REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Emergency Room Use By Virginia's Fee-For-Service Medicaid Recipients

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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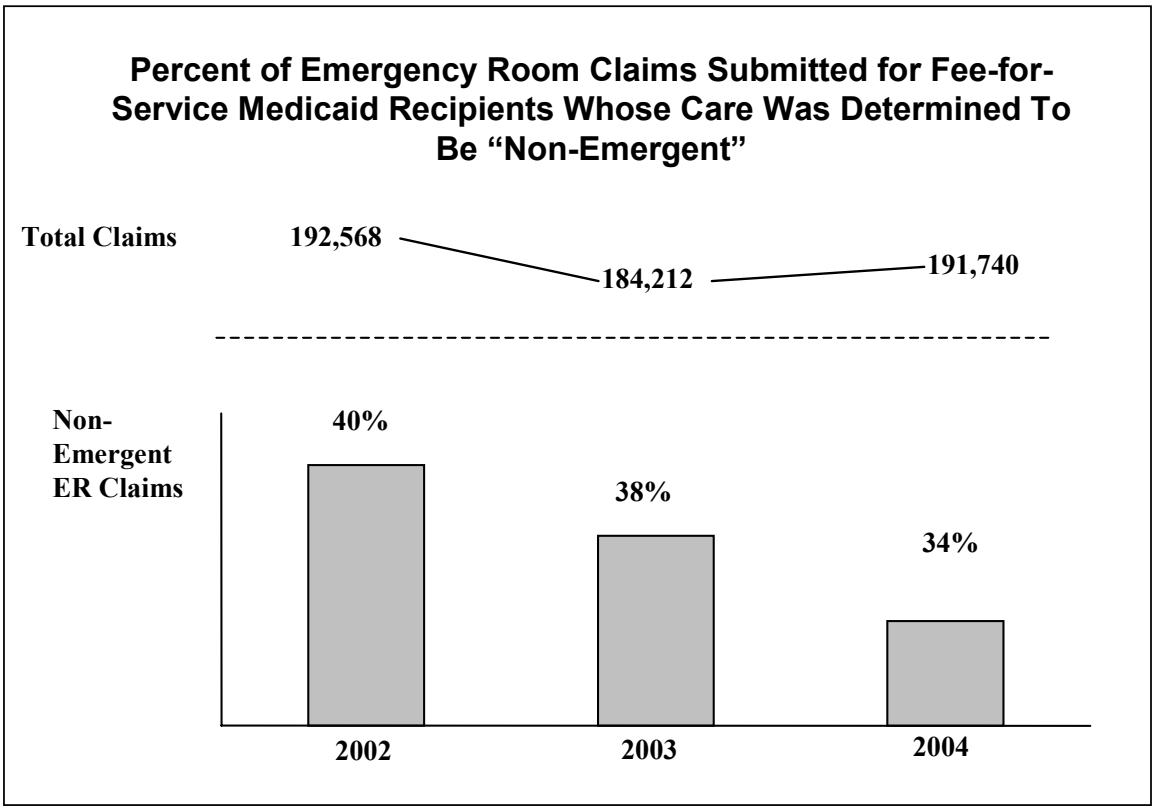
Executive Summary

In 2004, the General Assembly adopted language in the Appropriations Act -- Item 322 G -- directing the Department of Medical Assistance Services (DMAS) to study the degree to which hospital emergency rooms are being used by Medicaid fee-for-service (FFS) recipients for non-emergency care.

Because of 24-hour access policies and federal law that requires emergency rooms (ER) to treat and stabilize patients who present for treatment regardless of ability to pay, there has been a long-standing concern that ERs are being used as primary care clinics. Studies of this issue have concluded that anywhere from seven to 55 percent of all visits to ERs are for non-emergencies.

The results from DMAS' study, which focuses on Medicaid recipients who are not in a managed care program, found that in 2004, nearly 35 percent all Medicaid ER claims appeared to be for non-emergency care (see figure below). Other factors being equal, Medicaid recipients who are more likely to use the ER for non-emergent care are females, legal citizens, infants, and young adults.



Still, it is important to note that the rate at which Medicaid recipients use the ER for routine care has declined by 15 percent since 2002 when it reached as high as 40 percent. This decrease might reflect the increased efforts of hospitals such as the Virginia Commonwealth

University Health System that use outreach strategies to reduce the number of patients who use the ER as a substitute for a primary care physician.

Because of federal restrictions, State Medicaid agencies cannot require hospitals to immediately divert from the ER, those Medicaid patients who seek routine care on an emergency basis. Further, without a review of the claims, Medicaid staff cannot automatically reduce payments for the non-emergency care that was provided in the ER. Due in part to these restrictions, only ten of the 32 States surveyed for this study have established policies that are designed to discourage Medicaid recipients from using the ER for non-emergent care.

