JOINT COMMISSION ON HEALTH CARE

REDUCING UNNECESSARY EMERGENCY DEPARTMENT UTILIZATION

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

COMMISSION DRAFT

COMMONWEALTH OF VIRGINIA
RICHMOND
2022

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Reducing Unnecessary Emergency Department Utilization

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Reducing Unnecessary Emergency Department Utilization

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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.

Reducing unnecessary emergency department utilization

The Joint Commission on Health Care directed staff to review emergency department (ED) utilization in Virginia and to provide options the Commonwealth may take to address unnecessary ED utilization. Specifically, the study resolution (Appendix 3) directed staff to:

- review recent trends in emergency department utilization in Virginia, including the types and severity of conditions commonly treated in emergency departments;
- assess how health insurance coverage and access to primary care impact emergency department utilization;
- assess the impact of free standing emergency departments on utilization, cost and access to care; and
- identify options the General Assembly can pursue to ensure Virginians can be treated in lower cost, primary care, and other preventive settings when appropriate.

Data used in this report was provided to the Joint Commission on Health Care staff from Virginia Health Information (VHI). VHI operates several programs that collect information from hospitals, other health care providers, and health insurance carriers. The two main sources of data are from the Annual Licensure Survey Data (ALSD) and the All Payers Claims Database (APCD). The APCD and ALSD datasets are different, come from different sources and the level of analysis from each source is limited by their content. Throughout the report the data source is noted in tables and figures, and a more complete description of the data sources can be found in Appendix 1.

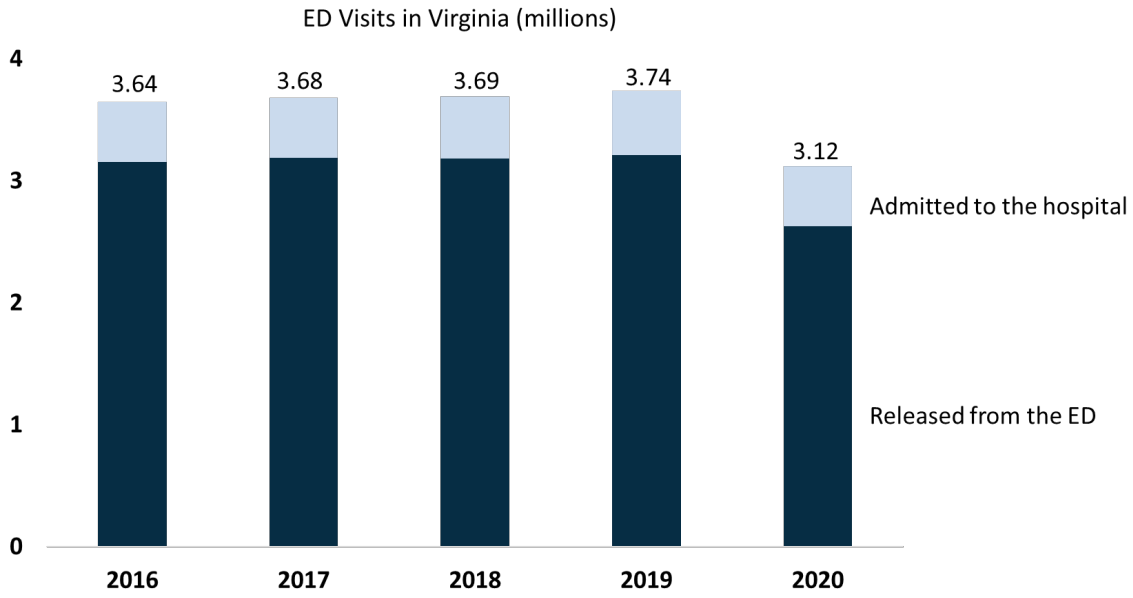
Total ED visits in Virginia decreased over the last five years while severity and cost per visit increased

Reducing the use of emergency departments has been a focus in Virginia for many years. The first step to reducing ED use is to understand the current trends in utilization. Not all changes in ED utilization represent "unnecessary" use, or problems that can be fixed. However, understanding what is driving changes in utilization and cost can help inform future policies to ensure patients are seen at the most appropriate, cost-effective setting.

Total ED visits in Virginia remained steady until 2020, the first year of the COVID-19 pandemic

There were 3.1 million ED visits recorded in Virginia in 2020, a rate of 36.3 visits per 100 residents. This is a decline of more than 600,000 visits from 2019 (-16.6%), reflecting the impact the COVID-19 pandemic had on ED visits. The overwhelming majority of patients (about 80%) bring themselves to the ED as opposed to arriving by ambulance. Additionally about 85% are discharged without being admitted to the hospital (FIGURE 1).

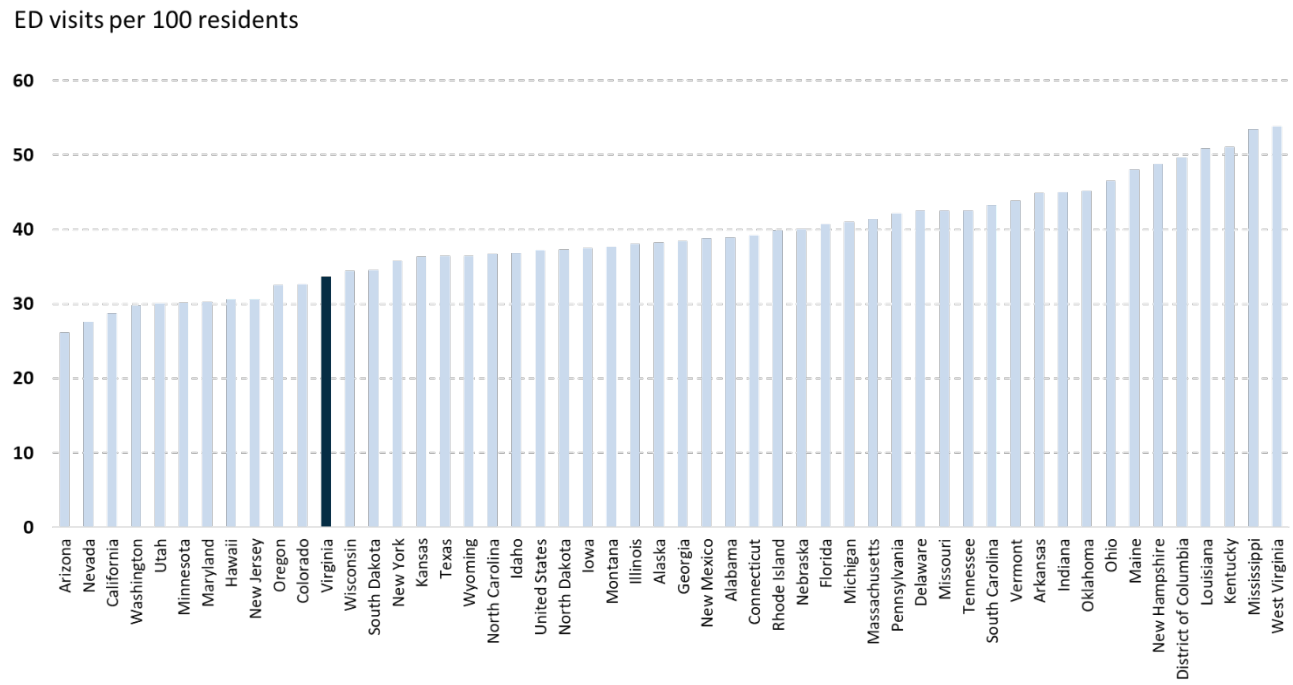
FIGURE 1: ED visits in Virginia remained steady before dropping during the COVID-19 pandemic



SOURCE: JCHC staff analysis of the Annual Licensure Survey Data collected by VHI.

Virginia's ED utilization rate is lower than the national average in the most recently available data from 2018. This data shows the rate of ED visits nationally was 37.2 per 100 residents. The rate for Virginia for the same year was 33.7 per 100 residents, which ranks the state 12th lowest in the nation (FIGURE 2). [1]

FIGURE 2: Virginia's statewide ED utilization rate was lower than most other states (2018)



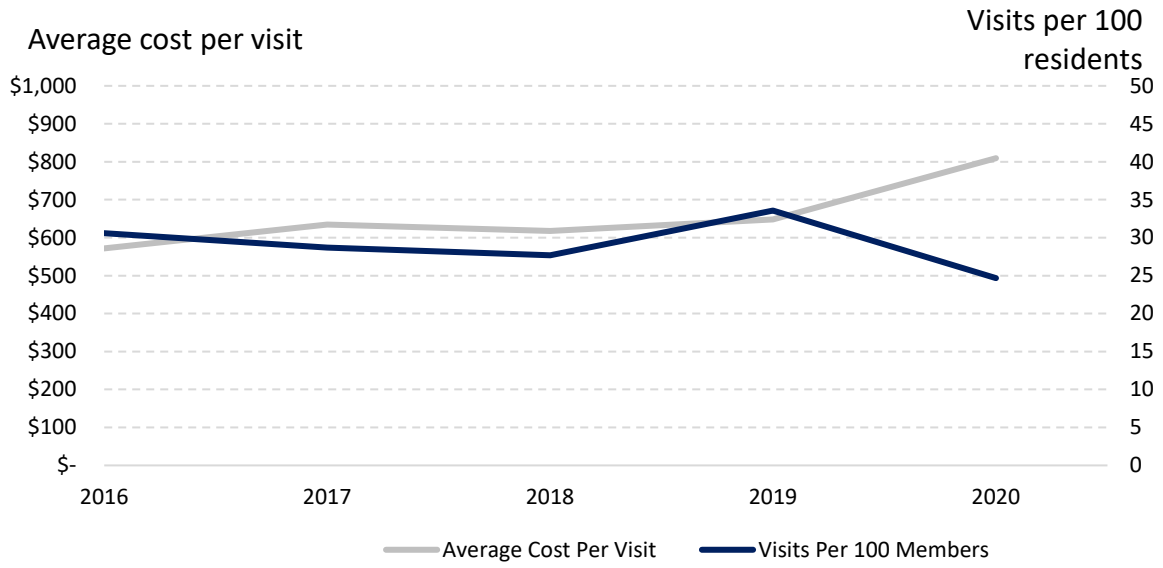
SOURCE: JCHC staff analysis of data from the AHA Annual Survey, as published by the Kaiser Family Foundation.

The cost of ED visits is increasing in Virginia, with an estimated $6 billion spent in 2019

According to the most recent data available, the average cost of an ED visit in Virginia was $1,598 in 2019, compared to $1,329 nationally. That average cost, multiplied by the 3.7 million ED visits in the state resulted in an estimated $6 billion in total spending in 2019 on ED visits.[2] ED spending represented 20.8% of all hospital spending ($28.8 billion) in Virginia and 6.5% of all health care spending in the state ($92.2 billion).[3]

The cost per ED visit increased by 41.5% between 2016 and 2020, while the number of visits declined (FIGURE 3). The decrease in visits largely occurred in 2020 as a result of the pandemic, while the cost per visit increased more steadily over the five year period. This trend is consistent with findings from national research on ED visits and costs. Overall ED utilization declined by 4% nationally between 2012 and 2019, while the price of an ED visit increased by 58% during the same period.

FIGURE 3: Cost per ED visit increased between 2016 and 2020



SOURCE: JCHC staff analysis of ED claims data from the All Payer Claims Database.
NOTE: The average cost per visit includes only the cost for the evaluation and management code portion of the claim.

Some ED visits can be safely treated in lower cost, alternative settings such as a primary care location or urgent care centers, where the cost of services is substantially lower than the costs from an ED. In 2019, the average cost of a primary care office visit ranged from $68 to $234 depending on the level of care needed by the patient. The average cost of an urgent care visit ranged from $100 to $500 depending on whether the patient had coverage and the level of care provided. A visit to the ED for a "very minor" issue may cost a Virginian between $257 and $1,097.[4]

ED patients are assigned "level of intensity" or "severity codes" twice during an ED visit. When a patient arrives at the ED the nurse triages them and determines the severity of presenting symptoms using the Emergency Severity Index (ESI). ESI is rated from 5 to 1, with 5 the lowest severity and 1 the highest severity.

