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)

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September 27, 2022

The Honorable George L. Barker, Chair
Joint Commission on Health Care
411 E Franklin Street
Ste. 505
Richmond, Virginia 23219

Dear Senator Barker,

Thank you for the opportunity to comment on the Joint Commission on Health Care's Emergency Room Utilization Study and report titled Provider Data Sharing to Improve Quality of Care. Our comments are presented on behalf of Bay Aging, https://bayaging.org , a Virginia non-profit 501(c)3 with a rich history of delivering professional quality programs and services for people of all ages in the Middle Peninsula and Northern Neck.

We support the Joint Commission's recommendation for community based care management. However, we ask that consideration be given to providing this service through community based organizations. Many patients struggle with health-related social needs related to gaps in food, housing, transportation, social connections, health literacy, medication management, and other skills for managing their conditions in the home and community setting. The research shows that addressing the health related social needs significantly improves health and reduces health care costs, such as unnecessary or preventable ED admissions. Health care institutions and providers are in the business of delivering medical care. Most health systems lack the expertise and relations to effectively provide community based care coordination.

There is a strong business case for partnerships between health care and social care providers, who bring the resources and expertise that health care providers do not possess. Community based organizations (CBOs) have been working in their communities for decades addressing social needs for diverse populations, such as those with multiple chronic conditions, persons with disabilities, mental health and drug abuse issues, caregivers, and the underserved and economically disadvantaged. They have trusted relationships with the residents of diverse communities where some are skeptical of medical providers. CBOs possess expertise in a full array of services, including care management with diverse populations, meeting with individuals in their homes, linking them with resources for health related social needs, and coordinating care with medical providers.

Some healthcare entities and CBOs are exploring ways to partner through community integrated health networks that coordinate health care and health-related social supports for defined populations. Bay Aging is leading the Virginia Community Integrated Health Network, a collaboration of 250 plus stakeholders representing over one hundred organizations, including health plans, health systems, health providers, government agencies, consumers, and CBOs, creating a statewide collaboration for integrating health and social care. Community integrated health networks are beneficial for all involved, especially patients.

We support the Joint Commissions' focus on provider data sharing but recommend expanding the vision. One key to success for community integrated health networks is the ability to share health care data and social care data across providers so that care is truly coordinated. Therefore, we ask that the health data exchange include data on health-related social supports provided by community-based organizations. Such data will integrate the network and provide a measure of health related social care outcomes, such as reduced ED admissions, fewer hospital admissions, improved follow up on medical appointments, and other key performance data related to health care costs and quality.

I would welcome the chance to address the Joint Commission to share more information on the cost-effective, health-improving benefits CBOs are providing to Virginians.
Thank you for your consideration of this request and for the opportunity to comment on this comprehensive and instructive report. I am at your service to discuss any of our comments in more detail as you proceed with next steps.

Sincerely,

Kathy E. Vesley
President & CEO
Bay Aging d/b/a VAAACares®
Director of the Virginia Community Integrated Health Network

Jeffrey Lunardi
Executive Director
Joint Commission on Healthcare
411 East Franklin Street, Suite 505
Richmond, Virginia 23219

September 30, 2022

Dear Mr. Lunardi,

Thank you for the opportunity to share comments in response to the Joint Commission on Healthcare (JCHC) draft report on "Reducing Unnecessary Emergency Department Utilization." We were pleased to welcome Mr. Weiss to Inova earlier this year, and we greatly appreciate that took the time and effort to visit with our teams to learn more about Inova's emergency services across our region.

As it relates to the findings and recommendations presented in the draft report, Inova associates its comments with that of the Virginia Hospital and Healthcare Association comment letter submitted on September 30.

In response to member discussion during JCHC's September 21 meeting, we would like to provide additional information on Inova's services that support our shared goal to ensure patients have access to the right level of care, at the right place, at the right time, regardless of ability to pay.

Inova Urgent Care

Inova maintains a robust urgent care network across the Northern Virginia region. Currently, Inova's six urgent care sites are open seven days per week from 8 a.m. to 8 p.m.

Inova maintains urgent care sites in Centreville, Dulles South, North Arlington, Reston, Vienna, and West Springfield.

Recently, Inova announced a partnership with GoHealth Urgent Care that will enable expansion of Inova's physical and virtual urgent care footprint across the Northern Virginia region in the years to come. Moreover, Inova recently established a partnership with DispatchHealth to offer same-day, in-home urgent care across our service area.

Inova Community Health Services

As a component of Inova's community benefit, Inova offers several programs that support the ability of uninsured or under-resourced patients to access the appropriate level of care throughout the Inova system:

Inova Cares Clinic for Community Bridging

Inova Cares Clinic for Community Bridging was developed to bridge gaps in care that patients experience as they transfer across care delivery settings between illness and recovery. The program supports patients discharged from an Inova hospital or Inova emergency room who either do not have a medical home or cannot get an appointment with their primary care provider within 72 hours following a hospital admission. Patients are typically followed by a hospitalist or nurse practitioner for one to three visits while the patient and the care team work together to establish a permanent medical home in the community or transition the patient back to their primary care provider.

Inova Cares Clinics for Community Bridging are located in Alexandria, Fairfax, and Leesburg.

Inova Cares Clinics for Families

Inova Cares Clinics for Families (ICCF) provide comprehensive primary care services at no cost to patients who reflect the culturally diverse community we serve. Our clinics serve as medical homes for patients of all ages who qualify for Medicaid, FAMIS, Inova's Financial Assistance Program, or are uninsured. For patients who qualify for Medicaid or Inova Charity Care, Inova assists patients with the enrollment application process.

Inova Cares Clinics for Families are located in Alexandria, Annandale, Fairfax, Herndon, Manassas, and Sterling.

Inova Medical House Calls

The Inova Medical House Calls Program brings primary care to homebound patients in Northern Virginia who are 65 years of age or greater. The program provides services in the home for routine chronic disease management, urgent sick visits, common lab and imaging orders, and other services.

Patients who have Medicare, Medicaid, or are uninsured and willing to apply for Inova's Charity Care are eligible for this program.