DMAS presently operates a program that is designed to discourage the inappropriate use of the ER. Recipients who use the ER in this way are subject to be enrolled in the agency's Client Medical Management program. Recipients targeted by this program are assigned a case manager and receive materials that educate them on the appropriate use of the ER. However, resource limitations have greatly restricted the scope of the program, which presently serves less than three percent of those who use the ER for non-emergent care. If this program is to be expanded, more staff resources will be needed.

Introduction

In 2004, the General Assembly adopted language in the Appropriations Act -- Item 322 G -- directing the Department of Medical Assistance Services (DMAS) to study the degree to which hospital emergency rooms are being used by Medicaid fee-for-service (FFS) recipients for non-emergency care (a copy of the budget language is found in Attachment 1). In mandating this study, the General Assembly required DMAS to:

- Assess recent trends in emergency room use for Medicaid FFS recipients;
- Estimate the rate at which Medicaid FFS recipients use emergency rooms for non-emergent care;
- Identify effective actions taken by Medicaid agencies in other states and Virginia's Medicaid Managed Care Organizations to limit the inappropriate use of the emergency room;
- Consult with physicians and hospital staff regarding programs that can be used to direct patients to primary care settings; and
- Develop recommendations to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees.

The use of emergency rooms (ERs) as the route to primary care has been cited as a recurring problem for hospitals over the past 20 years. In recent years, this problem has taken on new meaning because of the increased demand placed on emergency rooms around the country. Due to growth in the ranks of the uninsured, declining access to primary care, and an increase in the number of persons who are elderly and frail, hospitals are once again struggling with the problem of crowded emergency rooms. A central policy question for Virginia's Medicaid program is whether recipients who do not receive their care through a Managed Care Organization (MCO) are aggravating the problems of emergency room crowding by using these departments as a substitute for routine primary care.

This report presents the results of DMAS' study of this issue. The first section of the report provides some background information on the role of emergency rooms in the healthcare system and the longstanding problem of patients using ERs for non-emergency care. Next, a brief discussion of the framework used to conduct this study is provided. The third section of the report presents trends in emergency room use by FFS Medicaid recipients. As a part of this section, a comparison is made of the recipients who use the emergency room for the purpose intended to those who access these facilities for non-emergency care. Finally, information is presented on the strategies used by providers and MCOs in Virginia to limit the inappropriate use of emergency rooms.

Emergency Rooms Occupy A Key Position In Virginia Healthcare System

Emergency rooms (ER) represent a critical component of care in Virginia's system of healthcare. As departments, ERs exist for the primary purpose of providing

unscheduled, episodic care to patients who present themselves for immediate medical attention. As such, ERs must be open 24 hours per day.

In Virginia, there are 86 community hospitals that operate ER departments. Data from these hospitals show that over the three-year period from 2000 to 2002, patients have averaged more than 2.2 million visits to Virginia's ERs. There are three principle factors that increase the accessibility of ERs, which in turn fuels this volume of care. First as noted earlier, unlike primary care physicians, ERs are open 24 hours per day and are staffed to provide a full range of healthcare services. Thus during times when doctors' offices and clinics are closed, persons in need of medical care can visit an ER for treatment, regardless of the severity of their condition.

Second, the federal Emergency Medical Treatment and Labor Act (EMTALA) governs virtually all hospitals. This law requires hospitals participating in the Medicare program to offer emergency treatment to those who are unable to pay. To comply with EMTALA, hospitals must provide a medical screening that is sufficient to determine whether a patient has a medical emergency. Patients who are determined to have an emergency must be provided the care needed to stabilize them. Only after patients are stabilized can they be discharged or transferred to another hospital or clinic.

Finally, based on language in the 1997 Balanced Budget Act (BBA), the federal government established a "prudent layperson standard." In effect, this standard states that if a prudent layperson believes they are experiencing a medical emergency they cannot be denied emergency care and restrictions cannot be placed on their number of ER visits. As a result, State Medicaid agencies cannot universally require hospitals to divert from the ER, those Medicaid patients who seek routine care on an emergency basis. Moreover, without a review of the claim, the Medicaid program cannot automatically reduce the higher ER hospital and physician payments based on the patient diagnosis. In practice, any determinations as to whether the prudent layperson standard has been met must be made by providers and the State Medicaid program on a case-by-case basis.

Thus, the passage of EMTALA and BBA, which effectively reversed historical practices used by hospitals to deny care to the uninsured, allows those with and without insurance virtually unfettered access to hospital-based medical care.