After the medical screening examination (MSE) the final evaluation and management (E&M) code indicates the level of work done on the patient (e.g. labs, imaging, etc.). The level of intensity of the MSE becomes part of the claim for billing purposes and is identified by CPT Codes 99281 – 99285, with 99281 being the lowest intensity and 99285 being the highest intensity.

Intensity of services in the ED has increased over the last five years, particularly during 2020

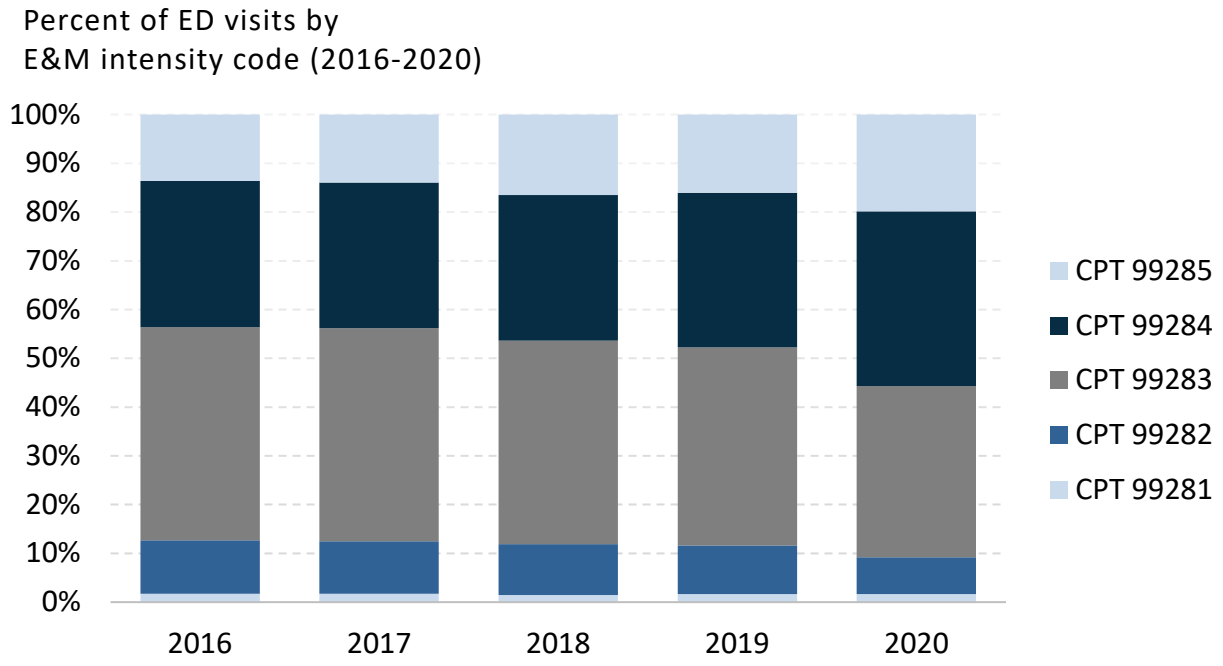
There has been a slight shift in Virginia from lower intensity visits to the ED to higher intensity visits, based on the final codes submitted for reimbursement. Visits for the highest intensity current procedural terminology (CPT) code, 99285, increased by 6.3% as a percentage of total visits, while visits for the lowest levels of intensity (CPT codes 99281 and 99282) decreased by a combined 3.5%. The largest shift in

intensity codes occurred between codes 99283 and 99284, the middle levels of intensity. Visits for CPT code 99283 decreased by 8.6% while those for CPT code 99284 increased by 5.8% (FIGURE 4). Hospital staff report that the shift is due to the increasing prevalence of alternatives to the ED (e.g. urgent care, retail clinics), improving technologies in the ED related to imaging and testing, and the changing situation with patients due to the pandemic.

National Research has identified this same trend nationally, with a 2021 study finding that patients with less severe illnesses are no longer using the ED at pre-pandemic rates, and that the overall acuity of ED visits during the pandemic has risen. [5]

The severity, or level of intensity, codes for an ED visit can only be assigned and billed from an ED. All health insurance carriers provide detailed guidance on how each code is assigned and hospital electronic medical records (EMR's) are automated to comply with the guidance. In addition, in 1996 CMS implemented a correct coding initiative to prevent improper payments by providers and to help providers properly code their services.

FIGURE 4: ED visits are shifting from lower to higher intensity



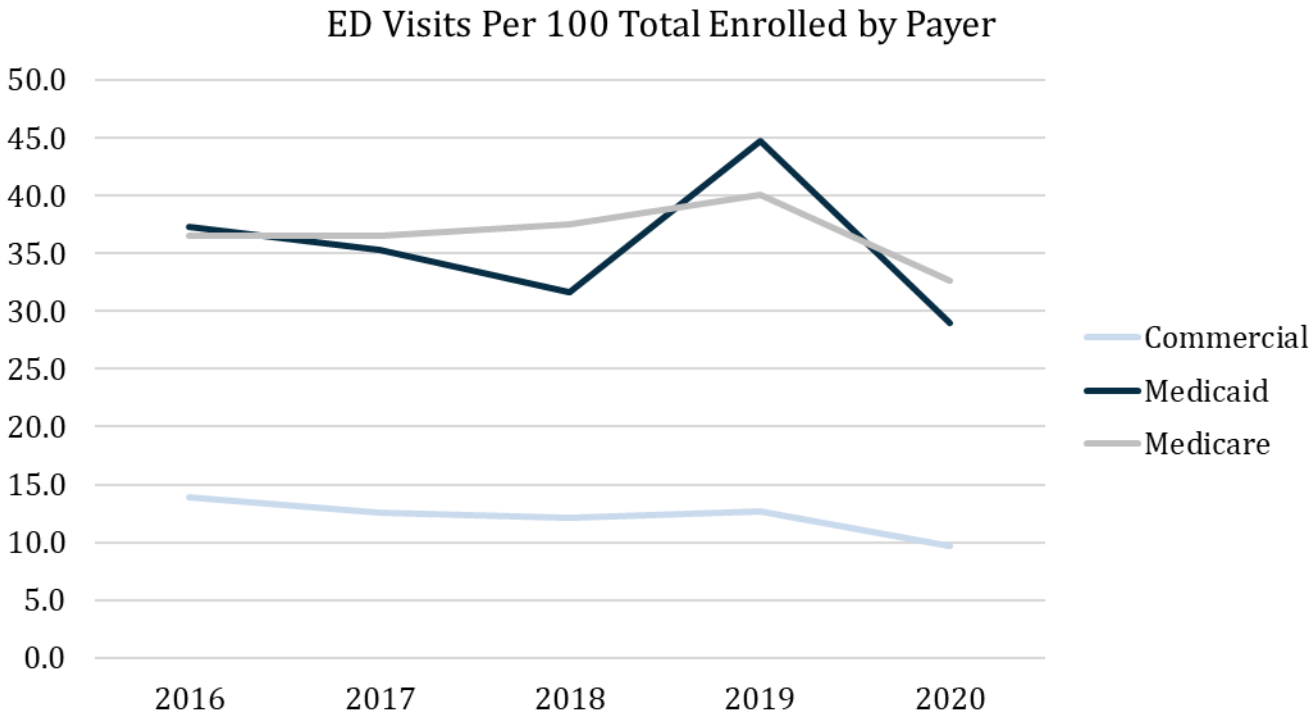
SOURCE: JCHC staff analysis of claims data from the All Payer Claims Database.

While the shifts in the intensity codes are relatively small as a percentage of total ED visits, the impact on cost can be significant. For example, going from CPT code 99283 in 2016 to CPT code 99284 in 2020 increased the cost per visit by $518.51, or 130%. This shift is part of the reason for the change in average cost of ED visits in Virginia, which increased 41.5% over this same five year period.

Medicaid and Medicare covered individuals are seen in the emergency department at a higher rate than individuals with commercial insurance

Medicaid and Medicare enrollees visit the ED more than those from commercial health plans (FIGURE 5). This is likely, at least in part, due to the high health needs of these populations. Individuals with low income on Medicaid are more likely to have high health needs, and the Medicaid population also includes individuals in need of long-term care. The Medicare population is made up of individuals over the age of 65 and with permanent disabilities, both of which tend to have higher health care needs. [6]

FIGURE 5: ED visits by Medicaid and Medicare enrollees are more frequent than those covered by commerical insurance



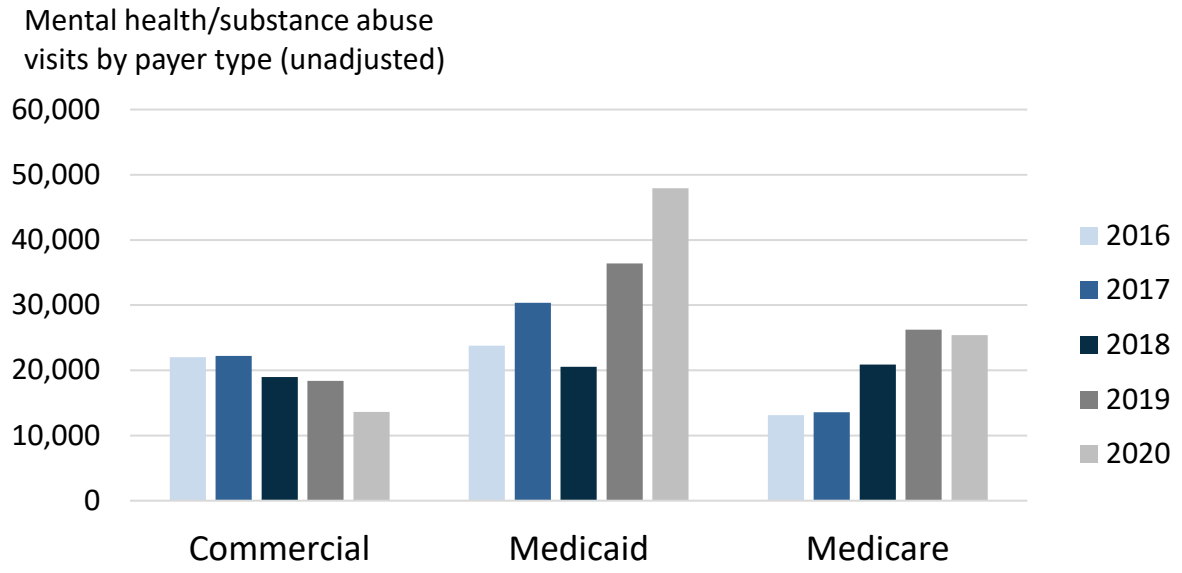
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

Changes to Virginia's Medicaid program, including Medicaid expansion, resulted in changes to ED utilization for the Medicaid population

Significant changes to Virginia's Medicaid program, including the implementation of the Addiction Recovery and Treatment Services (ARTS) program in 2017, and Medicaid expansion in 2019, resulted in significant utilization changes. The ARTS program started in April 2017, with the goal of increasing access to treatment of individuals with substance use disorders. The program expanded the availability of treatment services for Medicaid enrollees. A program evaluation by Virginia Commonwealth University found a 14%

decrease in substance abuse related ED visits during the first 10 months of the ARTS program. This is part of a broader trend of decreased ED utilization in Virginia's Medicaid program in 2018, including mental health and substance abuse (MHSA) related visits. This was followed by a 28% increase in substance use disorder (SUD)-related ED visits between FY 2019 and 2020, following Medicaid expansion (FIGURE 6).[7]

FIGURE 6: Mental health and substance abuse related ED visits for Medicaid members fluctuated with program changes