Inova Financial Assistance Policy

Inova maintains the most generous financial assistance, or charity care, policy in the Commonwealth. Inova provides patients who have no insurance, whose income is up to 400% of the Federal Poverty Guidelines, and who meet residency requirements (thirty days residency in Inova's service area, regardless of citizenship status) a 100 percent Financial Assistance Discount (i.e., free care).

Inova also provides a Financial Assistance discount for low-income patients with insurance to assist with the cost of co-payments and deductibles. Catastrophic Financial Assistance also is available for patients with extraordinarily high medical bills.

We hope this additional information is instructive as the Commission evaluates policy options that support access to timely, appropriate care for all Virginians regardless of ability to pay. Please let us know if we can provide additional information to support the work of the Commission.

Sincerely,

Michael Forehand
Vice President, Government & Community Affairs
Inova Health System

cc: Stephen Weiss, Senior Policy Analyst

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September 30, 2022

The Honorable Senator George Barker: district39@senate.virginia.gov
CC: Jeff Lunardi, Executive Director of the JCHC: jlunardi@jchc.virginia.gov

Re: Public Comment on Policy Solutions to Reduce Unnecessary ED Utilization

Dear Senator Barker,

The Medical Society of Virginia (MSV) represents the Commonwealth's physicians, PAs, residents, and medical students across all specialties and localities. We are grateful for the members and staff of the Joint Commission on Health Care for their review, presentation, and discussion of policy solutions to reduce unnecessary ED utilization.

Feedback from our emergency and primary care physician members support many of the study's conclusions and policy recommendations. Specifically, the MSV supports policy option #1 to address how reimbursement rates and MCO contracts are primary factors limiting Medicaid patient access. When an emergency department visit is deemed "unnecessary" after the fact by an MCO and the reimbursement is reduced, it creates financial strain by continuing to undercompensate care. This practice undermines patient care, lowers operational capacity, and strains emergency department staffing.

Similarly, the MSV supports policy option #3 to enhance hospital-based managed care programs for ED patients. Hospital-based managed care and MCOs are tasked with assisting patients in understanding cost, discharge planning, medication management, and otherwise reducing barriers to care. As summarized in the study, local case management is an effective strategy to reducing ED utilization and assist patients in adhering to treatment that both reduce healthcare costs. The role of clinicians is to diagnose and treat— time spent booking appointments or navigating insurance complexities is time not spent with patients.

Thank you for considering the perspective of Virginia's physicians. If you have any questions, please contact Clark Barrineau at cbarrineau@msv.org or 704.609.4948.

Sincerely,

M. Clark Barrineau
Assistant Vice President of Government Affairs and Policy
The Medical Society of Virginia

CC:
Scott Johnson, Esquire/Hancock, Daniel & Johnson, General Counsel/ MSV
Kelsey Wilkinson, Senior Government Affairs Manager/ MSV
Aimee Perron-Seibert/ VACEP/ CSG

Anna Healy James, MBA
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Sent Via Email

September 30, 2022

Mr. Jeffrey Lunardi
Executive Director
Joint Commission on Health Care
411 East Franklin Street, Suite 505
Richmond, Virginia 23219

Re: Sentara Healthcare comments regarding unnecessary Emergency Department utilization

Dear Mr. Lunardi,

Sentara Healthcare welcomes the opportunity to comment on the topic of Emergency Department (ED) utilization and share several innovative initiatives, that we think will assist in addressing this prevalent issue facing health systems today.

As a not-for-profit healthcare system, Sentara has always felt a higher calling to serve Virginia's most vulnerable populations, especially our Medicaid, Medicare, and underinsured patients. For the past 40 years, we've been able to grown this impact by operating as an Integrated Delivery Network (IDN) - a model that align hospitals, providers and insurance plans in coordination to deliver high-quality, cost-effective healthcare services. We've seen this model enhance the quality of patient care leading to better outcomes and ultimately yielding lower provider costs, lower premiums, and improving the quality of care.

Through our IDN, we've evolved our focus to benefit the health and wellness of the communities and members we serve, spanning beyond the walls of our hospitals to impact the full spectrum of factors that impact a person's health. By delivering this comprehensive range of care, we hope to increase access and drive higher utilization of primary and preventative care services, which has potential to significantly decrease the number of patients who need to utilize an emergency department.

One way we've leveraged our IDN model to enhance access is through an innovative new model of care we launched this year called, **Sentara Community Care**. Two Sentara Community Care Centers have begun offering services in Norfolk – one inside the Union Mission homeless residential facility and a second in the medically underserved Berkley neighborhood – while the

third program is servicing the entire Hampton Roads region via the Sentara Mobile Care bus Through this initiative Sentara Healthcare – and its health plans, Optima Health and Virginia Premier – is working in and with the community to dismantle barriers to healthcare services and provide greater levels of access to vital community resources.

These centers serve Medicaid and the uninsured only and are strategically stationed within neighborhoods to reduce traditional barriers to care, such as inconvenient times and lack of transportation. Sentara Mobile Care will be present at high-profile community events, and each community's list of rotating mobile locations will be chosen to maximize convenience and proximity to other essential community organizations and services.

Sentara Community Care Centers are stationary and embedded fixtures within neighborhoods. Like Sentara Mobile Care, Sentara Community Care Centers will be placed where the greatest gaps in access to care or widest health disparities currently exist by utilizing spaces near or within affordable housing communities or by repurposing strategically located community spaces. Sentara Community Care Centers also provide co-location potential for community partners to provide wraparound services on-site to address social determinants of health. We plan to expand to 10-12 sites across Virginia and North Carolina over the next two years.

This data driven approach to access looks predominately at claims data to identify zip codes in Virginia where we saw individuals accessing the EDs instead of a primary care environment. Our analytics team then did a deeper dive on these areas looking at access points, hours of operation, existing healthcare partners (free clinics and FQHCs) to get a better understanding of the issues. Next, Sentara held community conversations with local leaders, faith-based community and others to discuss from a qualitative standpoint these access gaps. With this data, we have identified through a heat map approach, areas of concern where we can build these centers and make a real difference in providing and encouraging people to seek preventative care.

