Reducing unnecessary emergency department utilization

Commission Meeting
September 21, 2022

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Study purpose

- This study is a review and report on emergency department (ED) utilization in Virginia; the study provides options the Commonwealth may take to address unnecessary ED utilization. The study resolution directed staff to:
  - Review trends in ED utilization;
  - Assess how coverage and access to primary care impact ED utilization;
  - Assess the impact of the location of free standing emergency departments on utilization, cost and access to care; and
  - Identify options the General Assembly can pursue, including community-based programs and regulatory changes to ensure Virginians can be treated in lower cost settings, when appropriate, to reduce unnecessary use of EDs

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Study methodology

- Primary data analysis came from two sources
  - Annual Licensure Survey Data submitted by hospitals
  - All Payer Claims Database data submitted by insurers
- Site visits to 17 emergency departments across Virginia

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Findings in brief

- Number of ED visits remained steady prior to COVID-19 pandemic, but severity of visits and costs increased from 2016-2020
- Alternatives to an ED visit need to be available and accessible
- Some ED visits for patients with chronic conditions and frequent ED users can be prevented
- Freestanding EDs should be easily identified to consumers

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Policy options in brief

- Direct DMAS to collect and report on claim denials from MCOs by provider type, specifically primary care
- 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
- Establish two grant programs for hospital and ambulance-based care management
- Require hospitals to submit triage intensity (ESI) codes, reason codes, and social determinant of health codes on claims and require them to be submitted to the APCD
- Require free standing emergency departments to better identify themselves to patients

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Trends in ED utilization and cost

Defining unnecessary ED utilization

Reducing non-emergent ED visits

Reducing preventable ED visits

Free standing emergency departments

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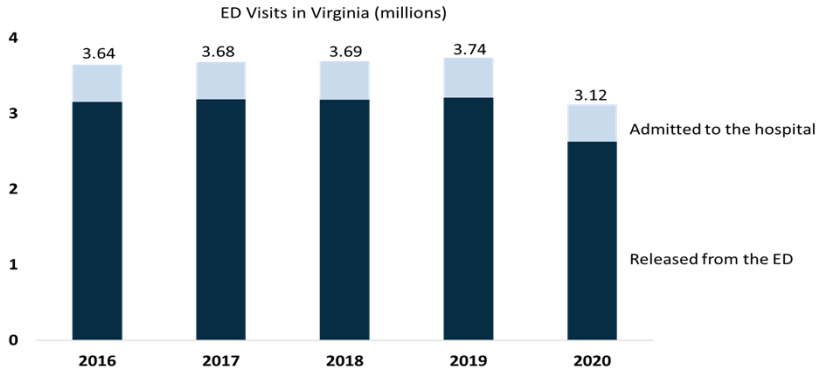
Total ED visits remained steady until 2020, first year of pandemic



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

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ED utilization in Virginia is lower than many other states

- Virginia's ED utilization rate was lower than the national average in 2018, using most recently available data
  - Virginia rate: 33.7 visits per 100 residents
  - National rate: 37.2 visits per 100 residents
- Virginia ED use ranked 12th lowest nationally

SOURCE: Health Care Cost Institute.

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Estimated $6 billion spent in 2019 for services provided in Virginia EDs

- ED spending represented 20.8% of all hospital spending in Virginia, 6.5% of total health care spending
- The cost per ED visit increased by 41.5% between 2016 and 2020, while the number of visits declined
- The trend is consistent with national research
  - ED utilization declined 4% between 2012 and 2019 while the price of a visit increased by 58%