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

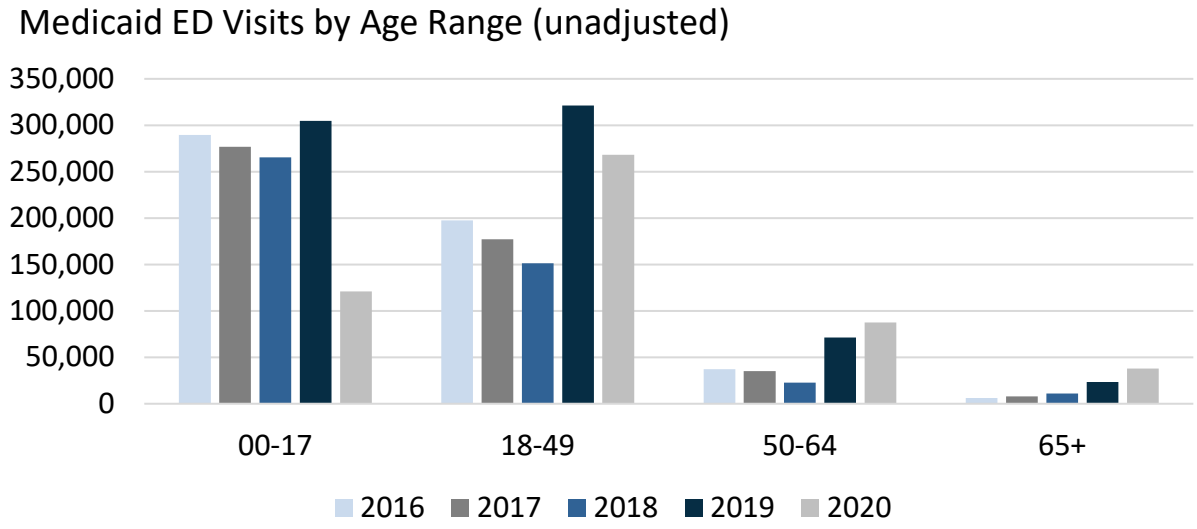
Virginia implemented Medicaid expansion in 2019. By the end of 2020 the state added over 510,500 new adult Medicaid enrollees between the ages of 18 and 64 to the Medicaid program. This resulted in an increase in total ED visits from Medicaid members, particularly for individuals between 18 and 49 (FIGURE 7). [8]

The Families First Coronavirus Response Act increased federal funding for Medicaid costs and also required state Medicaid programs to keep all current enrollees on the program until the end of the federal public health emergency.

The spike in ED use among the newly covered adults in Medicaid is not unique to Virginia. A 2016 study of the 2008 "Oregon Health Insurance Experiment" (see sidebar) found that extending Medicaid coverage to adults led to an increase in health care use across all provider settings including a 40% increase in ED visits by Medicaid enrollees. The increased use of the ED lasted for the first 15 months after people gained coverage.[9] Another study by the RAND Corporation compared health care utilization in Medicaid expansion states to states that had not expanded. The study found a 20% increase in the use of all hospital out-patient services, primarily from the ED, after the passage of Medicaid expansion. RAND also concluded that the conditions most patients were treated for may have been deferred and treatable outside of the ED, suggesting that the newly covered did not necessarily use the ED when they were uninsured. [10]

The Oregon Health Insurance Experiment started in 2008, and was a limited Medicaid expansion program for low-income adults through a lottery drawing of approximately 30,000 names from a waiting list of almost 90,000 persons. Selected adults still had to apply and meet eligibility requirements to enroll in the program.

FIGURE 7: Medicaid expansion resulted in increased ED utilization, particularly among adults on Medicaid



SOURCE: JCHC staff analysis of claims data submitted to the All Payer Claims Database.

ED utilization and spending for mental health and substance abuse visits are increasing, despite overall decreases in ED visits

There was a significant increase in MHSA visits between 2016 and 2020, even during the pandemic. MHSA visits increased by 47.4% between 2016 and 2020, while medical visits declined by 6.7%. MHSA visits went from less than 5% of all visits in 2016 to 7.1% in 2020

(TABLE 1). The changes in Virginia's Medicaid program, as well as the impacts of the COVID-19 pandemic, are likely the primary drivers of this trend.

TABLE 1: Mental health and substance abuse related ED visits increased in 2019 and 2020

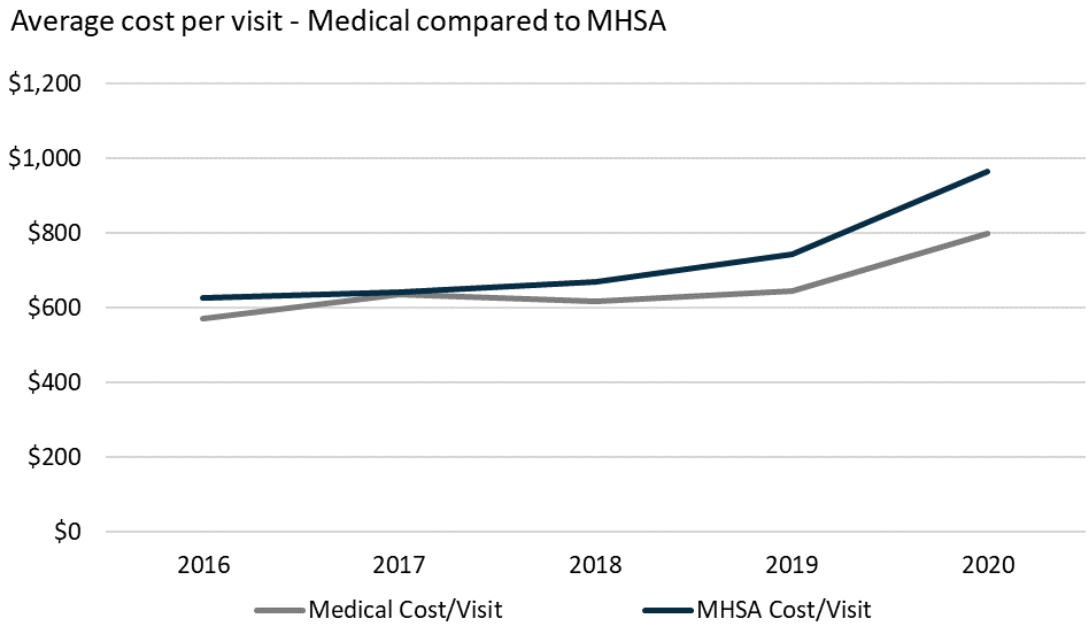
Emergency Department Visits in the APCD Medical compared to Mental Health & Substance Abuse				
Year	**Medical**	**MHSA**	**Total**	**MHSA Visit as % of Total**
2016	1,223,095	58,941	1,282,036	4.6%
2017	1,172,817	66,111	1,238,928	5.3%
2018	1,203,347	60,380	1,263,727	4.8%
2019	1,508,315	80,955	1,589,270	5.1%
2020	1,140,780	86,880	1,227,660	7.1%
Change	(82,315)	27,939	(54,376)	
Percent Change	**-6.7%**	**47.4%**	**-4.2%**	

SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

In addition to the number of visits increasing for MHSA related ED visits, the average cost of the evaluation and management (E&M) codes for a MHSA visit is increasing faster than the average cost of the E&M codes for a medical visit in the ED. In 2016 the average cost of an E&M code for a medical visit was $569, compared to $627 for a MHSA visit. In 2020 the average E&M cost for a medical visit increased to $797 (40% increase) compared to $963 for a MHSA visit (54% increase)(FIGURE 8).

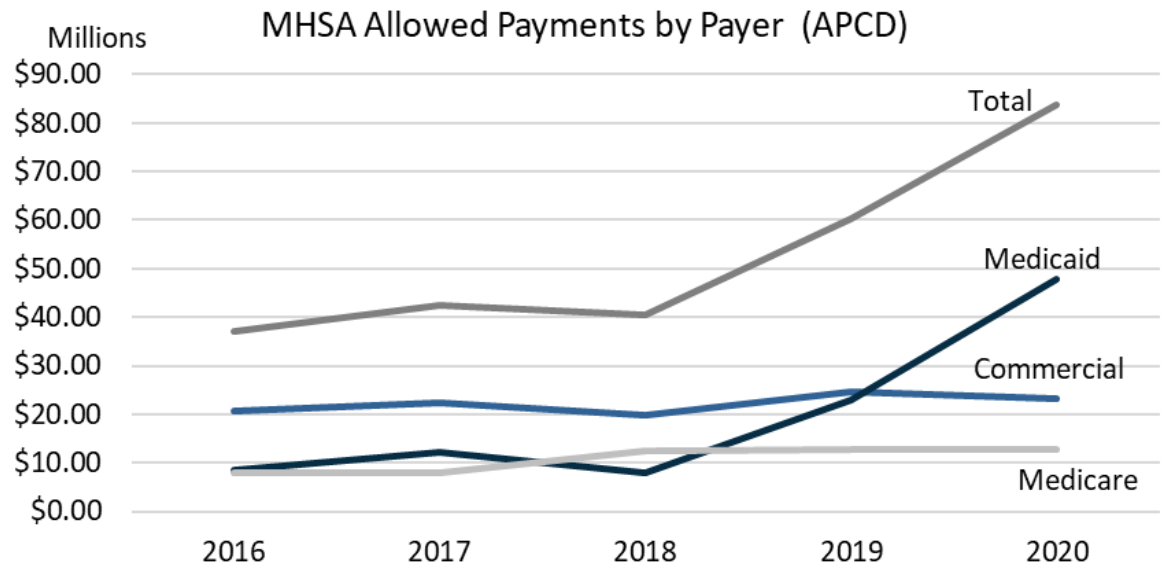
The increasing visits and cost per visit resulted in an increase by 126.5% for total payments for the evaluation and management code portion of MHSA ED visits between 2016 and 2020. During this same time period, total payments for all ED visits increased by 35.5%. As a result, MHSA payments went from 5% of total ED payments to 8.4%, an increase of $47 million. This was primarily driven by a 462.5% increase in Medicaid payments (FIGURE 9).

FIGURE 8: Average cost of MHSA related ED visits is increasing faster than the average cost for medical visits



SOURCE: JCHC staff analysis of ED claims data from the All Payer Claims Database.
NOTE: The average cost per visit includes only the cost for the evaluation and management code portion of the claim.

FIGURE 9: Total payments for MHSA related ED visits increased significantly between 2016 and 2020



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

Increase in MHSA ED visits had a significant impact on hospitals

Two large hospitals reported converting ED patient rooms into "safe rooms" due to the increase in the number of patients with MHSA issues. Safe rooms are stripped of anything a person can use to harm themselves with, and look like small one-car garages.

In addition, a person with an MHSA diagnosis requires more staff resources and time than one with a medical diagnosis. In many cases a staff person has to stay with the patient until they are either properly transferred or discharged.

Several hospitals reported issues related to children getting "stuck" in the ED because there is nowhere to transfer them to. Two hospitals indicated that they've had children in ED rooms for as much as two to three weeks while they wait for a place to transfer them to. While the child is in the ED room the hospital has to provide staff to sit with them. Treatment is provided if it is available and because of the setting the children are not in school.

EDs are a key part of the care continuum, but some patients could be treated in more appropriate settings

Strategies to reduce ED utilization, and studies of inappropriate or unnecessary ED utilization have been done by multiple federal agencies, every state, and many countries. These topics received increased scrutiny during the late 1990s and early 2000s. The studies focus on local hospitals, specific diseases, and medical compliance issues, as well as broader issues related to why people go to the ED instead of primary care or another less expensive alternative. JCHC staff focused on identifying situations when patients go to the ED when their condition could have been treated in a lower cost, community setting. These situations can occur when an individual does not get the preventive care they need, leading to a medical emergency (preventable), or it can occur when a patient chooses to go to the ED even though their medical condition could have been safely treated elsewhere (non-emergent).

Different definitions lead to different results for the Virginia Medicaid population. The VHI dashboard on preventable and avoidable ED visits indicates that 15.2% of 720,000 Medicaid visits included in their all payers claims database were classified as avoidable and preventable in 2020.

The Medicaid Payment Policy and Care Coordination Workgroup report stated that DMAS found 375,227 potentially preventable and avoidable ED visits out of a little over 1 million visits in their records from 2019, or over 35%.