In the near term, these savings should be achieved by assisting members address their non-emergent health care needs in an alternative setting rather than the ED, which will allow Sentara facilities to more effectively handle the patients which truly need ED -level care. Additionally, we expect a reduction of visits from avoidable inpatient admissions as well, particularly admissions for uncontrolled chronic conditions that can be prevented through the comprehensive ambulatory care the Care Centers are designed to deliver. In the first month alone of this model:

- 400 individuals were assisted (130 received direct patient care from a provider)
- 150 individuals received food from the local food bank
- 62 COVID vaccines were given
- Enrolled 35 in Medicaid
- Avoided ED usage for 20-plus individuals

One patient identified at Union Mission who saw our physician had 164 ED visits in the last 15 years, most in the last three years. Our physician has now met with this patient weekly, and this individual has yet to go to the ED.

In the longer term, we believe that early intervention and access to appropriate care will lower future medical costs by preventing treatable conditions from developing into more severe cases. The Sentara Community Care initiative will help us deliver the right care, at the right time, in the right setting to some of the Commonwealth's most vulnerable citizens. We would be happy to provide additional information to the Commission if needed.

More broadly, when it comes to addressing the health needs of the communities we serve, Sentara is committed to advancing health equity and ensuring that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives.

Today, Sentara Health Plans covers more than 730,000 Medicaid members in Virginia through Virginia Premier and Optima Health. Fifty-five percent of Sentara's total revenues is from Medicaid, so we are "all-in" in producing innovative solutions to better address outcomes and costs. Further, in 2021, Sentara's health plans returned to DMAS more than $190 million through various risk mitigation mechanisms.

And last year, Sentara provided approximately $167M in uncompensated care, most of which was in our hospitals. We also invested $87M in health and prevention programs, the teaching and training of healthcare professionals and that includes $16m in grants to numerous partner organizations who provide vital services and resources directly to our communities.

We look forward to working with you to reduce unnecessary emergency department visits, provide great access to care, and improve public health outcomes across the Commonwealth. Please let us know if we can provide any additional information.

Respectfully submitted,

Anna H. James
Senior Vice President, Government and Community Relations
Sentara Healthcare

Virginia College of
Emergency Physicians

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SENT VIA EMAIL

September 30, 2022

Jeffrey Lunardi
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411 East Franklin Street, Suite 505
Richmond, Virginia 23219

RE: VACEP Public Comment on JCHC 'Reducing Unnecessary Emergency Department Utilization' Draft Report

Dear Mr. Lunardi,

We are writing to you today to respectfully submit our comments on the JCHC draft report entitled "Reducing Unnecessary Emergency Department Utilization." First and foremost, we want to thank you and your lead researcher, Stephen Weiss, for all his hard work, especially for taking the time to meet with me in the Riverside emergency department and my colleagues across the state. As an emergency physician, I can safely say this is the first time someone from the state looking into patient utilization of the emergency department came and spoke to us in our workplace and I cannot over emphasize how impactful that was to us and I hope, to him.

Many of the trends highlighted in the report are what we are seeing every day in our emergency departments: increasing acuity of the patients we are treating; much higher than normal volume of behavioral health and substance abuse patients with ever increasing wait times for in-patient psychiatric care; patients returning for care because they cannot get primary care appointments, sometimes for as long as six months; and urgent care centers having to reduce their hours due to staffing issues.

We also think it's critical to re-emphasize the importance of EMTALA, the federal Emergency Medical Treatment and Labor Act that governs the care of patients who come to the emergency department. It was outlined on page 12 of the report, along with another key term- prudent layperson- which is the lens that we as physicians must look at someone presenting in the emergency department. It is then incumbent upon us to appropriately medically screen them, determine their emergency and stabilize them. These are patient safety laws that were enacted to ensure fair and equal treatment of patients, regardless of their ability to pay and we strongly stand by these important guidelines.

But as is outlined in the report, it makes it impossible and illegal, for any emergency physician to turn anyone away at the door. However, we are extremely supportive of continuing to work together to find ways to help patients get the care they need in the community- for both physical and mental health needs- so they don't have to get to the point where their condition becomes an emergency and they need the care we can provide.

To that end, here are our comments on the policy options presented in the report and some that we hope the JCHC will choose to add moving forward.

Policy Option 1: Direct DMAS to collect and report on claim denials from MCOs by provider type.

Support. The report outlines many reasons that primary care physicians, urgent care centers and even specialist encounter significant barriers when considering whether to take Medicaid patients. Further identifying what those payment barriers may be and how they vary by specialty is important. We would ask that emergency physicians also be included when looking at MCO claim denials because we are the only physician specialty who takes care of all patients, including Medicaid.

Policy Option 2: Direct a study of primary care practice scheduling processes for Medicaid enrollees, including whether Medicaid enrollees can get appointments in compliance with Medicaid MCO contracts.

Support, but expand study. We ask that this policy option be broadened to include a deeper analysis of how we are truly defining and tracking Medicaid MCO network adequacy when it comes to patient access to primary care physicians. Appointment availability in a timely manner needs to be addressed. A network should not be considered "adequate" if Medicaid patients who come to the ER cannot then get a primary care appointment for six months or longer. Network adequacy should also look at a practice's ability to take new patients. Without places to refer patients, they will have no choice but to return to the ED for care when their condition worsens.

Policy Options 3 and 4: Establish two grant programs for hospital and ambulance-based care management.

Support. The draft report identifies positive examples of these care management programs that could be expanded throughout the Commonwealth with the support of appropriate funding. It makes sense to look to EMS and first responders as continued allies in the effort to reduce ER utilization.

Policy Option 5: 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.

Generally support. This will require more details on how they will be collected and for what purpose. We certainly understand the role that social determinants of health play on the care our patients seek. It's important that all the coding participants agree that having these codes collected and submitted are useful and appropriate. Having "clean claims" is an issue on the payment side and we would not support having these codes collected and then the insurers rejecting the claims because having the codes on there are not technically diagnostic in nature. We do not support additional administrative burdens that do not benefit the patients we are caring for.

Policy Option 6: Require freestanding emergency departments to better identify themselves to patients.