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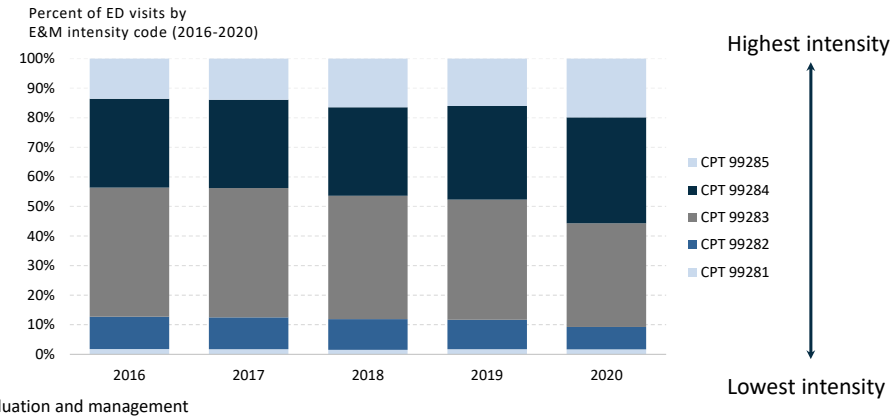
ED visits are shifting from lower to higher intensity



E&M = evaluation and management
SOURCE: JCHC staff analysis of claims data from the All Payer Claims Database.

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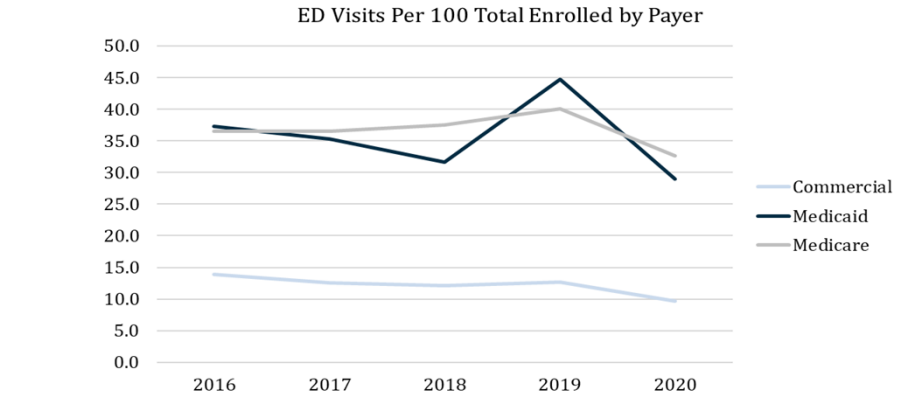
Medicaid and Medicare ED utilization exceeds commercial insurance



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

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Changes to Virginia's Medicaid program resulted in changes to ED utilization

- In 2017 the state added the Addiction Recovery and Treatment Services (ARTS) program
- In 2019 Virginia adopted the ACA Medicaid expansion, adding more than 375,000 new adults (18 to 64)
- Evaluations of Medicaid expansions in other states indicate increased ED use by the newly enrolled

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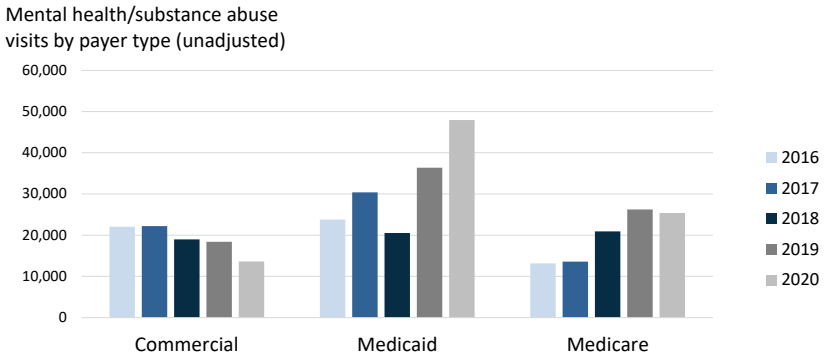
MHSA related ED visits fluctuated with program changes



MHSA = mental health and substance abuse
SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

