

September 2022

JCHC Analyst: Stephen Weiss

Policy Options

Joint Commission on Health Care
Reducing unnecessary emergency department utilization

OPTION 1
The Joint Commission on Health Care could introduce a Chapter 1 bill directing DMAS to modify its managed care contracts to require MCOs to collect and report on the number of claim denials, the reason for denials, and the number of claim resubmissions prior to payment by provider type. The bill could direct DMAS to report this information to the Joint Commission on the Health Care and the Joint Subcommittee for Health and Human Resources Oversight. (Page 20)

OPTION 2
The Joint Commission on Health Care could introduce a budget amendment directing the Virginia Primary Care Task Force, DMAS, and the Virginia Department of Health, Office of Health Equity to study whether scheduling in primary care practices is limiting access by Medicaid patients, and make recommendations to improve the ability of Medicaid patients to get primary care appointments. (Page 22)

OPTION 3
The Joint Commission on Health Care could introduce legislation and an accompanying budget amendment to establish a grant program within the Virginia Department of Health, Office of Emergency Medical Services to establish and enhance hospital-based care management programs. (Page 25)

OPTION 4
The Joint Commission on Health Care could introduce legislation and an accompanying budget amendment to establish a grant program within the Virginia Department of Health, Office of Emergency Medical Services to establish and enhance ambulance-based care management programs. (Page 27)

OPTION 5
The Joint Commission on Health Care could introduce legislation to require hospitals to submit ESI codes, reason codes, and social determinant of health codes Z55 to Z65 as part of hospital claims, and that these codes be required on claims submitted to the All Payer Claims Database. (Page 27)

OPTION 6
The Joint Commission on Health Care could introduce legislation requiring free standing emergency departments to appropriately identify that they are a free standing emergency department in their external signage and patient disclosures provided to patients. (Page 30)

JOINT COMMISSION ON HEALTH CARE

Senator George L. Barker, Chair *Delegate Robert D. Orrock, Sr., Vice Chair*

TO: JCHC Members
FROM: Stephen Weiss, Senior Health Policy Analyst
DATE: December 7, 2022
RE: Follow-up material for the study on *Reducing Unnecessary Emergency Department Utilization*

At the September 21, 2022 JCHC meeting, staff presented the results of the study on *Reducing unnecessary emergency department utilization.* Following member discussion and questions, there were two questions that required additional information. The answers to these questions are below.

Question: Can the data on frequent ED utilizers from TABLE 2 (page 24) of the report be broken down by age? (Senator McClellan)

Data on high ED utilizers from the Emergency Department Care Coordination program (EDCC) is broken down by age below (TABLE 1). The written report showed that behavioral health conditions are the primary driver of frequent ED utilization, with more than 70% of all ED visits for high utilizers stemming from a behavioral health issue. High utilizers also are much more likely to be adults. This may be driven by the fact that significant behavioral health issues that may lead to ED utilization, such as schizophrenia, typically begin to surface during the young adult years and continue into adulthood. Children are much less likely to be high utilizers of the ED. Children make up 21.7% of Virginia's population, but just 3.5% of frequent ED utilizers in the state[1].

TABLE 1: Count of frequent ED utilizers by age group (September 2021 – October 2022)

		Age Ranges					
Range of ED visits	**Total patients**	**0-12**	**13-18**	**19-26**	**27-55**	**56-64**	**65+**
10–14	12,372	355	196	1,433	5,783	1,771	2,834
15–19	3,219	39	33	329	1,673	506	639
20–29	1,847	7	20	172	1,058	323	267
30–49	809		4	73	534	113	85
50–74	219		1	15	144	33	26
75–99	83			5	61	11	6
100+	78			5	48	11	14
Total	**18,627**	**401**	**254**	**2,032**	**9,301**	**2,768**	**3,871**
Percent of total	100%	2.1%	1.4%	10.9%	49.9%	14.9%	20.8%

SOURCE: EDCC data obtained from Virginia Health Information.

[1] Due to data limitations, the percent of children in the total population is ages 0-17, while the percent of ED utilizers who are children is ages 0-18.