Oppose. We are very concerned that any further signage requirements beyond the required "Emergency Department" signs could discourage someone who is having an

emergency from seeking care. As emergency physicians, we do not support any barriers to patients seeking emergency care who need it right away. Any regulations that make patients second guess seeking treatment, especially for potential financial reasons, is in direct opposition to the federal EMTALA law that governs patient care. Providing information through signage to a patient when they are in the ED or telling them about financial issues could very well be a violation of EMTALA for the physician and the hospital.

We further request that you add additional options as outlined below:

Additional Policy Option 7: Repeal the budget policy of automatically downcoding of fees for emergency department visits based solely on a diagnosis list of 800 medium and high-risk codes (Item 304 HHH.1.)

It is clear from the report, particularly noted on page 22, that there are serious questions about this policy violating a variety of federal CMS regulations and guidance. We, along with VHHA, strongly believe this provision of the state budget does exactly that and we ask you to advocate for the repeal of the policy. There is no evidence that this policy reduces ER utilization or changes patient behavior. Rather it's clear all it does is single out the one set of physicians who are mandated by EMTALA to evaluate and treat patients without regard of their ability to pay and penalizes the physicians for providing care to VA Medicaid patients.

Instead of saving the MCOs money by not paying physicians, we ask you instead to focus on the other policy options offered in the JCHC report and in the previous 2 year DMAS report entitled "Medicaid Payment Policy and Care Coordination Workgroup Report."

Additional Policy Option 8: Incorporate the following recommendations of the DMAS "Medicaid Payment Policy and Care Coordination Workgroup Report" into the JCHC report.

In 2020, DMAS convened a two-year workgroup as directed by the state budget to develop recommendations to reduce ER utilization and improve care coordination. Some of the items that we recommend incorporating into the JCHC policy options are as follows:

- Increase primary care rates to promote increased access to care
- Include coverage of, and payment for, complex chronic care management services
- Targeted increased payment rates for access-promoting services
- Develop embedded care coordination models in areas with high behavioral health needs
- Increase access to behavioral health providers in the continuum
- Fund direct connection between MCOs and a community-based organization network coordinate to address related social needs

Additional Policy Option 9: Investigate Medicaid MCO compliance with existing contract provisions related to reducing non-emergent and preventable emergency department visits and coordination of care and related performance metrics.

There are several requirements of Medicaid MCO contracts that are directed towards reducing non-emergent and preventable emergency department visits, ensuring network adequacy, and improving coordination of care. JCHC should investigate the effectiveness of these contract provisions and related performance and outcomes to determine if Medicaid MCOs are following their contractual obligations to DMAS and Medicaid enrollees and whether any modifications are required.

We thank you for your time and consideration of our comments and request for additional policy options. We look forward to working with the JCHC staff and members as we all continue to work to ensure access to care across all spectrums of service and we will continue to provide excellent emergency care to all the patients who come to our emergency departments.

Please do not hesitate to contact us. We would welcome the opportunity to further discuss this issue with you.

Sincerely,

Todd Parker, MD, FACEP
President
Virginia College of Emergency Physicians

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SENT VIA EMAIL (jchcpubliccomments@jchc.virginia.gov)

September 30, 2022

Jeffrey Lunardi
Executive Director
Joint Commission on Health Care
411 East Franklin Street, Suite 505
Richmond, Virginia 23219

RE: **VHHA Public Comment on JCHC Reducing Unnecessary Emergency Department Utilization Draft Report**

Dear Mr. Lunardi,

On behalf of the Virginia Hospital & Healthcare Association (VHHA), please accept these comments submitted in response to the Joint Commission on Health Care (JCHC) draft report titled "Reducing Unnecessary Emergency Department Utilization." We appreciate this opportunity to comment on the various policy options contained in the report and to provide information in response to questions raised by members of the Commission in its September 21, 2022, meeting at which the report was presented. We also appreciate the amount of work that Stephen Weiss put into developing the draft report, particularly by undertaking to visit hospital emergency departments (EDs) across the Commonwealth.

Before injecting any specific comments or responses to requests for information, we would like to highlight two fundamental concepts in federal law that underlie patient care and provider duties in hospital emergency departments. The first is the "prudent layperson standard" through which the existence of an "emergency medical condition" is determined based upon a patient's symptoms, not a patient's final diagnosis following medical treatment and evaluation. Federal regulations define an "emergency medical condition" to include:

> [A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a *prudent layperson*, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
>
> (i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
> (ii) Serious impairment to bodily functions.
> (iii) Serious dysfunction of any bodily organ or part.[1]

The second is the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospital emergency departments and physicians to provide a medical screening examination when a patient presents to the emergency department requesting examination or treatment for an emergency medical condition (as determined by the prudent layperson standard), regardless of an individual's ability to pay. If an emergency medical condition exists, hospitals are then required to provide stabilizing treatment for patients within the hospital's capacity and capability. If a hospital is unable to stabilize a patient within its capacity and capability, or if the patient requests, an appropriate transfer is required.[2]

[1] 42 C.F.R. § 438.114 (emphasis added).
[2] *See* 42 U.S.C. 1395dd.

Both of these laws are designed to protect patients and ensure that where they reasonably believe that they are experiencing an emergency medical condition, they will receive treatment, regardless of ability to pay. These are critical protections for patients and it is important to keep in mind when considering any strategies to reduce visits to the emergency department, that once a patient presents to the hospital emergency department (or anywhere on the "campus" of the hospital defined as 250 yards from the main buildings or at an off-campus facility that is a designated emergency department) seeking examination or treatment, the hospital emergency department or physician *must* provide a medical screening examination. The patient cannot be redirected to any other more appropriate site of care without first conducting a medical screening examination, and if an emergency medical condition is determined to exist, any necessary stabilizing treatment. Stated differently, once the patient has presented to the emergency department, the opportunity to treat the patient in a more appropriate setting, such as a primary care office or urgent care clinic, is not possible.

We state this to point out the challenges that hospital emergency department physicians face in assisting with efforts to reduce unnecessary emergency department utilization. It is a reality of the regulatory environment in which we operate. That being said, hospitals and physicians recognize the importance of ensuring patient access care at the most appropriate setting at the most appropriate time, and that we play an important role in this as part of the larger health care delivery system.