There are no standard definitions for unnecessary ED visits

Estimates of the number of unnecessary ED visits range from 9% and 54% in the United States, 26% and 60% in Canada, and 20% and 41% in Europe. [11] These broad ranges reveal challenges with defining what an unnecessary ED visit means. Some studies suggest that people with more than a certain number of visits to the ED, frequent users, use the ED unnecessarily for all of their health care needs. Other studies suggest that

certain diagnoses can be used to determine if an ED visit is unnecessary, but both approaches lack a clear definition. For example, studies on frequent users define the term "frequent" differently, e.g. 4, 6, 10, or 12 times a year. Studies that use diagnosis lists to define unnecessary ED visits often use different diagnoses and apply different methods to create their lists. For example in Virginia, VHI, the Virginia Hospital and Health Care Association (VHHA), and the Department of Medical Assistance Services (DMAS) use different diagnosis lists to define and report on preventable and avoidable ED visits (see sidebar). The lack of a single definition led to a policy option recommendation by the Medicaid Payment Policy and Care Coordination Workgroup requesting that each organization align and unify their different definitions to improve analysis and policy development related to ED utilization. [12]

Through site visits to EDs throughout Virginia, JCHC staff identified two primary situations that can be addressed to reduce ED visits. In these situations, the ED visits are not always "unnecessary," but rather are either preventable or non-emergent.

- **Preventable ED visits:** For the purposes of this report, preventable ED visits are situations when an individual needs preventive care or treatment for a chronic condition to maintain their health. If they do not get that care, the situation gets worse to the point that they have a medical emergency and require a visit to the ED.
- **Non-emergent ED visits**: For the purposes of this report, non-emergent ED visits are when a patient chooses to go to the ED for treatment of a more minor medical condition that could have been treated in either a primary care or urgent care setting.

Policy efforts should focus on keeping people from going to the ED

The federal Emergency Medical Treatment and Labor Act (EMTALA) governs the care and treatment of people who visit the emergency department. EMTALA was passed in 1986 in response to the practice of "patient dumping" by hospitals based on a patient's coverage or ability to pay. As a result, federal law specifically prevents ED staff from asking if and how a person will pay for their visit. EMTALA applies to all critical access hospitals and Medicare participating hospitals that have a dedicated emergency department. EMTALA has four core principles:

- Application of the **"prudent layperson standard"** for any person without medical training but with an average knowledge of health and medicine to determine whether their symptoms might lead to serious consequences (emergency medical condition, EMC) without immediate medical attention. [i]

[i] 42 CFR § 438.114 (a) "Prudent lay person standard" person determines if they have an emergency if they believe that: 1. the health of the individual in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child); 2. there is serious impairment to bodily functions; or 3. there is a

- **Medical Screening Examination (MSE)**: all patients, regardless of insurance status, nation of origin, race, religion, etc., are entitled to an MSE if they are on a "hospital campus" (within 250 yards of a hospital building). The MSE is used to determine whether or not an underlying emergency medical condition exists.
- **Stabilization**: If an EMC exists, as determined by a licensed physician, the law mandates that the person be stabilized for either discharge, admission, or transfer to another hospital.
- **Transfers**: if a patient requires a transfer to another hospital, EMTALA requires the transferring hospital to treat and stabilize the patient to the fullest extent possible, provide care en-route, and transfer the patient with appropriate copies of medical records. The law further mandates that the receiving hospital must accept the patient, as long as it has the appropriate resources and capacity to provide treatment.

Hospitals that fail to comply with provisions of EMTALA are subject to investigation and fines. Complaints are filed anonymously and can be filed by anyone. If a complaint involves a transfer then both hospitals are investigated. [13] Complaints and investigations can result in violations against the hospital (case studies).

CASE STUDY: EMTALA violation for failure to stabilize

A hospital failed to stabilize a 58-year-old patient who presented to the ED for blurred vision and dizziness. After failing to provide an appropriate MSE, an ED nurse directed the patient to a local eye doctor and failed to provide medical treatment to stabilize the patient's emergency medical condition, a cerebral infarction (a stroke).

SOURCE: US Department of Health and Human Services, Office of the Inspector General (2018).

serious dysfunction of any bodily organ or part. The definition includes mental health conditions and substance use disorders.

CASE STUDY: EMTALA violation for failure to appropriately screen and stabilize

An independent 71-year-old entered an ED complaining of leg pain, weakness, inability to walk, and a drastic change in behavior and functioning. His daughter reported that he was occasionally disoriented but in good health during a recent visit. The ED physician ordered labs and IV fluids; after ten hours the patient was discharged with a diagnosis of dehydration and weakness. Six hours later the patient returned to the ED with similar complaints; a different physician diagnosed the patient with a traumatic subdural hemorrhage and transferred the patient to another hospital for brain surgery. The patient remained in the hospital for two weeks before passing away the following week.

SOURCE: US Department of Health and Human Services, Office of the Inspector General (2018).

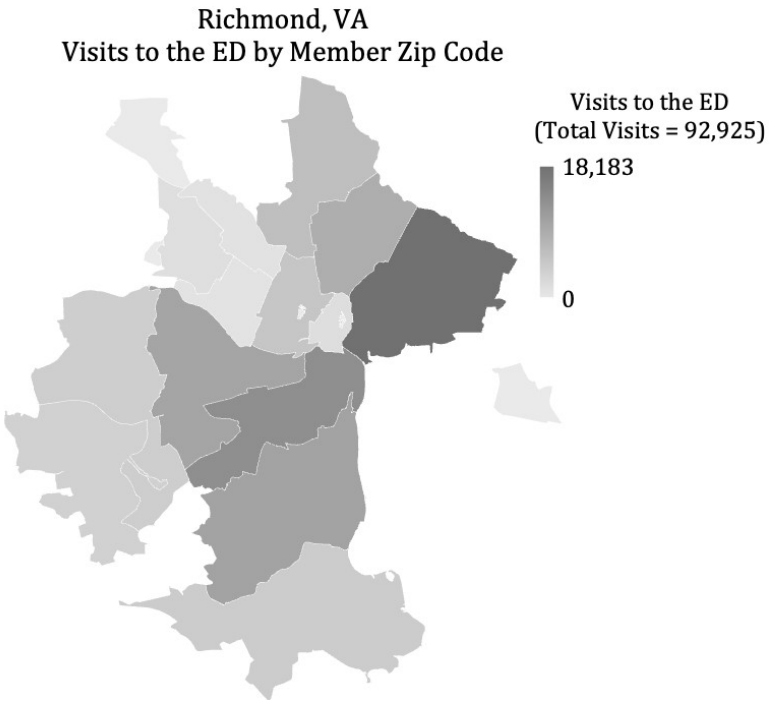
Medical directors, physicians and the nursing staff of Virginia EDs stated that concerns over potential EMTALA violations and patient complaints require the patient to be diagnosed, treated and discharged appropriately. Doing anything less is perceived as a failure to serve the patient. While the law does provide written flexibility on whether to diagnose and treat after the evaluation, EMTALA complaints, malpractice suits, and the penalties for noncompliance create an environment where ED staff feel they can not realistically discharge someone even if the initial evaluation indicates they have a minor medical condition.

Staff in EDs also indicate that patient expectations often exceed the purpose of the ED. If the patient is released without a diagnosis and some level of treatment, hospital staff report that they may file a complaint and submit a negative satisfaction survey about the hospital. These satisfaction surveys are used by CMS and others as part of the hospital quality program. ED staff indicate the bigger concern is if a person is examined and released based on a determination that an emergency did not exist and the person goes to another hospital for the same reason, or gets sicker, the hospital and its staff can be investigated for an EMTALA violation and sued for malpractice.

Non-emergent ED visits are most common when a patient is unable to access primary care or urgent care

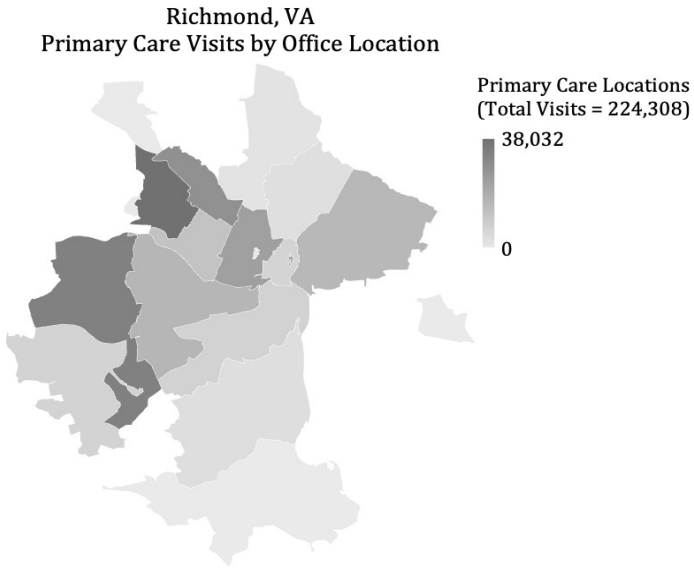
One of the most common reasons that patients choose to visit an ED with a non-emergent medical condition is because a more appropriate setting of care is either not available in their community, or if they do exist, is not accessible to them for another reason. This is illustrated by comparing the location of primary care provider visits, to the number of ED visits based on where patients live. In both Richmond and Roanoke for example, data indicate fewer ED visits from zip codes where there are more primary care visits (FIGURES 10-13).

FIGURE 10: ED visits by patient zip code in the Richmond area



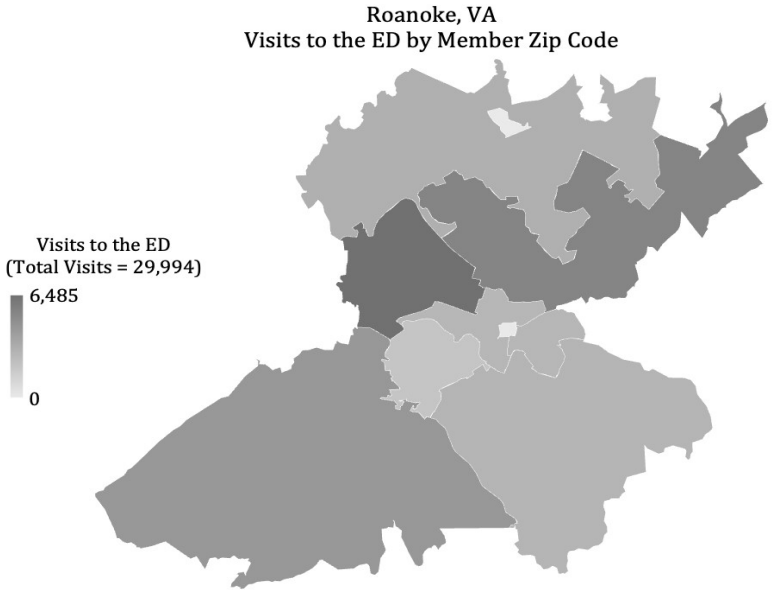
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local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

FIGURE 11: Primary care visits by office location zip code in the Richmond area



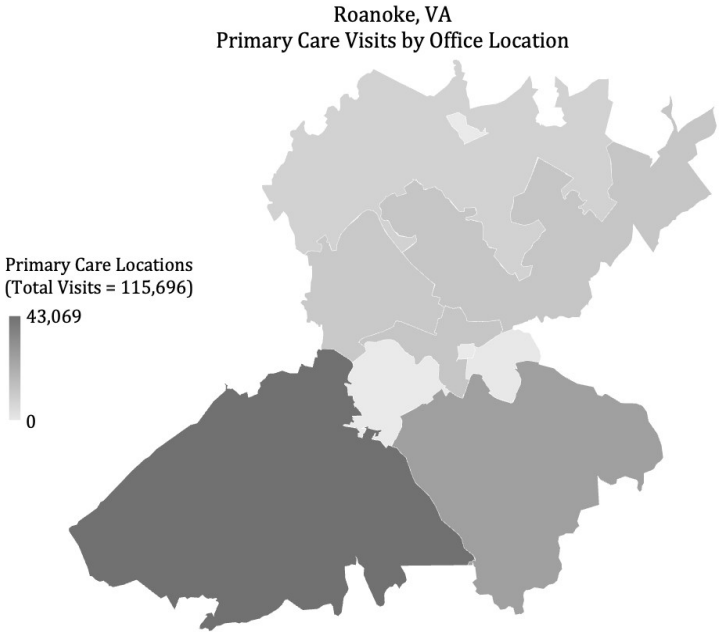
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.
NOTE: 4-year average of APCD claims between 2017 and 2020; claims were filtered by state to only include providers in Virginia. Primary care includes retail clinics, urgent care centers, independent clinics, state and local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

FIGURE 12: ED visits by patient zip code in the Roanoke area



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 13: Primary care visits by office location zip code in the Roanoke region



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.