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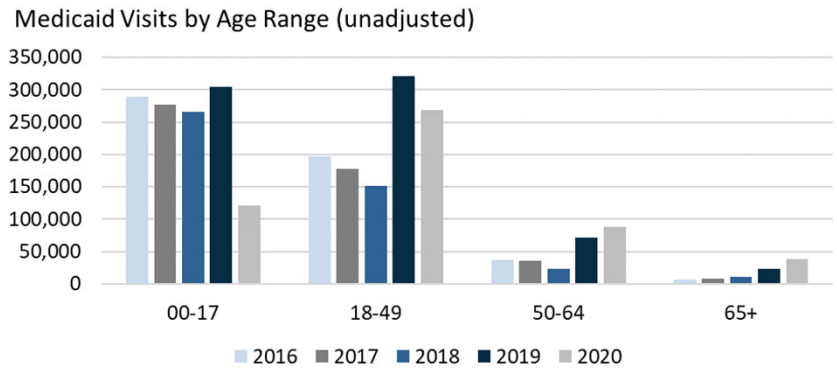
Increases in ED utilization concentrated in expansion population



SOURCE: JCHC staff analysis of claims data submitted to the All Payer Claims Database.
NOTE: Medicaid expansion covers eligible adults between the ages of 19 and 64.

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MHSA related ED visits increased in 2019 and 2020

Year	Medical	MHSA	Total	MHSA as a % 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.

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The cost of MHSA visits increased faster than medical visits

- Total payments for the emergency department E&M codes increased by 35.5% between 2016 and 2020
- Average cost for E&M codes increased 54% for MHSA visits
  - Average cost for medical visits increased 40%

E&M = evaluation and management

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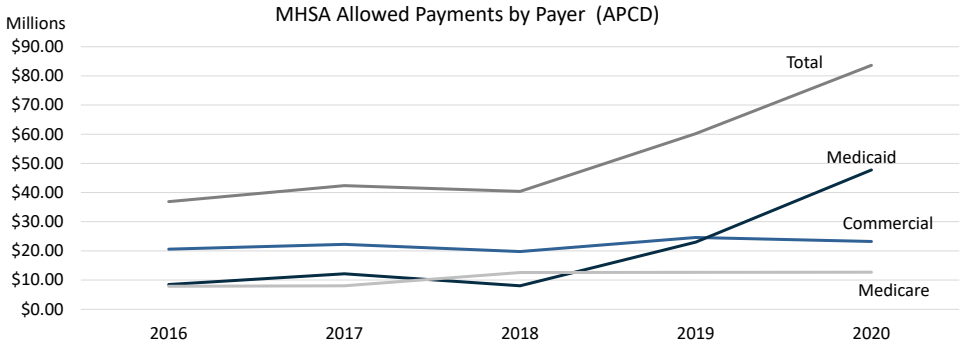
Increase in MHSA payments is driven by the Medicaid population



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

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Increase in MHSA ED visits is having a significant impact on hospitals

- Two large hospitals reported converting ED patient rooms into "safe rooms"
  - Safe rooms are stripped of anything a person can use to harm themselves with, and look like small one-car garages
- MHSA patients require more intense services – staff are assigned to stay with patients while they are in the room

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Several hospitals report children with MHSA needs being "stuck" in the ED

- Hospitals report there is nowhere to transfer children if the hospital does not have the capabilities to treat them
- Two hospitals indicate children staying in ED rooms for as much as 2-3 weeks while they wait for a placement
- Children in ED rooms may not get any treatment while they wait for a transfer and they are not in school

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Reducing preventable ED visits

Free standing emergency departments

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There is no standard definition for unnecessary ED visits

- Diagnosis lists used to define unnecessary ED visits are often different
  - VHI dashboard on preventable and avoidable ED visits indicates that 15.2% of Medicaid visits were avoidable and preventable (2020)
  - DMAS reported over 35% of ED visits were avoidable and preventable (2019)
- There is no agreement on how many ED visits in a year is excessive, the numbers range from 4 to 10 or more

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ED visits may be either non-emergent or preventable