Review of Findings

The findings identify several trends in emergency department utilization that are consistent with data collected and shared among our members:

- Decrease in emergency department visits coupled with increasing severity and intensity of visits.
- Medicare and Medicaid recipients are seen in the emergency department at a higher rate than individuals with commercial insurance.
- A marked increase in emergency department visits following Medicaid Expansion, particularly for mental health and substance use disorder related conditions.
- Increased utilization in emergency department visits for mental health and substance use disorders despite an overall decline in visits.
- Increased utilization in emergency department visits for mental health and substance use disorders continues to have a significant impact on hospital emergency departments.

Despite these trends, it is promising that Virginia's statewide emergency department utilization rate is among the lowest in the nation. The findings indicate that the cost of visits is increasing, but this is consistent with findings that visits are of higher intensity involving more complex patients, and that efforts to reduce avoidable emergency department visits and treat lower intensity needs in more appropriate settings are having an impact.

We agree with the focus on identifying situations where patients go to the emergency department when their condition or medical needs could have been addressed earlier in a lower cost, community setting, including both preventable and non-emergent visits as defined in the draft report. We reiterate, however, that even if preventable or non-emergent, once the patient presents to the emergency department, the hospital and physician are obligated to provide a medical screening and examination to determine if an emergency medical condition exists, and if it does, to provide stabilizing treatment.

There are several findings in the draft report that point to the conclusion that any policy options adopted to reduce preventable and non-emergent visits should focus on ensuring that there is appropriate access to care outside of the hospital emergency department, improving coordination of care for patients before and after they receive care in an emergency department, especially for those with chronic conditions and in higher need populations, and addressing unmet behavioral health needs. Such findings are consistent with strategies

highlighted in a 2014 Informational Bulletin from the Centers for Medicare & Medicaid Services providing guidance to states to reduce non-emergent use of hospital emergency departments ("2014 CMS Bulletin").[3] It identifies three main approaches for states to reduce non-emergent use of emergency departments and to deliver care in the most appropriate settings: (1) broadening access to primary care services; (2) focusing on frequent emergency department utilizers to best address the needs that bring them back to the emergency department; and (3) targeting the needs of people with behavioral health problems.

The findings focus largely on the role of hospitals and physicians in treating patients, coordinating care, and addressing the needs of patients seeking care in emergency departments. Additional and more in-depth discussion is needed on the role of health insurers and managed care organizations (MCOs) in reducing preventable and non-emergent visits, ensuring that there is appropriate access to care outside of the hospital emergency department, and that there is improved coordination of care for patients. Of particular importance for the Commonwealth is the role of Medicaid MCOs, especially given findings of higher utilization of emergency department visits in this population.

Federal regulation of Medicaid MCOs at 42 C.F.R. § 438.208 requires MCOs to implement procedures that ensure coordinated patient care for all members, paying particular attention to the needs of enrollees with complex, serious, or disabling conditions. In accordance with 42 C.F.R. § 438.208(b), the DMAS Medallion 4.0 Managed Care Services Agreement specifically states:

- "The Contractor shall maintain adequate provider network coverage to serve the entire eligible populations . . . twenty-four (24) hours per day, seven (7) days a week.
- The Contractor shall make arrangements to refer members seeking care after regular business hours to a covering physician or shall direct the member to go to the emergency room when a covering physician is not available . . . . In accordance with § 38.2-4312.3, as amended, the Contactor shall maintain after-hours telephone service . . . for the purpose of rendering medical advice, determining the need for emergency and other after-hours services."
- "Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the member's request."
- "Appointments for routine, primary care services shall be made within thirty (30) calendar days of the member's request."
- The contractor shall have in place a specific process for hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via toll free phone line to obtain assistance from members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternative treatment setting."
- Similar provisions are contained in the Commonwealth Coordinated Care Plus MCO Contract.

As noted in the draft report, many of the factors that contribute to preventable and non-emergent visits relate to access to and utilization of appropriate primary care and community-based support services. As demonstrated by these contract provisions, Medicaid MCOs are explicitly charged with and are compensated for ensuring adequate networks to provide needed care, coordinating care across settings, and providing case management services for complex cases.

[3] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf.

Option 1: Direct DMAS to collect and report on claim denials from MCOs by provider type.

VHHA supports this policy option. For reasons discussed above, identifying barriers to greater access to primary care is critical to reducing preventable and non-emergent visits. Low reimbursement rates, administrative hassle, and untimely reimbursements are often cited as reasons why physicians choose not to participate in some public and private programs. Administrative hassle has also been shown to be a significant contributor to provider burnout, creating a larger impact on the overall healthcare workforce.

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

VHHA generally supports this policy option. The suggestion that automated scheduling programs are creating unintended consequences for Medicaid patients and patients of color is concerning and should be investigated. Although, for purposes of focusing on overall access to care, we think greater emphasis should be placed on ensuring that Medicaid MCOs are meeting standards for network adequacy and patient access. This should include travel time and distance standards, appointment availability, and readily available access to non-emergency transportation.

Options 3 and 4: Establish two grant programs for hospital and ambulance-based care management.

VHHA supports these policy options. The draft report identifies positive examples of these care management programs that could be expanded throughout the Commonwealth with the support of appropriate funding.

Option 5: 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.

VHHA generally supports this policy option. In the 2022 General Assembly, VHHA advocated for HJ5/SJ42 which aimed to study the current landscape of social care and best practices; the weight health disparities have on the Commonwealth's health care delivery system; and the details, benefits, and costs of possible public policy interventions and payment reform. This included the use of Z-codes in addressing social determinants of health and health disparities, and in helping to reduce non-urgent emergency department utilization and hospital readmission. Z-codes are ICD-10-CM codes used by hospitals and other providers to identify and track the health-related social needs of patients. To date, unlike many other diagnostic codes, they play no part in the billing process. Virginia hospitals are national leaders in Z-code utilization. In 2019, only 1.59% of Medicare beneficiaries had claims including a Z-code. In 2020, 9% of all Virginia hospital discharges had at least one Z-code, more than three times the national average.