Question: Can you update the maps showing ED and primary care utilization (FIGURES 10-13 in the report) to more clearly show the surrounding areas, and add a map of member visits to primary care by member zip code? (Senators McClellan and Suetterlein)

Staff added additional zip codes, geographic boundaries, notable city or community names, and the hospitals located within each area for both the Roanoke and Richmond maps. Each set of maps provides zip code level data for:

- Primary Care Visits by Office Location Zip Code
- Primary Care Visits by Patient Location Zip Code
- Emergency Department Visits by Patient Zip Code

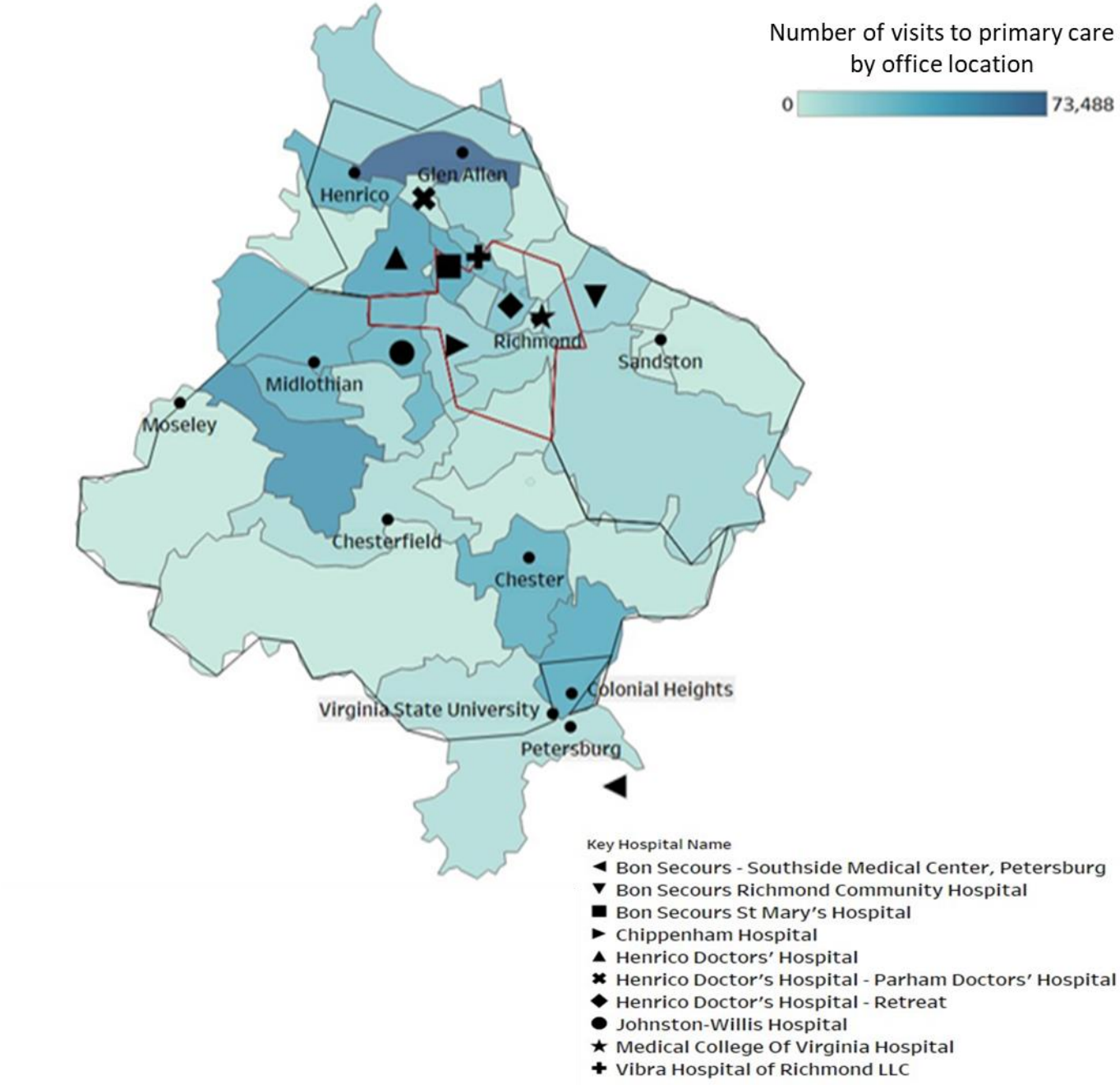
Figures 1 through 3 below cover zip codes for the City of Richmond and surrounding areas where zip codes cross into other counties, primarily Henrico and Chesterfield counties. Figures 4 through 6 cover zip codes for the City of Roanoke, Roanoke County and the surrounding counties where zip codes cross into other counties.