- **Non-emergent ED visits** are when a patient goes to the ED for a minor medical condition that could have been treated in another setting
- **Preventable ED visits** are situations when an individual has a chronic condition and does not get care they need, resulting in a medical emergency

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Federal law and its relationship to ED visits

- Four core principles of EMTALA
  - will symptoms lead to serious consequences (prudent layperson standard)
  - every person gets an exam regardless of ability to pay
  - patient must be stable for admission, discharge or transfer
  - transferred if hospital cannot treat due to lack of specialist or capacity
- Failure to comply may lead to investigations, fines, and lawsuits

EMTALA = Emergency Medical Treatment and Labor Act

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Policy efforts should focus on community care

- EMTALA limits the ability to divert patients once they arrive in the ED
- Making sure alternatives are available and that patients can access those alternatives is important
- Working with patients to ensure they utilize community alternatives

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Findings

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

Access to primary care or urgent care requires available providers, and the ability to get appointments.

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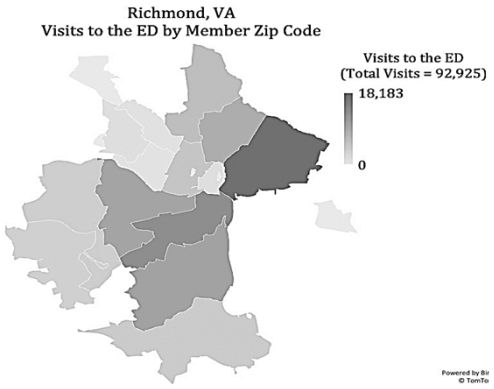
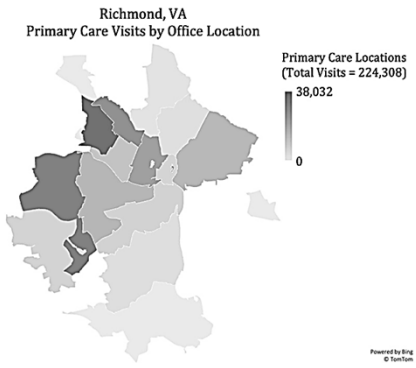
ED utilization is higher in areas with fewer primary care options (Richmond)





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

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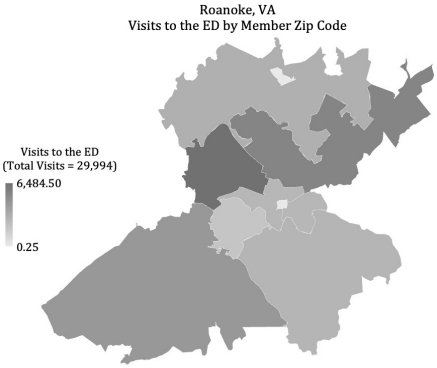
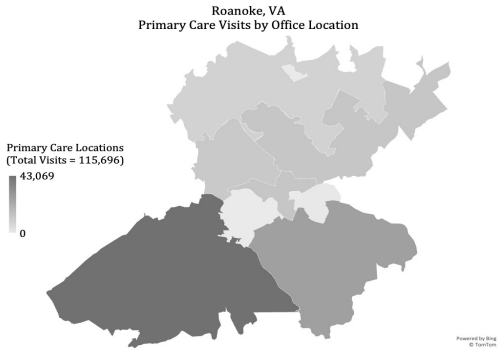
ED utilization is higher in areas with fewer primary care options (Roanoke)





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Urgent care centers are an alternative to ED use but must be available

- UCCs tend to be located in more populated areas, but less likely in areas with high Medicaid enrollment
- 67% of UCC visits are by privately insured patients
- Most UCCs operate between 8 a.m. and 10 p.m.
  - Some UCCs operate with reduced hours on weekends

UCC = urgent care center

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Limited studies on the impact of UCCs indicate they can reduce ED visits