We have heard anecdotally; however, that including Z-Codes and other codes not approved by health insurers and Medicaid MCOs can result in rejection of claims or delays in payment of claims. Accordingly, any requirement for providers to submit codes must be coupled with a requirement for health insurers and Medicaid MCOs to accept them and ensure that they do not result in denial of or delays in payment of claims. Consistent with Option 1, it is also important to ensure that this does not create an additional administrative burden for providers.

Option 6: Require freestanding emergency departments to better identify themselves to patients.

VHHA does not support this policy option. The draft report cites other states that have passed laws to require freestanding emergency departments ("FSEDs") to better identify themselves with signage laws and consumer information to eliminate confusion, but there are various reasons why the same risks of patient confusion is not present in Virginia. Other states such as Florida and Texas have passed such laws, but the regulatory framework in Virginia is different than in other states.

From a regulatory standpoint, there are two types of "freestanding" emergency departments" — hospital affiliated and independent non-hospital affiliated. Virginia law only allows hospital-affiliated freestanding emergency departments. These hospital affiliated emergency departments are owned by and financially, clinically, and operationally integrated with a hospital and typically bill under the same National Provider Identifier as the affiliated hospital. In this regard they are not truly "freestanding."

Under Virginia law, hospital affiliated emergency departments are a department of the hospital and included on the same hospital license as the affiliated hospital, and under VDH licensure rules and CMS regulations, cannot be located more than 35 miles from the affiliated hospital. They must comply with the same federal and state regulations applicable to hospitals, including EMTALA and Medicare conditions of participation, which include strong patient rights protections.[4] Virginia licensure requirements for hospital emergency departments include requirements for 24-hour physician coverage and nurse staffing, and equipment and ancillary services commensurate with scope of anticipated needs, including radiology and laboratory. Additionally, hospital affiliated emergency departments are included in the financial assistance policy for the hospital, providing support for indigent and low-income uninsured patients.

These hospital affiliated emergency departments are distinguished from independent freestanding emergency departments, which can be owned by a multitude of outside groups. Independent freestanding emergency departments are not permitted under Virginia law and are not recognized as hospital departments or as emergency departments by CMS and thus are not subject to the same licensure rules and CMS regulations, including EMTALA and Medicare conditions of participation. As a result, patients have fewer protections in independent freestanding emergency departments. Because they are not subject to EMTALA, they are not obligated to accept all patients regardless of ability to pay. Under Medicare billing rules, the services are billed as a physician visit and the patient is responsible for paying a separate facility fee.

As demonstrated in the findings, hospital-affiliated emergency departments appear to serve patients with a similar mix of severity to emergency departments located in the main hospital and as discussed above, hospital-affiliated emergency departments have the same billing rules as emergency departments in the main hospital. This suggests that additional regulation of hospital-affiliated emergency departments is not indicated.

Furthermore, we are concerned that implementing signage and provision of consumer information requirements for hospital-affiliated emergency departments could create a chilling effect on patients seeking access to treatment of an emergency medical condition. Patients believing that they may be experiencing an emergency medical condition require expedient medical attention. Regulations that cause patients to second-guess seeking immediate treatment for financial reasons or require additional communications with staff will delay treatment and could result in patient harm. Additionally, for reasons discussed above, once the patient has come to the emergency department seeking treatment for an emergency medical condition (as determined by the patient under the prudent layperson standard), providing information about possible alternatives or financial consequences could cause the hospital and physician to violate EMTALA. Similarly, any signage in the emergency department that could have the effect of deterring patients from seeking care could result in a violation of EMTALA.[5]

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[4] For example, CMS requires the posting of an Outpatient Medicare Coinsurance Notice and for the same notice to be given to patients with financial materials. This notice informs patients that the facility operates and will be billed as a hospital, and that the patients may incur multiple bills (*e.g.*, physician bills) for their visit.

[5] In 2013, CMS strongly discouraged the use of pain posters to address inappropriate opioid-seeking behavior. In a guidance letter CMS stated that the suggested (and any similar) language "might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions, thereby violating both the language and the intent of the EMTALA statute and regulations." When questioned further, the author explained the sign "appears designed to indiscriminately discourage any individual seeking treatment for pain from remaining in the ED for a medical screening examination or from coming to that ED in the future." *See* ACEP Now. (2014, January 8). ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA https://www.acepnow.com/article/ed-waiting-room-posters-prescribing-pain-medications-may-violate-emtala/.

Additional Option: Reverse the Medicaid emergency department downcoding penalty.

The draft report at page 22 discusses a provision of the state budget that allows Medicaid MCOs to automatically downcode and reduce fees paid to hospital emergency departments and physicians claims 99282 (Level II), 99283 (Level III), and 99284 (Level IV), to 99281 (Level I) based solely upon a list of almost 800 diagnosis codes, regardless of the intensity or amount of services actually provided. We believe that the downcoding penalty violates the prudent layperson standard and federal Medicaid regulations that prohibit DMAS and Medicaid MCOs from (i) denying payment for treatment for an emergency medical condition and (ii) limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

As highlighted above in discussion of the prudent layperson standard, the existence of an emergency medical condition is determined based upon a patient's symptoms, not a patient's final diagnosis following medical treatment and evaluation. In other words, the cornerstone of what constitutes a Medicaid-covered emergency medical condition is a patient's symptoms, as would be perceived by a prudent layperson. It is for this reason that federal regulations prohibit an MCO and DMAS from denying payment for treatment when an enrollee had an emergency medical condition, even if the absence of immediate medical attention would not have resulted in placing the health of the individual (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[6] This language prevents MCOs or DMAS from denying payment for treatment obtained when an enrollee had an emergency medical condition, even in cases that may not have resulted in the outcomes specified in the definition of "emergency medical condition."[7]

Federal regulations also prohibit MCOs and DMAS from limiting "what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms."[8] CMS has stated that the prudent layperson standard "clearly requires managed care plans and states to base coverage decisions for emergency services on the apparent severity of the symptoms at the time of presentation" and that the "final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis."[9]

The assumption underlying the downcoding penalty is that so-called "avoidable emergency room claims" do not necessarily require emergency department level services. This is incorrect. In fact, the explanation of the genesis of the list of diagnosis codes used for the downcoding penalty contained in the DMAS Clinical Efficiency Performance Measure Technical Specifications SFY 2021 Version 1.0 (April 2020) states the opposite:

> These [diagnosis codes] are *not intended to imply that members did not need or should have been denied access to ERs*. Instead, the analyses are designed to reflect the objective that more effective, efficient, and innovative managed care could have prevented or preempted the need for some members to seek care in the ER. The [diagnosis code list] *identifies visits that could have occurred in a lower acuity setting or been avoided through the provision of consistent, evidence-based, primary care, proactive care management and health education*.