The maps for the Richmond City and Roanoke areas indicate that:

- Individuals are travelling to seek primary care, because there is primary care utilization throughout the regions, even though there are more primary care locations in certain zip codes; and
- Emergency department visits are greatest where there are few or no primary care locations.

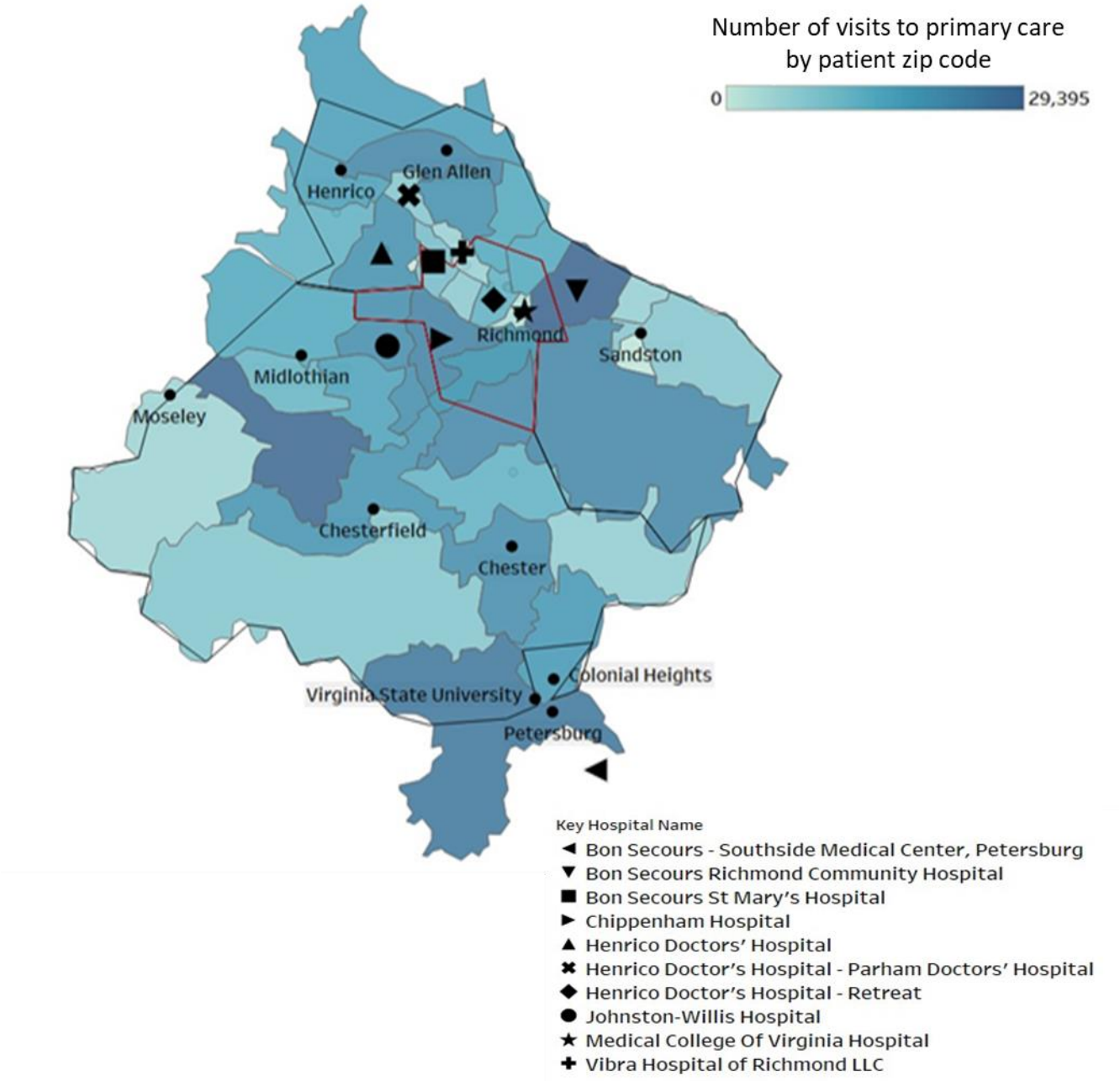
Primary care and ED utilization for the City of Richmond, Henrico and Chesterfield counties