- One study found that when an urgent care center closes, non-emergent ED visits increase by 1.43%
  - the effect was only among the privately insured and only where there were multiple urgent care centers in an area
- Another study found that when UCCs are open, non-emergent visits to the ED decreased by 17%
  - under the same conditions, access to an UCC reduced ED visits for both Medicaid (29%) and the uninsured (21%)

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

- ED arrival times concentrated in the early morning and evening hours when school lets out, individuals get off from work
- Also many arrivals in the late evening/early morning hours when physician offices or urgent care centers are closed

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Patients may be referred to the ED by their primary care provider or UCC

- Hospital staff reported that patients are often sent to the ED for tests, imaging, or based on certain symptoms such as chest pain, severe headaches or abdominal pain
  - Texas study found nearly one-third of patients who called their PCP for an appointment were referred to the ED without any physician input
- Patients' perceptions of access and/or confidence in primary care is a key factor in the decision to go to an ED

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Medicaid enrollees use the ED more frequently in part due to access issues

- By the end of 2019 the state added over 375,000 new members to the Medicaid program through expansion
- Not clear if new enrollees can always get appointments they may need with a physician or a specialist
- Federal law allows physicians and other health care providers to accept or decline Medicaid patients
  - The only place this is not true is in the ED

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The number of providers does not guarantee access to care

- Each practice manages their mix of patients by payer type
- Even for providers that accept Medicaid patients there are limits
  - 22% of the 3,422 primary care physicians that accept Medicaid in Virginia reported seeing fewer than 10 per year
  - 42% of the 5,388 primary care clinicians do not accept new Medicaid patients

NOTE: primary care practices include physicians (MDs, DOs) and advanced practice providers (nurse practitioners and physician assistants)

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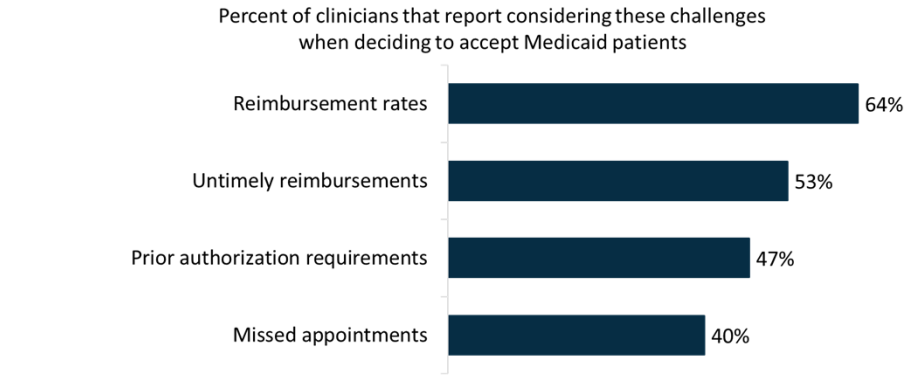
Reimbursement rates are one of many factors limiting Medicaid access



SOURCE: Primary Care in Virginia, 2019.

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MCOs must report the total denied claims, but not by type of provider

- DMAS requires MCOs to report the number of claim denials and the number of times providers must resubmit claims before payment
- Data is aggregate, can't be broken down by provider type, such as primary care

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Policy 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.

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Missed appointments directly impact a physician practice's revenue

- The Medicaid population poses the most significant challenge to most primary care practices
  - VCU Health's primary care practice has a 30% no-show rate
  - Other research found 35% to 50% of Medicaid recipients in the Philadelphia area miss appointments on a daily basis
- Patients miss appointments for many reasons
  - Forget due to scheduling issues, can't get off work, or don't have a ride

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Missed appointments result in negative patient and provider experiences

- Patients who miss one appointment are much more likely to miss future appointments
- Patients might then get double or tripled booked for the same appointment, or scheduled multiple weeks after a call for an appointment
- Negative patient and provider experiences make it less likely that a patient will seek primary care

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Solving the missed appointment issue is complicated and not well understood