JCHC hospital ED visits indicated that this trend is also found in rural areas of the state where there is very little primary or urgent care available. One ambulance director from Southwest Virginia said that some individuals within her service area are isolated and lonely. They will often call 911 for an ambulance and then go to the emergency room just to have someone to talk to. In many rural areas the primary care physician is also the emergency room physician. One medical director of a rural hospital said people circle the parking lots looking for the physician's vehicle and may call others to let them know that the "doc is working the emergency room tonight if they need to see him."

Urgent care centers offer an appropriate alternative to ED use for most patients seeking non-emergent care, but must be available for patients to use them

Urgent care centers (UCCs) are becoming an increasing source of care for individuals with non-emergent medical conditions. However, UCCs tend to be located in more populated areas, with a younger, more racially diverse, wealthier, and more educated population. UCCs are also most likely to be located in areas of low rates of Medicaid enrollment. As a result, 67% of UCC visits are from privately insured patients. [14] Most UCCs open at about 8 a.m. and close between 8 p.m. and 10 p.m. Some are open on weekends but the hours of operation may be reduced.

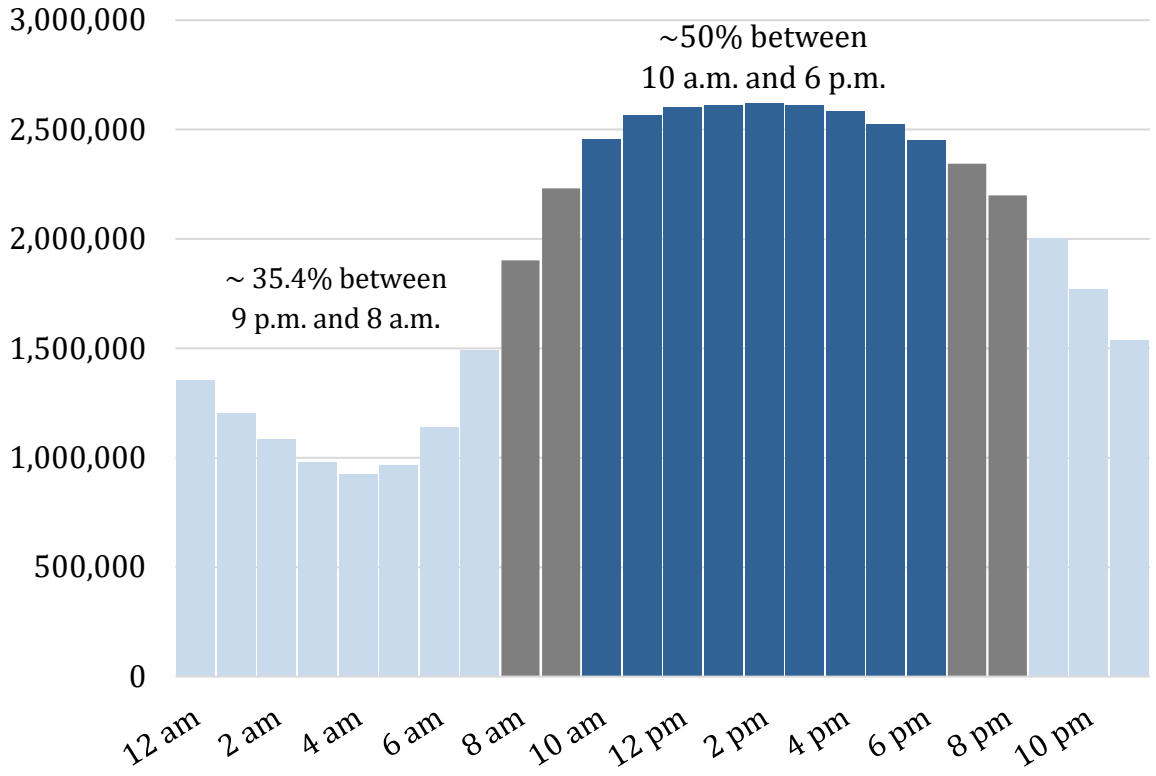
Studies on the impact that UCCs have on ED use are limited but the findings suggest that when a UCC is open and accessible it may reduce ED utilization. One study concluded that when an urgent care center closes, non-emergent ED visits increase by 1.43%. However the effect was only present among the privately insured and only where there are multiple urgent care centers in an area. [15] Another study found that for people living near a UCC, when those centers are open, non-emergent visits to the ED decreased by 17%. The study also found that, under the same conditions, access to a UCC reduced ED visits for both Medicaid (29.1%) and the uninsured (21%). [16]

Primary care and urgent care are not always utilized even when they do exist

Hospital staff reported that arrival times for patients bringing themselves to the ED are concentrated in the early morning and evening hours. Staff indicated that this is because it is when school lets out, individuals get off from work, or in the late evening/early morning hours their physician offices or local urgent care centers are closed.

Individuals arriving by ambulance to the ED tend to occur more evenly throughout the day. This is likely because ambulance trips to the ED are more likely to result from falls, car accidents, or other emergency situations that occur as people go about their daily lives. Virginia ambulance records indicate that roughly 50% of the ambulance transports occur between 10 a.m. and 6 p.m (FIGURE 14). An additional 35.4% occur between 9 p.m. and 8 a.m. however, this is when urgent care and primary offices are often closed. [17]

FIGURE 14: Ambulance transports to Virginia EDs by time of day (2020-21)



SOURCE: JCHC staff analysis of ambulance transport data from the National Emergency Medical Services Information System (NEMSIS) Technical Assistance Center; special Report for JCHC.

Literature indicates that patients sometimes choose to go to the ED for non-emergent conditions even if primary care or urgent care are available and open. For example, many patients are referred to the ED by their own PCPs and urgent care centers. One study found that 155 patients called their PCP for an appointment and 54 were referred to the ED, some without any consultation with the practicing physician. [18] Another study found that people go to the ED for many reasons, including their perceived urgency of the medical condition, convenience, or the views of family, friends, or other health professionals. This study emphasized that patients' perceptions of access to and confidence in primary care was a key factor in the decision to go to an ED. When patients experience difficulties in obtaining appointments or are unsatisfied with the care they receive with their current providers, these factors may impact future health-seeking behavior and choices.

Medicaid enrollees use the ED more frequently than commercially insured patients in part because they have difficulty accessing other sources of care

By the end of 2020 the state added over 510,500 new Medicaid enrollees to the program due to Medicaid expansion, increasing the number of people in Medicaid managed care to 1.3 million people in 2020. This has increased to more than 2 million Virginians as of September 2022, as a result of the federal public health emergency for COVID-19. It is not clear however if these enrollees can always get the appointments they need with a physician or a specialist.

The Families First Coronavirus Response Act increased federal funding for Medicaid costs and also required state Medicaid programs to keep all current enrollees on the program until the end of the federal public health emergency.

Physician offices have the choice of whether or not to accept Medicaid patients. Medicaid reimbursement rates are typically the lowest of any major payer, and so as a business, physician practices have to manage their mix of patients (known as their payer mix) to generate sufficient revenue. With the exception of the ED, federal law allows physicians and other health care providers to accept or decline Medicaid patients, even if they have a contract with the Medicaid program to serve Medicaid patients. [19]

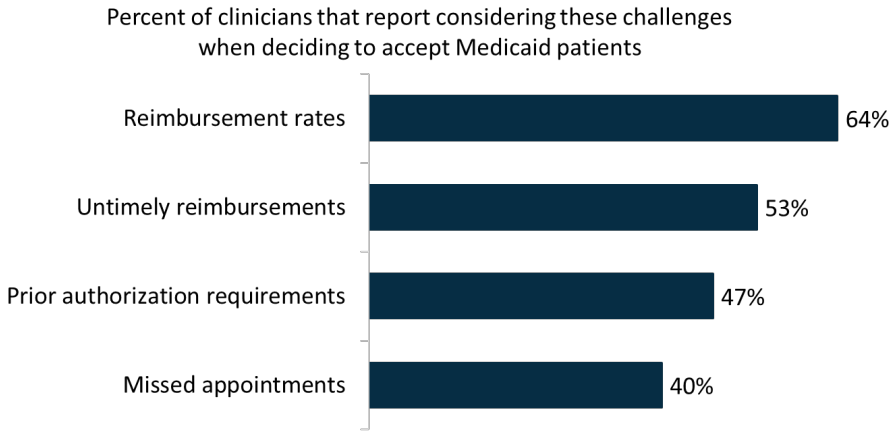
Even for providers that do accept Medicaid patients, there is no guarantee that a person can get an appointment to see a doctor in a timely manner. Physicians, clinical practices and other health care providers can, and often do, limit the number of Medicaid patients they see. Large physician practices report that if they accept Medicaid enrollees then all of the clinicians in the practice must accept Medicaid enrollees. However, according to the AMA, about half of physicians work outside of large practices. [20]

How one large primary care practice chooses to take Medicaid patients. During an interview with a large primary care practice in Northern Virginia the practice administrator reported that the practice accepts all Medicaid enrollees under the age of 18 but will not accept any new adult Medicaid enrollees unless the person was a patient at the practice before they went on Medicaid.

According to a 2019 primary care report to DMAS, there are an estimated 1,622 primary care practices in Virginia, with 5,338 practicing clinicians and 3,422 primary care physicians (PCP). Most of the 5,338 practicing clinicians report that they accept Medicaid, (4,056 or 76%), and roughly 3,000 (58%) accept new Medicaid patients. While these numbers indicate that most practices accept at least some Medicaid patients, there are more than 40% who are not accepting new Medicaid patients. The bigger challenge is that the report found that 22% of primary care physicians saw fewer than 10 Medicaid patients per year, indicating that while most are serving some Medicaid patients, the total availability of appointments for Medicaid patients may be limited. [21]

The top four barriers Virginia PCCs identified as very important when considering whether to accept Medicaid were reimbursement rates, untimely reimbursement, prior authorizations, and missed appointments (FIGURE 15).

FIGURE 15: Reimbursement rates and administrative burdens are the top reasons clinicians consider not accepting Medicaid patients



SOURCE: *Primary Care in Virginia*, 2019.

While reimbursement rates for Medicaid remain a significant issue, the other barriers identified in the primary care study may be equally as important. Recent research on administrative challenges with the Medicaid program found that physicians lose about 17% of Medicaid revenue to billing problems, compared with 5% for Medicare, and 3% for commercial payers. The research concluded that the losses from administrative "hassle" dissuade some doctors from accepting Medicaid patients. [22]

DMAS requires MCOs to report the number of claim denials and the number of times providers have to resubmit claims before they are paid. However, this information is collected in an aggregated form, and can not be analyzed for just primary care providers. Because access to primary care providers is a significant factor in ensuring patients are not visiting the emergency room for non-emergent ED visits, DMAS should collect data on claim denials and resubmissions by provider type.

➔**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.

Missed appointments directly impact a physician practice's revenue, and this is particularly challenging within the Medicaid population. When a patient misses an appointment and no one else is booked for that time, then the physician loses that revenue. VCU Health's primary care practice has a 30% no-show rate. [23] A study by the Illinois College of Optometry found that the average overall no-show rate in their clinic was almost 25% — but among their Medicaid patients, the number jumped to over 41%. [24] Other research indicates that 35% to 50% of Medicaid recipients in the Philadelphia, PA, area miss appointments on a daily basis. [25]

Patients miss appointments for a variety of reasons, including simply forgetting, not being able to get off of work, or not having transportation. Transportation to and from an appointment is one of the most often cited reasons why Medicaid patients in particular miss appointments. Medicaid seeks to address this with a non-emergency transportation program, which provides free transportation to and from medical appointments. The challenge with Medicaid non-emergency transportation is that a patient has to provide advanced notice of 2 to 5 days in order to arrange for a ride, and at least one legislative study in Virginia found significant challenges with the timeliness and reliability of the program.