FIGURE 1: Primary care visits by office location zip code (City of Richmond, Henrico and Chesterfield Counties)



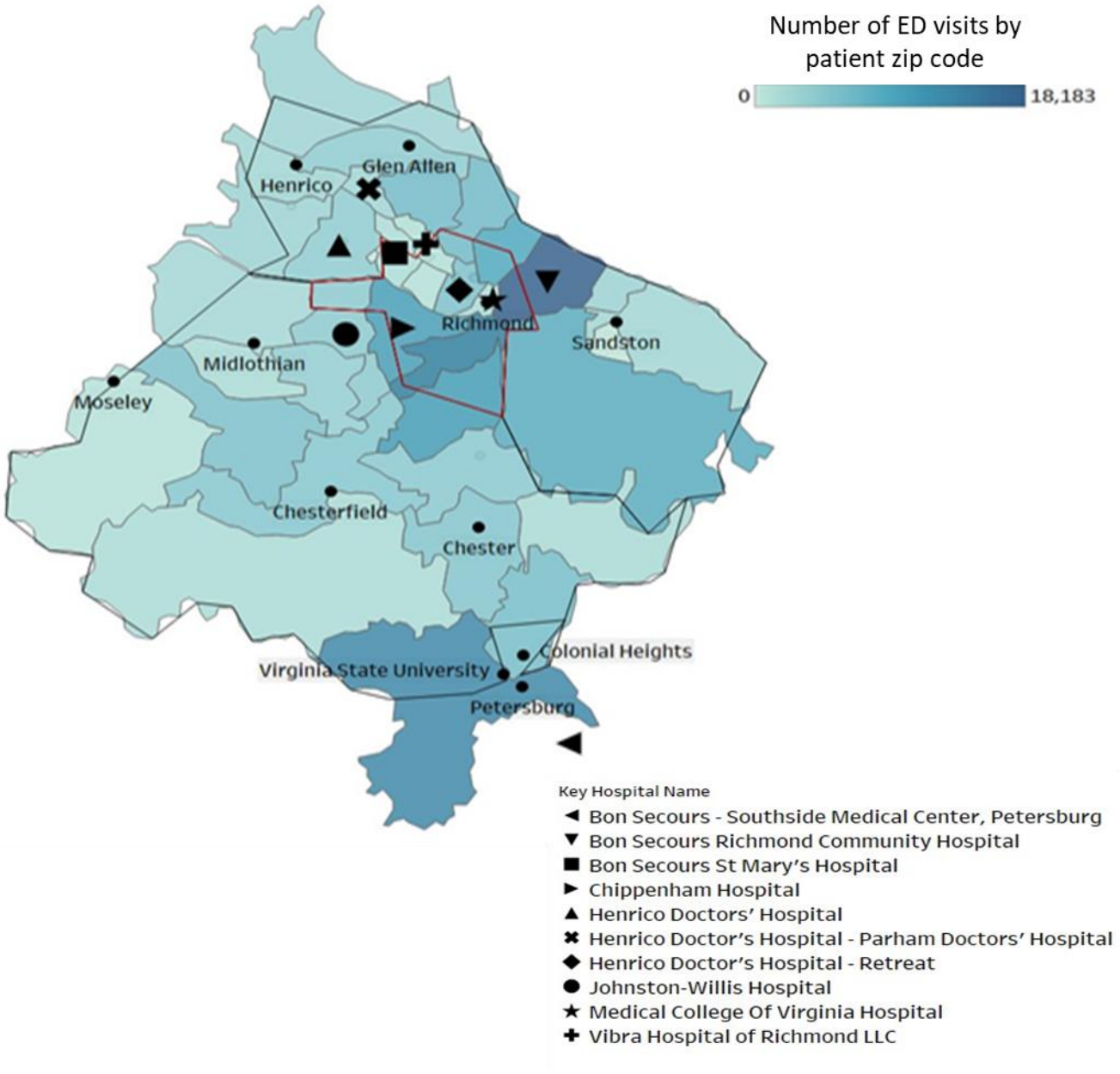
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local public health clinics, FQHCs, and rural health clinics.