- One solution being reviewed involves using automated scheduling programs
- Current research indicates that these programs may have unintended consequences of discriminating against people of color and Medicaid patients
- This issue is complicated and needs further study

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Network adequacy in MCO contracts does not equal access to primary care

- A 2019 JLARC study reviewed DMAS oversight process to ensure Medicaid patients had sufficient access to services
- The study found that the contract requirements for primary care appointment availability were strong
  - Appointments within 24 hours for urgent need
  - Appointments within 30 days for routine appointment
- Data to assess compliance with appointment requirements was not collected

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Policy Option 2

The Joint Commission on Health Care could introduce a Chapter 1 bill directing the Virginia Primary Care Task Force, DMAS, and the Virginia Department of Health, Office of Health Equity to study primary care access challenges for Medicaid patients, including why primary care practices limit the number of Medicaid patients in their practice and 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.

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Free standing emergency departments

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Findings

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

Frequent ED utilizers account for a disproportionate number of ED visits, often due to MHSA diagnoses.

Preventing ED visits for these patients requires case management at the hospital and community level.

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Patients sometimes require an ED visit for preventable emergencies

- Chronic conditions need to be managed proactively or they result in preventable ED visits
- Medication and treatment adherence can reduce costs
  - Ranging from 9% for lower outpatient costs for diabetics to 41.9% lower inpatient costs for patients with hypertension
  - Medicaid enrollees with asthma that take their rescue medication tend to have fewer ED visits
  - Missed dialysis appointments may lead to ED visits for dialysis

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Less than 1% of ED patients account for more than 8% of all ED visits

- Frequent utilizers made up 8.2% of all ED visits in 2020 (10 or more ED visits in a year)
  - 16,022 patients used the ED an average of 16 times in a year
  - More than two thirds of visits are MHSA related
- Remaining patients average a little over one ED visit per year

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

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Overwhelming majority of visits from high utilizers are MHSA related

Range of Visits	Patients	Number of Visits	Visits with MHSA	% MHSA
10-14	10,507	119,807	79,005	66.0%
15-19	2,859	47,380	35,683	75.5%
20-29	1,645	38,362	31,527	82.3%
30-49	703	25,800	22,609	87.7%
50-74	182	10,830	9,761	90.3%
75-99	62	5,204	4,825	92.9%
100+	65	9,014	8,876	98.6%

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

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Preventing ED visits requires local case management

- Patients should be managed for health care and services in person during or before visits
- Care management at the local level, and refocusing state policy to address frequent users of the emergency department, may be an effective strategy in addressing ED utilization

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Large hospital systems are creating care management programs within their EDs

- Hospital-based care management programs help ED patients
  - understand discharge plan - prescription management, follow up office visits and transportation from the ED
  - identify social determinants of health that present barriers to care
  - help connect patients with other services at the time of discharge
- Hospital staff indicated that their hospitals are absorbing the costs to establish ED care management programs

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Hospital based case management programs could be expanded

- Hospital based case management would require 1 to 2 full time staff, depending on the size of the hospital
- Estimated grants between $85,000 and $190,000
- Providing grants to 30 hospitals will cost $4.1 million per year

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Policy 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 for ED patients.

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Community para-medicine programs seek to reduce ED visits

- Several ambulance and EMT providers working with chronically ill patients or those being discharged
  - House calls are arranged to help patients monitor health, assist with medication adherence, avoid unnecessary 911 calls, ED visits and readmissions to the hospitals
  - Programs are paid for by the communities or hospital systems, patients are not billed

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Examples of community para-medicine programs

- Chesterfield County began its program in 2013
  - Receives 500 to 600 referrals each month, 33% are opioid related
  - Prevents an estimated 1,700 transports to the ED each year
- Lynchburg para-medicine targets patients being discharged with chronic conditions
  - Receives 400 referrals a month and provided 724 home visits within the past year

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Policy 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.