[6] 42 C.F.R. § 438.114(c)(1)(ii)(A).
[7] *Id*.
[8] 42 C.F.R. § 438.114(d)(1)(i).
[9] 81 Fed. Reg. 27498, 27749 (May 6, 2016). CMS has also addressed MCO payment requirements in an April 2000 letter to State Medicaid Directors stating that when an MCO or a state denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard has been met must be focused on the presenting symptoms and not on the final diagnosis, and must further take into account that the individual seeking emergency services is making the decision as a prudent layperson (rather than a medical professional). *Available online at* https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd041800.pdf.

When hospital emergency departments and physicians render care, they do so based upon a patient's presenting symptoms as required by EMTALA.[10] A patient's ultimate final principal diagnosis does not constitute an accurate or reliable indicator of the care that was necessary when the patient presented to the emergency department.

Further, the 2014 CMS Bulletin specifically raises concerns about EMTALA compliance when states implement policies of pay differentials in an effort to decrease inappropriate ED utilization. CMS asserts that states need to be sensitive to the "potential that methodologies intended to affect provider or enrollee behavior in the ED, if not designed properly, could create provider EMTALA compliance issues." The 2014 CMS Bulletin further notes that "[g]enerally, hospitals must fulfill their obligations to an individual under EMTALA prior to employment of any processes required by a specific payer."[11]

At the same time, the 2014 CMS Bulletin also raised concerns about state-based strategies that attempt to reduce ED usage by determining a patient's need for those services on an individual basis. CMS stated that experience and research suggest that "narrow strategies to reduce ED usage by attempting to distinguish need on a case by case basis *have had limited success in reducing expenditures to date*" due in part to the multitude of unmet health needs and limited access to alternative health care services for the Medicaid population.[12]

Several of the policy options presented in the draft report are all appropriately aimed at addressing these unmet health needs and limited access. Accordingly, we respectfully submit that the downcoding penalty be reversed and that these more appropriate policy options be pursued. Penalizing hospital emergency departments and physicians for performing their duties to patients and complying with EMTALA is not an equitable or effective means of reducing preventable or non-emergent visits to the emergency department.

Additional Option: Incorporate recommendations of the DMAS Medicaid Payment Policy and Care Coordination Work Group Report to the Joint Committee for Health and Human Resources Oversight into the policy options being considered by JCHC.

Pursuant to a provision contained in the state budget,[13] DMAS convened a workgroup to evaluate and develop strategies and recommendations to improve payment policies and coordination of care in the Medicaid program. Its charge included assessing how to prevent inappropriate utilization of emergency department services. The report for this study included several policy recommendations that are consistent with the findings and recommendations included in the draft report.[14] These include:

- Increase primary care rates to promote increased access to care.
- Include coverage of complex chronic care management services.
- Targeted increased payment rates for access-promoting services.
- Develop embedded care coordination models in areas with high behavioral health needs.
- Increase access to behavioral health providers in the continuum.
- Fund direct connection between MCOs and a community-based organization network to address related social needs.

Additional Option: Investigate Medicaid MCO compliance with existing contract provisions related to reducing non-emergent and preventable emergency department visits and coordination of care and related performance metrics.

[10] 42 U.S.C. § 1395dd.
[11] *Supra* note 15
[12] *Id.* (emphasis added).
[13] Item 313 YY of the 2021 Appropriation Act.
[14] https://rga.lis.virginia.gov/Published/2021/RD569

As discussed above, there are several requirements of Medicaid MCO contracts that are directed towards reducing non-emergent and preventable emergency department visits, ensuring network adequacy, and improving coordination of care. JCHC should investigate the effectiveness of these contract provisions and related performance and outcomes to determine if Medicaid MCOs are in compliance with their contractual obligations to DMAS and Medicaid enrollees and whether any modifications are required.

Response to member inquiries regarding establishing urgent care facilities.

JCHC members asked for more information on efforts by hospitals to establish urgent care facilities as an alternative to the emergency department. In keeping with their missions to ensure access to quality, affordable care, many hospitals and health systems have dedicated resources to develop urgent care facilities or alternatives to emergency department visits at times when more traditional medical providers are not available to provide services. While not all-inclusive of these ongoing efforts, below are examples of innovative initiatives currently underway:

- Riverside Health System operates five urgent care locations that are open seven days a week during the hours of 9:00 AM to 9:00 PM.
- Carilion Clinic VelocityCare provides urgent care medical services 365 days a year for non-life-threatening illnesses and injuries. With no appointment necessary and extended hours, patients can walk into one of six locations for the treatment of common ailments.
- HCA operates three Care Now clinics in Northern Virginia and in June 2022, HCA purchased BetterMed with eight locations in the Richmond market. These clinics are typically open during the hours of 8:00 AM to 8:00 PM daily with reduced hours on Sundays.
- Sentara Healthcare has recently established two neighborhood clinics – one with an emergency homeless shelter to provide access to care for vulnerable populations. Additionally, Sentara Healthcare has deployed mobile care vans to provide care to patients in the community where limited options may be available.
- UVA Health launched a virtual urgent care service in the hospital emergency department during COVID-19, which has continued successfully. UVA Health also has plans to work with a major national insurer on an effort to improve access to virtual urgent care through community pharmacies.
- VCU Health launched a successful virtual urgent care service through the hospital emergency department, which continues today. Additionally, VCU Health operates an urgent care clinic at its campus in Tappahannock, Virginia.
- Mary Washington Healthcare currently operates two urgent care centers and anticipates opening additional sites. These sites provide services twelve hours a day during the week and eight hours a day on the weekend.