FIGURE 2: Primary care visits by patient location zip code
(City of Richmond, Henrico and Chesterfield Counties)



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local public health clinics, FQHCs, and rural health clinics.

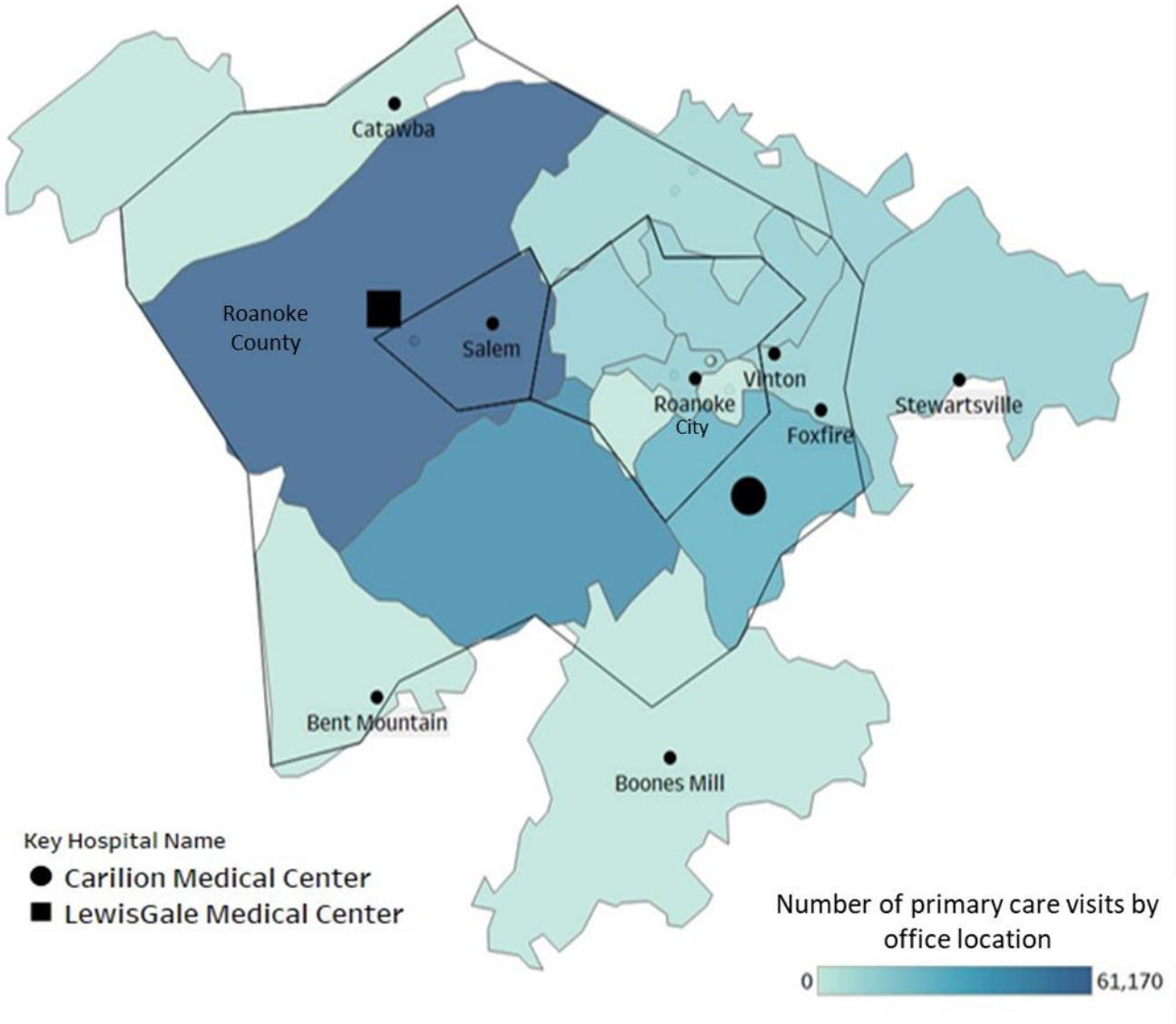
FIGURE 3: Emergency department visits by patient zip code (City of Richmond, Henrico and Chesterfield Counties)



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local public health clinics, FQHCs, and rural health clinics.