Research indicates that patients who miss one appointment are much more likely to miss future appointments. This can result in the person getting double or triple booked because the practice doesn't want to lose out on that appointment time. If the patient does then go to their appointment, they may end up waiting for an hour or more to see their provider. Another issue is that the patient may not be able to get an appointment for several weeks because the scheduler expects that they will either not accept the appointment or will miss the appointment. All of these scenarios result in a negative patient and provider experience, making it less likely that the patient will seek care in the primary care setting, increasing the risk that they will visit an ED with a non-emergent issue.

Physician offices, group practices, business managers and IT specialists have been working on solutions for missed appointments for years. The latest research indicates that automated scheduling programs being developed and promoted may have unintended consequences of discriminating against Medicaid patients and patients of color. [26] This issue is complicated, and requires further analysis to fully understand the current state in Virginia, and its potential implications for primary care access and ED utilization. Virginia's Primary Care Task Force, with support from DMAS and the Virginia Department of Health, Office of Health Equity, are well positioned to further investigate the issue.

DMAS requires MCOs to meet standards for network adequacy and patient access. This entails travel time and distance standards, provider to patient ratio standards, and appointment availability standards. Based on the challenges identified in this research, appointment availability is a critical measure of access for Medicaid patients. The requirement for primary care appointment availability is 30 days for a routine visit, and 24 hours for an urgent, medical need. Travel time and distance standards are necessary, but

even when primary care providers exist in an area, appointments may not be available for Medicaid patients.

A JLARC study in 2019 reviewed the DMAS oversight process to ensure Medicaid patients had sufficient access to services. At the time, DMAS was not collecting data from the MCOs to ensure compliance with the appointment availability standards. MCOs indicated that they collected survey data for their own compliance purposes and for their external quality review organizations, however this data was not always sufficient to determine if Medicaid patients could get the primary care appointments that they needed.

➔**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.

New federal rules address the use of lists of diagnoses to reduce payments for ED visits

The Appropriation Act includes language that allows Managed Care Organizations to reduce fees for emergency room claims if the final E&M CPT codes are 99282, 99283 or 99284, and the final diagnosis is from a designated list. The list is the same one used for a MCO clinical efficiency rate adjustment program. [ii] If a claim meets these criteria, the MCO can reduce the payment down to the fees for code 99281 for both the physician and facility portion of the claim.

The federal rules and associated preamble implementing the "No Surprise Act" state that group health plans and health insurance issuers that cover emergency services must cover those services without limiting what constitutes an emergency medical condition solely based on lists of final diagnosis codes. The preamble further states that when a health plan denies all or part of an ED claim for payment, the determination must be based on the "prudent lay person standard" as defined by EMTALA, which requires that all pertinent documentation focused on presenting symptoms be taken into consideration. The rules extend these requirements to all health plans and health insurers, including Medicare Advantage and Medicaid Managed Care Organizations. [27] Several state associations have asked for clarification of whether this state policy is in compliance with the federal rules. However, CMS has yet to respond with any additional clarification or guidance specific to Virginia.

[ii] 2022 Special Session I, Budget Bill - HB30 (Ch. 2), Department of Medical Assistance Services, Item 304 HHH

Patients sometimes require an ED visit for emergencies that could have been prevented

In some cases, patients visit the ED with a medical emergency, but it could have been prevented if they were able to get appropriate care prior to the emergency. These situations can result from a variety of chronic conditions, including asthma or diabetes. There are also patients who repeatedly use the ED for care, the vast majority of whom have a behavioral health diagnosis. Both categories of patients, those with chronic conditions and frequent ED users, require case management to ensure they get appropriate outpatient care and can avoid having their medical conditions deteriorate into an emergency.

Chronic conditions need to be managed proactively or they result in preventable ED visits

Literature on chronic disease and medication adherence consistently points to a link between nonadherence and increased use of the health care system, including increased use of the ED. A study of claims data on patients with hypertension, high cholesterol, and diabetes found that medication adherence was associated with lower costs and use of the health care system. The study found that adherence was associated with lower outpatient, inpatient, and total expenditures, ranging from 9% lower outpatient costs for diabetics to 41.9% lower inpatient costs for patients with hypertension. [28]

Most asthma hospitalizations are also considered preventable. The symptoms are preventable and can be controlled by the appropriate use of medications as well as proper asthma management at home and through outpatient care. One study of Medicaid enrollees found that patients that take their rescue medication tend to have fewer emergency visits and inpatient admissions than those who do not. [29]

Another example that was raised during multiple ED visits involved patients needing dialysis. Medical staff at hospitals reported that patients will arrive after not receiving needed dialysis. They may miss their dialysis for a variety of reasons, but often these patients do not seek care until they are in crisis and have to be stabilized in the ED. Had these patients gotten the treatment they needed sooner rather than later, they could have been treated as an outpatient in a less costly area of the hospital.

Virginia Commonwealth University Health System reports that on average the majority of patients being seen in the ED are only seen once in a year. But 3% of patients with higher utilization (5 or more visits) account for roughly 16-18% of total ED visits.

More than 8% of all ED visits are from the same patients and the overwhelming majority of them have an MHSA diagnosis

Many patients with chronic conditions who require appropriate outpatient services to stay out of hospital EDs visit the ED multiple times for the same conditions. According to the Emergency Department Care Coordination program (EDCC), 16,022 patients were

considered high users of the emergency department, using the emergency department an average of 16 times per year. These patients accounted for 256,395 of the 3.11 million emergency department visits in 2020 (8.2%). [30] The remaining 91.8% of visits to the emergency department were from 2.9 million patients with an average emergency department use rate of just over one visit per year. [31] Of the 256,395 visits, 65% were from patients that used the ED 10-20 times per year; and between 66% and 75.5% had a behavioral health diagnosis (TABLE 2). [32]

TABLE 2: Number of patients and visits for frequent ED users (2020)

Range of Visits	Patients	Number of Visits	% MHSA visits	Visits with MHSA	Visits w/o MHSA
10-14	10,507	119,807	66.0%	79,005	40,802
15-19	2,859	47,380	75.5%	35,683	11,696
20-29	1,645	38,362	82.3%	31,527	6,835
30-49	703	25,800	87.7%	22,609	3,191
50-74	182	10,830	90.3%	9,761	1,069
75-99	62	5,204	92.9%	4,825	379
100+	65	9,014	98.6%	8,876	138
Total	**16,022**	**256,395**	**70.8%**	**181,293**	**75,102**

SOURCE: JCHC staff analysis of EDCC Program Annual Report, March 5, 2021, and the EDCC Program Overview for Downstream Providers, February 17, 2022.

Preventing ED visits for patients with chronic conditions and high utilizers requires case management at the hospital and community level

Hospital administrators and health plan represantatives interviewed for this report state that patients cannot be managed for health care and services based on telephone calls, mailers and text messages. Care management at the local level, and focusing state policy to address frequent users of the emergency department, may be a more effective strategy in addressing ED utilization.

Hospital-based care management programs

Hospital-based care management programs help ED patients understand their discharge plan, including prescription management, follow up office visits and finding ways to help patients get home from the ED. The staff of the programs often identify social determinants of health that are presenting barriers to care for the individual, and can help connect them with necessary services at the time of discharge.

Large hospital systems are creating care management programs within their EDs. The programs identify high users of their EDs, defined as more than 4 or 6 visits per year,

depending on the hospital system. For example, Sentara Healthcare and its health insurance company, Optima Health, are in the process of implementing a company-wide care coordination model that integrates patient information from both entities to provide a unique care management program based on ED use and community needs. The program has identified areas across the state where frequent ED users are located and patient needs can be identified and addressed. [33]

Hospital staff indicated that their hospitals are absorbing the costs to establish ED care management programs. Many of the programs were created within the past few years, some as a result of the pandemic as a way to better manage over-crowded EDs caused by highly contagious patients who could not be transferred to other rooms or hospitals due to their illnesses.

Hospital based case management programs could be expanded with additional grant funding. Based on the current programs that exist, it is estimated that larger hospitals would require two full time staff, while smaller hospitals could manage the program with one full time staff person. Based on these assumptions, larger hospitals could receive about $190,000 per year to cover the cost of staff, with smaller hospitals receiving about $85,000. The funding required for the grant program will depend on how many grants are made. Providing 30 grants to both large and small hospitals would cost about $4.1 million annually. As part of this program the care managers should be required to identify and report on the social determinants of health that may be affecting why the frequent users of the ED do not pursue other options for their health care.

➔**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.

Ambulance-based care management programs

Several ambulance and EMT providers are intercepting chronically ill patients who are either frequent users of their services or are being discharged from a hospital with multiple chronic conditions. The EMT services are arranging “house calls” to help patients monitor their health, assist with medication adherence plans, and avoid unnecessary ambulance calls, ED visits and readmissions to the hospitals. There are two examples of locally developed programs that serve as a bridge between home health care and a hospital discharge (Chesterfield Count and the City of Lynchburg). Neither program bills for services as both programs are operated to fulfill their community needs.

CASE STUDY: Ambulance program in Chesterfield County

Chesterfield County established a community paramedic program in 2013, originally established to address hospital readmissions. Patients are referred to the program by hospital case managers, EMT crews, and through a weekly review of patients transported multiple times by ambulance to a hospital ED. The community program makes house calls to patients and helps with chronic disease management, medication adherence and other issues the patient may need addressed to stay out of the hospital. The program receives 500 to 600 referrals each month (33% are opioid related), and prevents an estimated 1,700 transports to the ED each year.

CASE STUDY: Ambulance program in the City of Lynchburg

The Lynchburg para medicine program targets patients being discharged from the hospital who have chronic conditions. Paramedics assigned to the program introduce themselves to patients in the hospital and arrange a home visit to help with medication adherence and any other issues a patient may need to avoid returning to the hospital and going to the ED. The program receives 400 referrals a month and provided 724 home visits within the past year.

There are additional ambulance or mobile medical models being implemented on a very limited scale, such as Medicare's Emergency Triage, Treat, and Transport (ET3) 5-year grant program for fee-for-service enrollees. According to CMS, ET3 grants were awarded to Arlington County, Chesterfield County and the City of Richmond. Another mobile program is being operated by Dispatch Health, a private company that provides urgent care services at people's homes in the City of Richmond and Fairfax County.

Ambulance-facilitated community programs like these could be expanded with grant funding. The grant program could enhance and expand the Community Paramedicine/Mobile Integrated Healthcare (CP-MIH) program operated by VDH. The purpose of this program is to assist with public health, primary healthcare and preventive services to underserved populations in the community. The program targets people who call 911 for non-emergent situations and are transported to the ED. The goal is to help people manage their health conditions at home and to prevent unnecessary transports to the ED. It is estimated that a $200,000 grant for one supervisor and one EMT could assist communities to develop program that meet the Virginia Department of Health requirements to implement a Community Paramedicine/Mobile Integrated Healthcare (CP-MIH) program. Providing five grants would cost an estimated $1 million annually.

➔**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.

Any grant program to improve hospital or ambulance based care management should be competitive, with programs designed locally that will compete for grant funding. The programs should include a cost sharing component by the hospital or the community, and neither should be used to supplant the funds of any existing programs.

Improved data collection would enable a better understanding of why patients use the ED for conditions that could have been better treated elsewhere

Improved information about the underlying reasons why frequent ED utilizers go to the ED will help case managers locally and policy makers at the state level. When a patient visits the ED, multiple important pieces of information are captured, but these are not always reported. Staff who triage the patient will provide an Emergency Severity Index (ESI) code, that indicates the anticipated severity of the visit before a full diagnosis. In addition, the reasons for the visit are recorded on the claim (in Box 70 of the UB04 claim form) and there is also a place on the claim for additional codes that identify social determinants of health (often referred to as Z codes Z55 to Z65). [34] This information can be used to properly identify frequent users of the EDs and provide information on why people use the ED that can help with care management. However, Z codes are currently being reported by less than 10% of the hospitals in the state. According to coders interviewed for this study, health insurance carriers discourage the use of the codes on claims because the codes may interfere with claim processing.