Some health systems report that they are evaluating utilization patterns in their markets to identify community needs and optimal locations for urgent care facilities. Others report that they have attempted to operate an urgent care center in the vicinity of hospital emergency departments, but that this proximity actually created more confusion for patients, due in part to EMTALA requirements. Hospitals and health systems also report that they typically include on their websites and social media, information to educate patients on when to utilize urgent care versus an emergency department. Lastly, although not specifically asked by JCHC members, health systems are also developing community paramedics programs similar to those referenced in the draft report.

Response to member inquiries regarding patient medical homes and care coordination within hospitals.

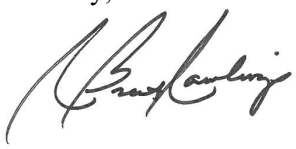
JCHC members asked for more information on efforts by hospitals to establish patient medical homes and care coordination models within hospitals and health systems. Again, in keeping with their missions to

ensure access to quality, affordable care, many hospitals and health systems have dedicated resources to develop these models even though payment structures from health insurers and Medicaid MCOs have not aligned to support them financially. While not all-inclusive of these ongoing efforts, below are examples of initiatives currently underway:

- Riverside Health System primary care locations integrate medical home standards in their practices using an ambulatory care coordinator model with patients assigned to a coordinator based upon risk.
- VCU Health has an emergency department "super utilizer" program that uses a care coordination model and medical homes designed to address the needs of these patients and decrease utilization of emergency department visits. This involves care coordination teams in multiple settings across the health system, emergency departments, specialty clinics, and primary care practices.
- VCU Health has complex care clinics that are medical homes designed for complex patients (those having five or more chronic illnesses or a history of frequent emergency department utilization or recurrent hospitalization). This model includes screening patients for social determinants of health, navigating patients to available community resources, and providing frequent follow-up care by medial home teams.
- Carilion Clinic has a formal high-utilizers committee to manage and develop care plans for frequent emergency department utilizers.

Thank you for your consideration of these comments. Please let us know if we can provide you with any further information on this matter.

Sincerely,



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September 30, 2022

Jeff Lunardi
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Joint Commission on Health Care
411 E. Franklin Street, Suite 505
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Re: Comments Regarding the Study, *"Reducing Unnecessary Emergency Department Utilization"*

Thank you for the opportunity to provide comments regarding the Commission's recent study regarding reducing unnecessary emergency department (ED) utilization. The Virginia Association of Health Plans represents ten health plans that provide health insurance coverage to 5 million Virginians; six of these plans operate managed care organizations (MCOs) that provide Medicaid to over 2 million residents. As health insurance providers, we are very interested in reducing unnecessary ED utilization and supporting access to alternative care options, such as urgent care centers, to appropriately serve individuals.

With respect to Option 1, which requests DMAS to collect the number of MCO claim denials, reason for denials, and claim resubmissions by provider type, VAHP would like to note that a workgroup at the Bureau of Insurance is looking at a potential dashboard that includes this type of information. The results of that workgroup's deliberations will be reported to the General Assembly on November 1, 2022. We strongly encourage these two efforts be coordinated to streamline efficiency for the health plans, policy makers, and health system stakeholders. We do not believe claims denial is a substantive cause of ED utilization.

VAHP would like also to emphasize that these metrics alone will not provide a complete picture of why certain groups utilize the ED more than others. Another important set of metrics is related to urgent care and primary care office hours and how that impacts patient's access to care. The majority of physician practices in Virginia are owned by hospital systems. Consequently, any study of this issue requires a closer look at how this incentivizes or disincentivizes utilization of the ED, urgent care, and primary care.

VAHP encourages policy makers to look carefully at variations in primary care and urgent care access hours by practice ownership status. Ideally, Medicaid provider reimbursement would incentivize hospital systems that own physician practices and urgent care centers to extend urgent care and primary care office hours/access to divert individuals from the ED. There also should be a close look at hospital systems and location of urgent care centers by ownership status and how these two interact with each other. The current system incentives do not encourage hospital systems to divert to urgent care, in fact, they do the exact opposite. Furthermore, hospitals continue to heavily advertise their Eds with billboards touting short wait times to presumably encourage use by those who have no cost-sharing requirements. It may be necessary for the Commonwealth to consider ensuring the creation of primary care after hours office or urgent care facilities near high volume Eds if the ED owner will not offer the service.

Option 2 will help drill down on these complex issues further, but another important piece of how and when individuals use care are the financial incentives. Commercially insured patients are often charged significant fees for ED use when they are not admitted (e.g. $300 or more) and this spurs greater utilization of primary care and urgent care where cost-sharing is lower. There are no such incentives for Medicaid patients. While a large co-pay may not be appropriate for this patient population, the stakeholders asked to study primary care access and utilization in Option 2 should consider ways to better incentivize primary care utilization for Medicaid members.

Options 3 and 4 recommend funding to establish a grant program for enhance hospital-based care management programs for high ED utilizers and other at-risk patients as well as ambulance-based care management programs. VAHP respectfully asks the Joint Commission to consider the important role MCOs play in care coordination and how that would interface with any hospital-base care management programs. These programs should not overlap with the requirements MCOs have to conduct care coordination and ensure Medicaid enrollees are utilizing the ED appropriately. A grant program with one time or limited funding might duplicate effort and requirements already in place for the Medicaid MCOs.

VAHP supports Option 5 to collect additional data regarding patient needs. VAHP also supports Option 6, freestanding emergency departments are equipped with many resources to care for patients in an outpatient setting. However, these facilities do not have the necessary resources to treat critical patients requiring inpatient care. Permitting these facilities to provide inpatient care without full integration with a hospital can present a significant risk to the health and safety of patients who would either require a transfer to a higher level of care or a receive a substandard level of treatment due to both the physical environment and caregivers available at the facility. Any efforts to better educate individual patients about these risks as well as additional cost-sharing they may incur are valuable.

Best regards,

Doug Gray
Executive Director