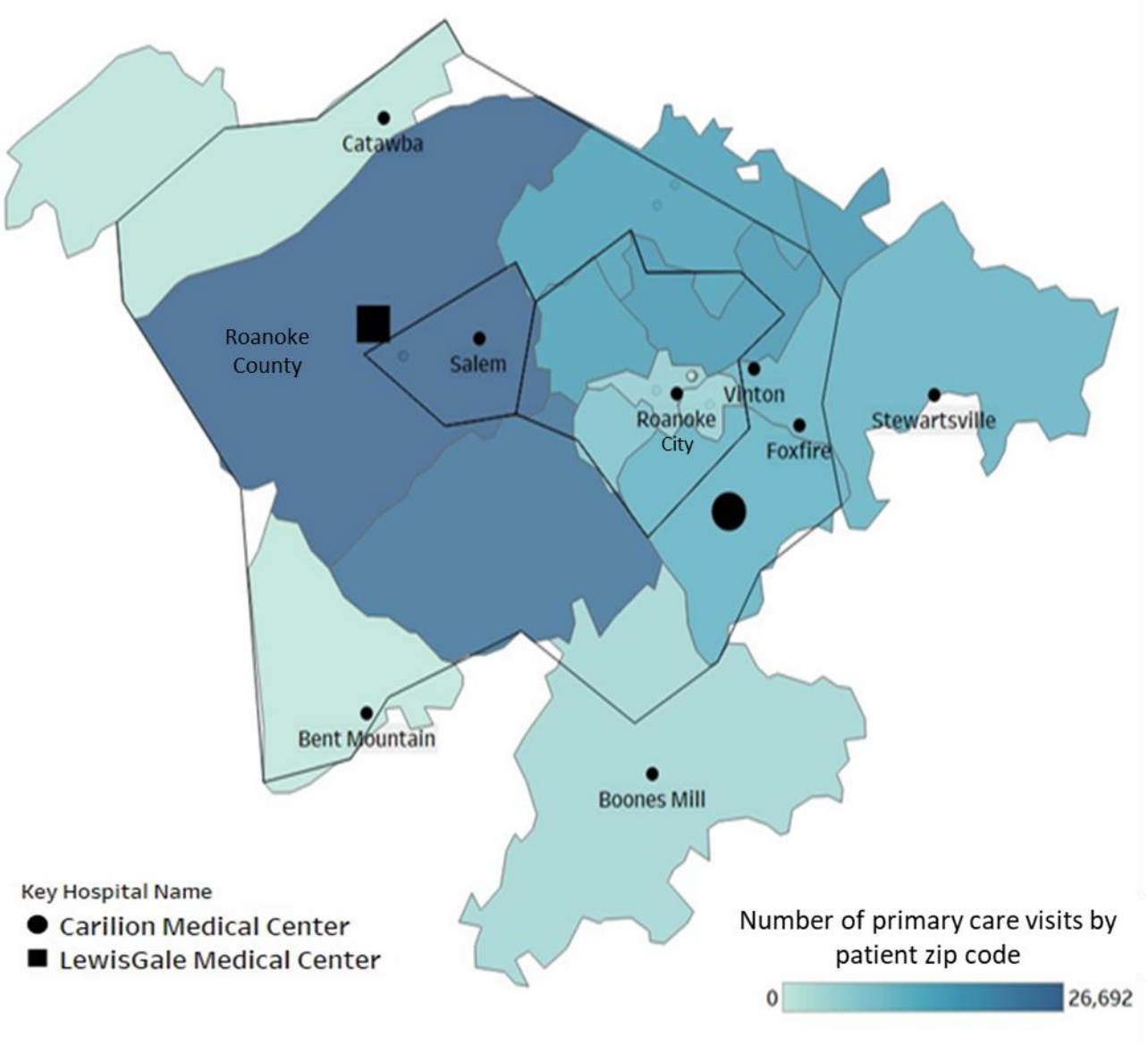
Primary care and ED utilization for the City of Roanoke, Roanoke County, and surrounding counties

FIGURE 4: Primary care visits by office location zip code (City of Roanoke, Roanoke County, and surrounding counties)