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Improved data collection is needed to better understand preventable ED visits

- Multiple important pieces of information are captured during an ED visit but are not always reported
  - Emergency Severity Index (ESI)
  - Reason for the visit (Box 70 of the UB04 claim form)
  - Z-codes for social determinants of health
- Information can be used to analyze why people use the ED and inform care management

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Policy Option 5

The Joint Commission on Health Care could introduce legislation to require hospitals to submit ESI codes, reason codes, and social determinants of health Z-codes as part of hospital claims, and that these codes be required on claims submitted to the All Payer Claims Database.

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Findings

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

Patient confusion about the level of care provided in FSEDs can lead to surprise medical bills.

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Free standing emergency departments are licensed as part of hospital EDs

- FSED are 24/7 facilities without inpatient capacity
  - Subject to EMTALA and other provider based requirements for hospitals; including integrated medical records, staffing, billing, record keeping
  - Hospitals required to revise their license to include the FSED and/or apply for a COPN if they add equipment subject to the laws (e.g. imaging)
    - No separate license or COPN for the FSED
- Medicare considers FSEDs part of the hospital ED if they are within a 35 mile radius of the main campus

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FSEDs are built in cooperation with communities where they are located

- In most cases, communities approach hospital systems for services, which can lead to an FSED being constructed
  - Communities must approve the construction
- FSED that include imaging devices apply for COPN and that process evaluates community need
- FSED in Virginia are part of the overall health care system and the need for them evolves as communities change

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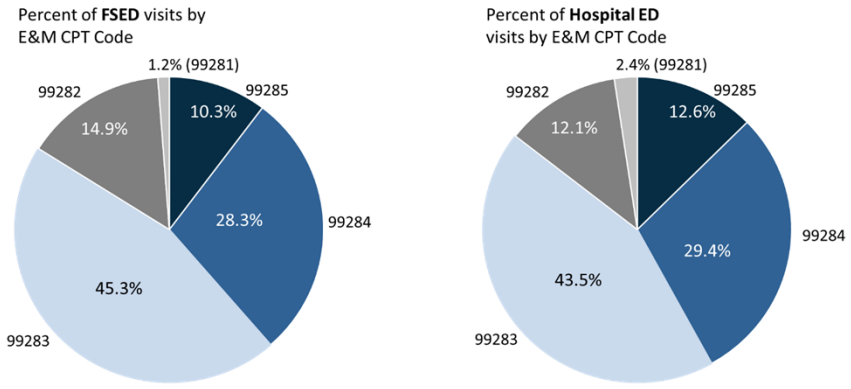
Severity of visits is similar between FSEDs and hospital-based EDs



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

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Patients need to be aware that they are using an FSED

- A review of academic literature finds that:
  - Patients can confuse FSEDs with UCCs or hospitals
  - Road signs for FSED are the same as road signs for hospitals
- Risk to patient is getting two ED bills for what appeared to be the same visit
  - Average of about 13,000 transfers from an FSED to hospital annually from 2015-2020
  - Patients transferred or transported from a FSED to a hospital operated by a different company may not be aware and may receive 2 ED bills

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FSEDs should be better identified for the consumers and data collection

- 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 who go to a FSED expecting that it is a full hospital may be transferred to another hospital in a different system and billed twice for ED services and transportation costs
- While not common VDH identified 77,482 transports from a FSED to an ED between 2015 and 2020, less than 1% of ED visits for the year

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Policy 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.

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Next Steps

- Written public comments accepted through Friday, September 30th
- Member review of public comments and discussion of policy options at October JCHC meeting (10/5)
- Member vote on policy options at December JCHC meeting (12/7)

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Opportunity for public comment

- Submit written public comments by close of business on Friday, September 30th

  Email: jchcpubliccomments@jchc.Virginia.gov

  Mail: 411 E. Franklin Street, Suite 505
  Richmond, VA 23219

NOTE: All public comments are subject to FOIA and must be released upon request.

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Joint Commission on Health Care

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