➔**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.

Free standing EDs appear to serve patients with a similar mix of severity to hospital-based EDs

Free standing emergency departments (FSED)[iii] are 24 hour/7 day a week facilities without inpatient capacity. However, they are subject to EMTALA, and all other provider-based requirements for hospitals including integrated medical records, staffing, billing and record keeping. [35] Virginia does not separately license FSED nor does the facility have to receive a

[iii] FSED is structurally separate and distinct from a hospital and provides emergency care. In Virginia the FSEDs are off-site hospital-based or satellite emergency departments. Other states, e.g. Texas, also have independent freestanding emergency centers that are not part of a hospital.

Certificate of Public Need (COPN), like a hospital does. Medicare laws and rules allow an FSED located within a 35 mile radius of a main hospital campus to submit claims under the main campus billing process and to be reimbursed as an ED. The claims do not identify that the patient was treated in an FSED.

There have been concerns about whether FSEDs are having unintended consequences in health care. These concerns include whether they are built to serve a community need, or are simply a competitive advantage for hospitals to try and get more patients into their facilities. There is also concern that patients may not be aware that an FSED is an emergency department, and are instead using them as they would a UCC, even though the cost of care for an FSED visit will be the same as a hospital-based ED visit.

Reston and its plans for a health care delivery system. In 1976 the developer of Reston in Northern Virginia approached INOVA Fairfax about constructing a hospital. INOVA determined that it could not support a hospital but that a smaller entity could be supported. As a result, a FSED was constructed. In the early 1980s the Reston community asked again for an acute care hospital and when INOVA decided against it, HCA constructed the Reston Hospital Center with an ED, which is within 2 minutes of the INOVA FSED.

FSEDs must demonstrate community need before building and opening

JCHC staff visits to EDs found that in most cases, communities approach hospital systems for services, which can lead to an FSED being contructed. Hospital administrators also indicated that their business development teams may approach a community to construct a FSED. In both situations the FSED cannot be built unless the community where it is located approves of the construction. Additionally, the COPN application for imaging services must support the needs for those services. In Virginia entities cannot install imaging devices unless they can show through a COPN application the need for those services in the geographic area where they plan to operate. Finally, while approval is not part of the process, hospitals that add FSEDs are required to revise their license applications, thus notifying VDH of their plans.

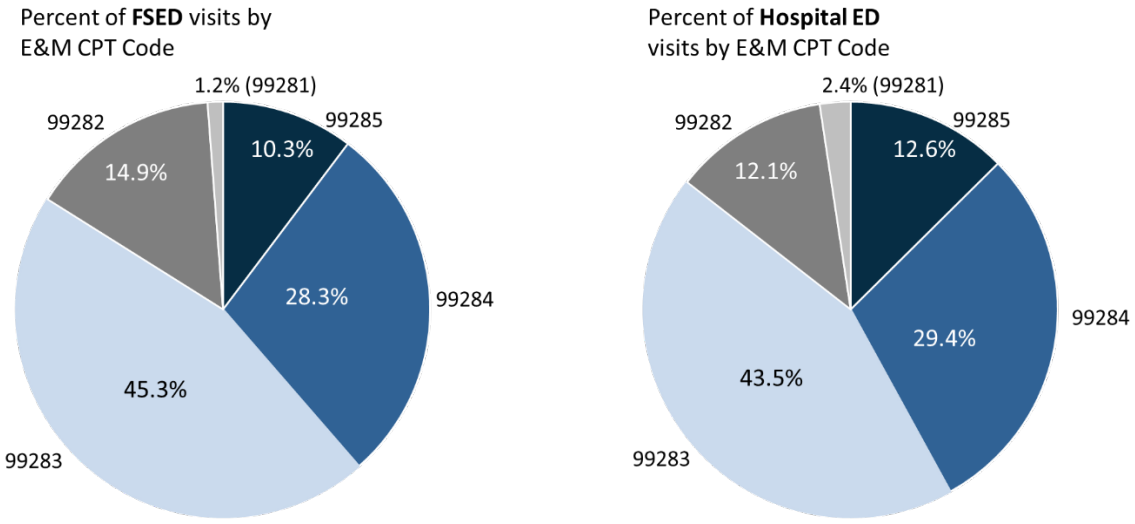
FSEDs in Virginia are part of the overall health care system and the need for them evolves as communities change (see sidebar). As health care systems expand and new opportunities emerge, FSEDs may close, or new ones may open in different locations. Several hospital administrators indicated that their systems are reviewing the costs and benefits of smaller mini-hospitals, opening urgent care centers and expanding primary care practices as alternatives to FSEDs.

Sample of FSED claims show a similar severity of patients as hospital based EDs

Because claims data do not identify whether a patient was treated in an FSED or a hospital-based ED, it is difficult to determine conclusively if patients use FSEDs more like a UCC, or like a true ED. However, JCHC staff were able to identify 5 hospitals with FSEDs in the APCD claims data. These hospitals had a combined 494,065 ED visits between 2016 and 2020. Based on data on the location of service from the APCD claims, the FSEDs served less than

3% (13,686) of the hospital's total ED visits. In addition, the intensity levels of the patients served at the FSED appear to be similar to the intensity levels of patients served at the hospital EDs (FIGURE 16).

FIGURE 16: FSEDs appear to serve patients with a similar mix of acuity to their parent hospital



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

Patients need to be aware they are using an FSED to avoid surprise medical bills

A review of academic literature finds that patients can be confused as to the type of facility they are using when they walk into a FSED. Patients can confuse the facility for an urgent care center or an actual hospital. Road signs for FSEDs are the same as road signs for hospitals, while the location and size of FSEDs tend to be more like a UCC. Some states are addressing this confusion by requiring FSEDs to better identify themselves with signage laws and consumer information. In 2021 Florida passed a law requiring FSEDs to post notices on the premises indicating that the facility is an FSED and not an urgent care center. Connecticut has a similar signage law.

One risk of patient confusion is that patients who go to a FSED expecting that it is a full hospital, and then are transferred to another hospital can be billed for two ED visits, plus the transportation services from the FSED to the hospital. This would occur if the patient is transferred to a hospital in a different system, and is not admitted as an inpatient.

This is not a common occurrence, but there are still a large number of FSED to hospital transports due to the large total volume of ED visits. VDH was able to identify transports from a FSED to an ED, and found that between 2015 and 2020, there were 77,482 transports of this kind (an average of nearly 13,000 each year). This represents less than

1% of the ED visits for the period. Ensuring that patients are aware of the type of health care facility they are using can combat this confusion, and limit any unnecessary bills.

➔**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.

End Notes:

[1] Report to Congress. Trends in the Utilization of Emergency Department Services, 2009-2018. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. March 2, 2021; and Kaiser Family Foundation. Hospital Emergency Room Visits per 1,000 Population by Ownership Type. State Health Facts. 2022. (https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

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Appendix 1: Sources and methods

JCHC staff conducted extensive data analysis, site visits, and literature reviews to complete this study. This included analysis of two data sources obtained from Virginia Health Information (VHI), and site visits to 17 emergency departments across Virginia.

Data analysis

JCHC staff used two different data sources for analysis in this report. These were the Annual Licensure Survey Data (ALSD) and the All Payers Claims Database (APCD). The APCD and ALSD datasets are different, come from different sources and the level of analysis from each source is limited by their content. These data sets were used as appropriate to analyze ED utilization and costs across the following characteristics:

- Trends over time
- Medical versus mental health and substance abuse
- Geography
- Payer source
- Patient demographics
- Patient diagnosis

Annual Licensure Survey Data (ALSD) data provides hospital level details related to admissions but not costs

The ALSD data is reported to VHI by hospitals. The data provides hospital level details related to admissions, specific health care related conditions of patient visits (e.g. behavioral health visit, medical visit, etc.) and visits. ALSD data does not include information on hospital financial data or patient demographics. The ALSD data was used in this report to determine total number of ED visits and some of the health care related conditions of the patients visiting the ED as well as how the patient arrived to the ED.

All Payers Claims Databaes (APCD) provides specific claims information from health insurance carriers but does not include all of the information on a claim

The APCD data is reported to VHI by health insurance carriers. The APCD includes specific data from certain fields of a claim but not the entire claim. Claims reported to the APCD are adjudicated by the carriers for payment. The data includes details about patient visits, the location of service, and type of payer (e.g. Medicare, Medicaid and Commercial). The APCD data includes all Medicare, Medicaid and approximately 40% of all commercial claims. Large companies that provide employees with self-insured health care coverage are

regulated by federal law and are not required to participate in the APCD. The APCD does not include information on uninsured or claims from TRICARE.

The APCD data provides health care claims information for almost 4 million Virginians in any given year. This report covers ED utilization from 2016 to 2020 and contains emergency department data from approximately 40 million claims which cover approximately 37.5% of the total number of ED visits reported in the ALSD.

The APCD data for this report focuses on EDs. ED use was defined by the CPT Codes 99281-99285, as well as by the revenue codes that identify the place of service as the ED (0450-0459). Finally, the APCD claims were divided by medical services and mental health and substance abuse services using primary and secondary diagnosis codes.

Hospital ED site visits

JCHC staff toured the EDs of 14 hospitals across the state and 3 FSEDs (TABLE 3).

TABLE 3: Name and location of ED site visits

Name	Location
Carillion Giles Community Hospital	Pearisburg, VA 24134
Carillion Roanoke Memorial Hospital	Roanoke, VA 24014
Chesapeake Regional Medical Center	Chesapeake, VA 23320
HCA - Chippenham Hospital	Richmond, VA, 23225
Dickenson Community Hospital	Clintwood, VA 24228
Virginia Hospital Center - Arlington	Alexandria, VA 22304
Inova Fairfax Medical Campus	Falls Church, VA 22046
Lynchburg General Hospital	Lynchburg, VA 24501
Riverside Regional Medical Center	Williamsburg, VA 23185
Russell County Medical Center	Lebanon, VA 24266
Sentara Norfolk Hospital	Norfolk, VA 23507
VCU Health System	Richmond, VA 23298
VCU New Kent FSED	Quinton, VA 23141
Sentara Belle Harbour FSED	Suffolk, VA 23435
Swift Creek/ Chippenham FSED	Chesterfield, VA 23832
StoneSprings Hospital Loudoun County	Dulles, VA 20166
Reston Hospital	Reston, VA 20190

Appendix 2: Supplemental data on ED utilization and trends in Virginia

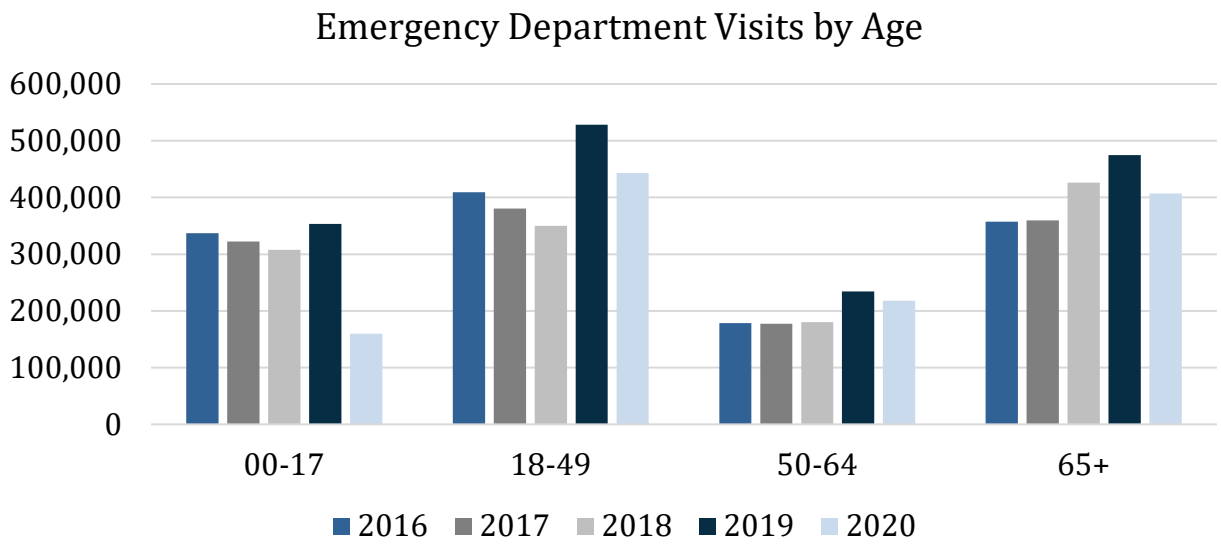
JCHC staff conducted several analyses of ED visit data that does not appear in the body of the report. The following tables and graphs provide additional information on ED visit trends, the demographics of patients, and common conditions of those patients.