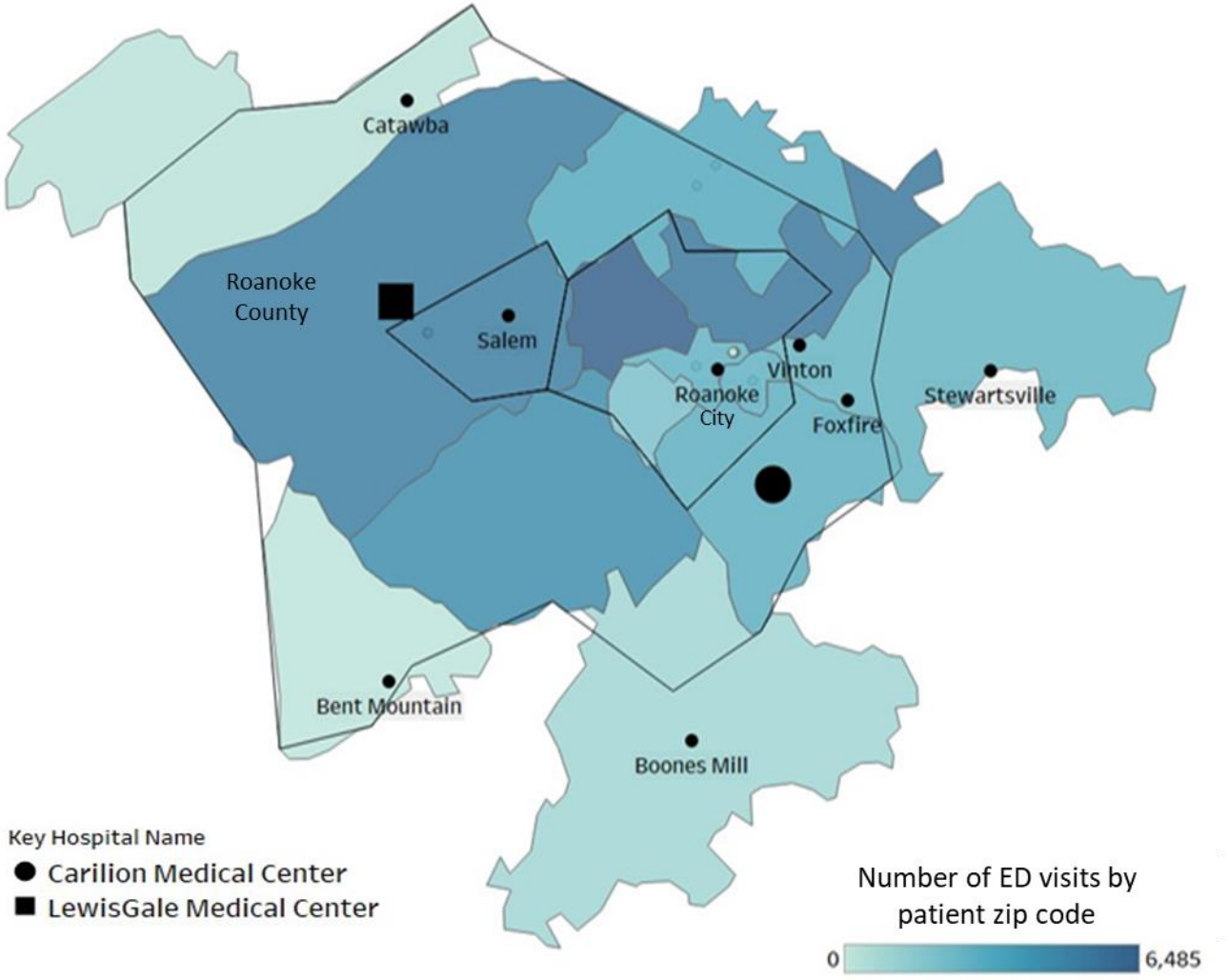
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local public health clinics, FQHCs, and rural health clinics.

FIGURE 5: Primary care visits by patient location zip code
(City of Roanoke, Roanoke County, and surrounding counties)



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local public health clinics, FQHCs, and rural health clinics.

FIGURE 6: Emergency department visits by patient location zip code (City of Roanoke, Roanoke County, and surrounding counties)



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local public health clinics, FQHCs, and rural health clinics.