TABLE 4: ED visits by arrival type, hospital admission, and type of condition (2016-2020)

Year	ED Visits	Released w/o Admission	Walked In	% w/ medical diagnosis	% w/ MHSA diagnosis
2016	3,643,352	86.50%	82.00%	96.40%	3.60%
2017	3,680,252	86.60%	82.30%	96.30%	3.70%
2018	3,692,534	86.10%	82.30%	96.40%	3.60%
2019	3,735,869	85.98%	81.70%	96.20%	3.80%
2020	3,117,335	84.32%	78.90%	95.80%	4.20%
Change	-526,017, (-14.4%)	-2.18%	-3.10%	-0.60%	0.60%

SOURCE: JCHC staff analysis of Annual Licensure Survey Data.

FIGURE 17: ED visits by age group (2016-2020)



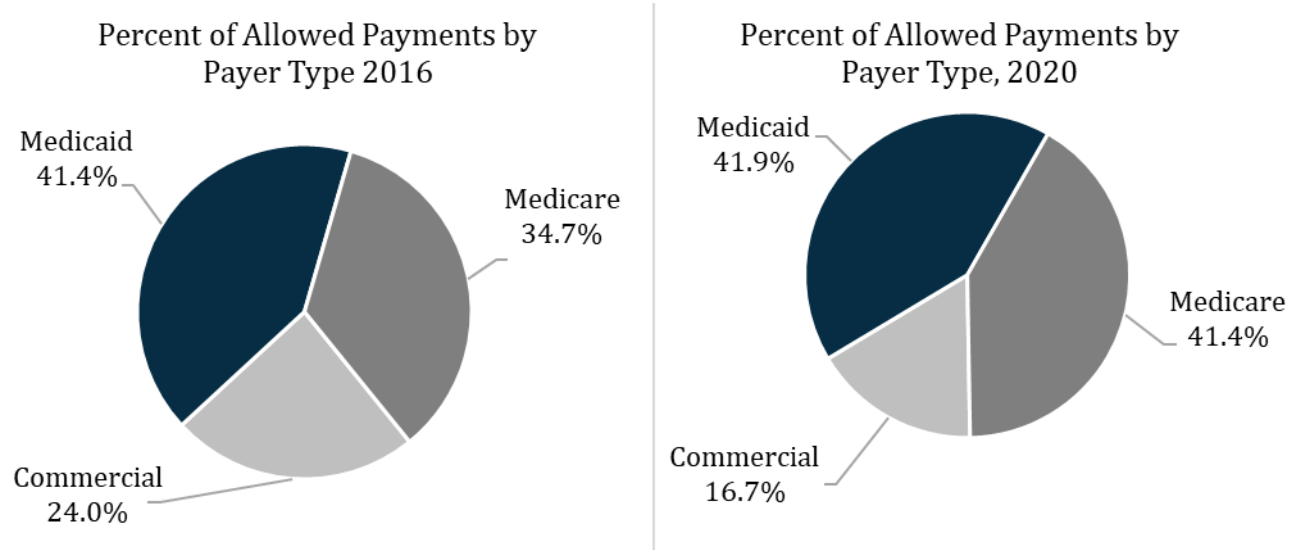
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

TABLE 5: ED visits by payer type (2016-2020; per 100 enrolled)

Year	Commercial	Medicare	Medicaid	Total All Payers
2016	13.89	37.30	36.57	26.44
2017	12.58	35.33	36.54	25.04
2018	12.13	31.67	37.48	24.82
2019	12.68	44.78	40.12	30.34
2020	9.64	28.95	32.70	22.50
Change	-4.25	-8.35	-3.87	-3.94
% Change	-30.6%	-22.4%	-10.6%	-14.9%

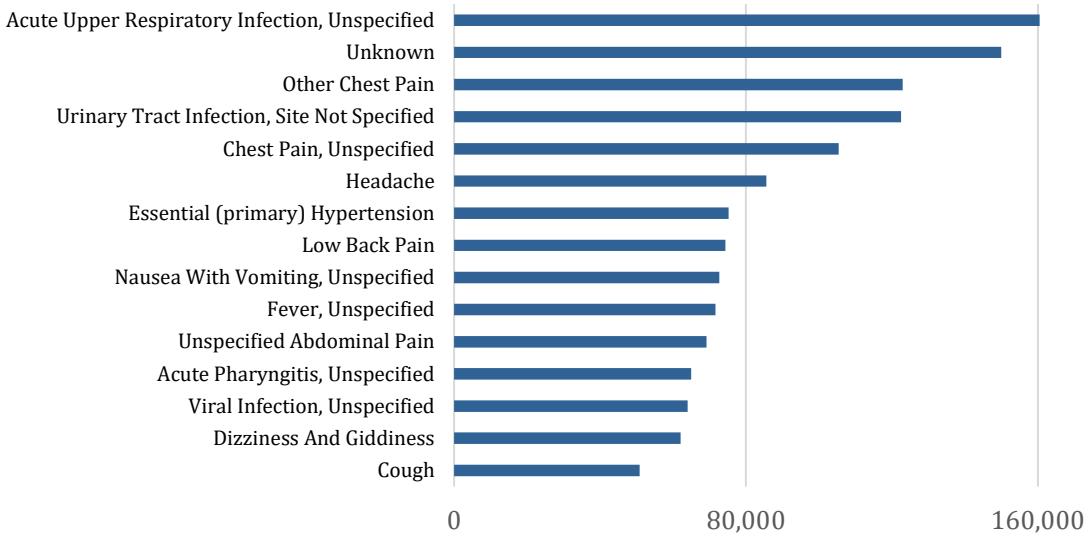
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

FIGURE 18: Percent of allowed ED payments by payer type (2016 and 2020)



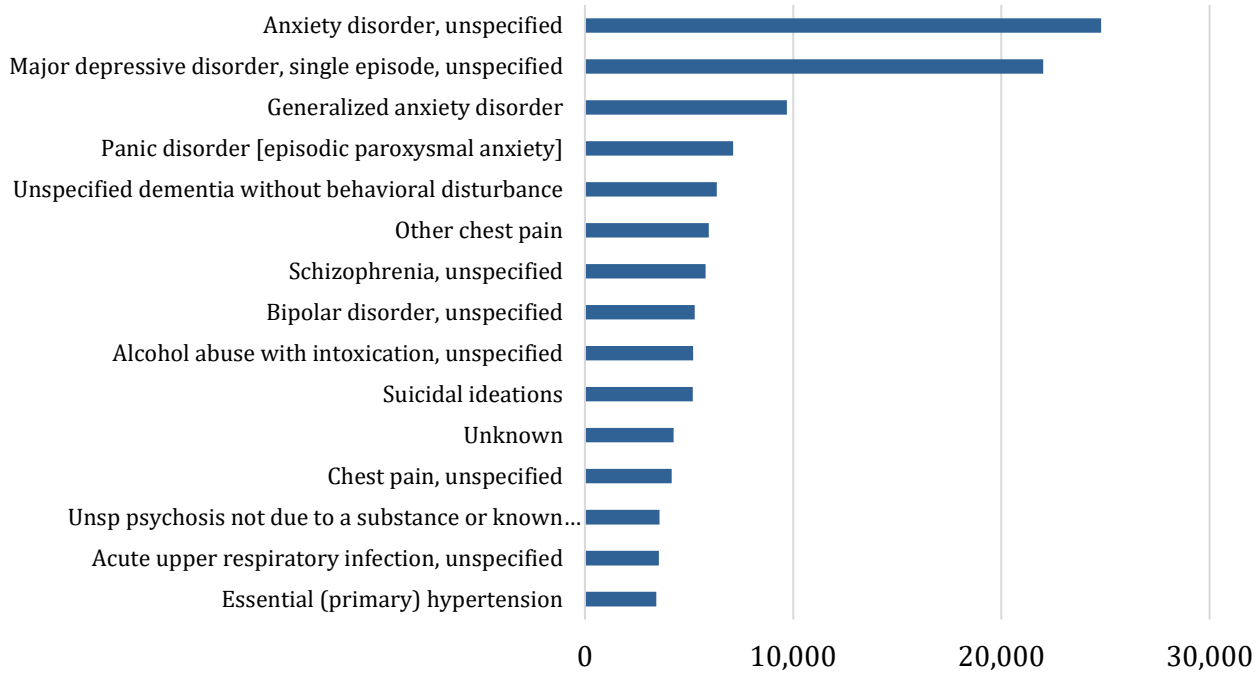
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

FIGURE 19: Most common diagnosis codes for ED visits (2016-2020)



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

FIGURE 20: Most common diagnoses for mental health and substance abuse related ED visits (2016-2020)



SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

TABLE 6: Most common reasons for ambulance transports from FSEDs to hospitals (2015-2020)

Primary Impression Category	Transports
Bleeding/blood/circulatory problem	13823
None/Unknown/Other	13082
Cardiovascular problem	10454
GI/GU problem	7384
General symptoms (e.g., fatigue, syncope, fever)	6328
Respiratory problem	5262
Pain	4966
Infection	4602
Neurological problem	2640
Mobility problem	2239
Injury	1392
Stroke/TIA	1056
Behavioral/mental health concern	985
Endocrine problem	839
Alcohol or substance use/abuse	462

SOURCE: JCHC staff analysis of ambulance transport data from the Virginia Department of Health.

Appendix 3: Study mandate

Reducing unnecessary emergency department utilization

Authorized by the Joint Commission on Healthcare on December 7, 2021

WHEREAS, literature reviews and cost-of-care comparative analyses continually show that the emergency department (ED) is the most expensive location of care in the United States healthcare system; and

WHEREAS, national data indicate that ED visits are more than six times more expensive than primary care visits for the same conditions; and

WHEREAS, a national analysis of claims found 30 percent of ED visits could have been treated in a lower cost primary care or other ambulatory setting; and

WHEREAS, studies indicate that unnecessary ED use is often due to either a lack of access to, or patient awareness of more appropriate settings; and

WHEREAS, there continues to be an increase in the construction of hospital based free standing EDs in Virginia; and

WHEREAS, unnecessary ED utilization and the associated costs of those visits may be contributing to increasing healthcare costs in Virginia; and

WHEREAS, multiple legislatively directed studies and policy actions by the General Assembly continue to examine unnecessary ED use in Virginia, including allowing the state to reduce Medicaid payments for ED services later deemed unnecessary, now, therefore be it

RESOLVED, by the Joint Commission on Health Care that staff be directed to study unnecessary ED utilization in Virginia.

In conducting its study, staff shall (i) review recent trends in emergency department utilization in Virginia, including the types and severity of conditions commonly treated in emergency departments; (ii) assess how health insurance coverage and access to primary care impact emergency department utilization; (iii) assess the impact of the location of free standing emergency departments on utilization, cost and access to care; and (iv) identify options the General Assembly can pursue, including community-based programs and regulatory changes, to ensure Virginians can be treated in lower cost, primary care, and other preventive settings when appropriate to reduce unnecessary use of emergency departments.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Department of Health, Virginia Health Information (VHI) and the

Virginia Department of Medical Assistance Services shall provide assistance, information, and data to the JCHC for this study upon request.

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