Concerns About Inappropriate Use. Because of the ER's 24-hour access policy and EMTALA's "screen and stabilize" provisions, there has been a long-standing concern that ERs are being used as primary care clinics. This problem is believed to have two aspects. Numerous studies indicate that ERs have become the sole source of care for many persons who do not have a primary care physician. This mostly involves persons who are uninsured and are either unwilling or unable to pay the cost of an office visit to a primary care physician. While the care they seek from ERs is often for problems of an emergency nature, these patients will also rely on ERs for the treatment of routine medical problems as well.

The second aspect of this problem and the focus of this study is the use of ERs for non-emergency care by persons who are insured but do not have a primary care physician whom they regularly visit. Many health policy experts contend that this problem reflects the growing inability of our system to ensure access to primary care even for the insured. Because of the declining number of primary care providers, insured patients sometimes face significant delays when seeking appointments and subsequent long waits upon arriving for medical care. For Medicaid recipients, this problem is exacerbated because of the growing number of physicians who eschew the treatment of this population because of the problems routinely encountered when providing care to this group. Primary care physicians cite missed appointments, low reimbursements, and the frequent refusal of these patients to follow prescribed treatment regimens as key factors in their decisions to no longer serve Medicaid recipients.

The use of the emergency room as a substitute for primary care raises significant policy concerns. When some patients rely on the ER as their medical home, they usually do not practice any continuity of care; they often refrain from seeking preventative care; and they delay seeking necessary treatment until their health problems reach a crisis stage and become more difficult and costlier to treat. For others who do not wait but routinely visit the ER for basic care, they simply add to the crowding problems that exist in many of these departments. This effectively delays treatment not only for themselves but also for others who may be struggling with more serious illnesses.

These problems of crowding also place a significant strain on public hospitals and make it that much more difficult for these facilities to carry out one of their key missions as providers of last resort for the uninsured. Because of these issues, the ER utilization patterns for Medicaid recipients who are not in a managed care plan have come under scrutiny by the General Assembly and as a result form the basis for this review.

Study Framework

In order to meet the requirements of the study mandate, DMAS staff developed a narrowly defined research plan focusing first on the degree to which Medicaid FFS recipients use the emergency room for primary care, and second, on the strategies in place to limit such use. Within this framework, the following research questions were identified to sharpen the focus of the study:

1. What has been the overall trend in emergency room use among Medicaid FFS recipients?
2. How much of this use appears to be for non-emergency care?
3. What factors distinguish those Medicaid FFS recipients who use the emergency room appropriately from those who do not?
4. What strategies are available that might prove successful in curtailing this practice among Medicaid recipients?

To address these questions, the following three major research activities were conducted: an analysis of hospital claims and recipient data for Medicaid recipients; structured interviews with physicians and hospital administrators; and telephone surveys of other state Medicaid programs.

Claims Analysis. To develop estimates of the degree to which Medicaid recipients use the ER for non-emergency care, DMAS staff relied upon data generated by the agency's claims review process. Under this system, the ER Revenue code on each hospital emergency room claim and the Procedure code on each physician emergency room claim are automatically compared to the codes in a "pay list" file. If a match is found the claim is paid at normal calculated ER provider rate. If there is no match, the claim is flagged for review.

Once a claim is flagged, the computer generates a letter requesting additional documentation if the provider has not already submitted supplementary information to support the claim. The provider has 21 days to return the needed documentation. Should the provider fail to submit the required documentation, payment for the claim is reduced by the system. For those claims for which documentation is returned, DMAS staff manually reviews the information and determines whether the diagnoses and procedures were appropriate for the ER. If the documentation does not support an ER visit, the claim is paid at a reduced amount -- $30 for hospitals and $20 for physicians. For this study, all ER claims that were paid at a reduced rate were categorized by DMAS as "non-emergent."

It should be noted that DMAS modified its claims review process for physicians in May 2004. Now each physician's claim contains a procedure code numbered 99281-99285 based on the severity of the medical condition treated. Under current policy, claims that are assigned procedure codes 99284 or 99285 (the higher severity codes) are no longer subject to later review and both the hospital and attending physician are paid at the higher ER rate for the services provided.

Interviews with Providers. As required by the study mandate, DMAS staff interviewed representatives from each MCO participating in Virginia's Medicaid program, several hospital administrators and some physicians to question them about any strategies that might be used to successfully divert from the ERs, those recipients who seek routine care. Particular attention was paid to a program that the VCU Health System (VCU/HS) has in place to address this very problem.

Telephone Survey of Other Medicaid Agencies. The last research activity conducted for this study was a telephone survey of other Medicaid programs. A total of 32 states participated in the survey. Through this survey, DMAS staff determined if other states had established policies or programs to address the problem of ER use for routine care by Medicaid FFS recipients.

Trends in Emergency Room Utilization Patterns for Medicaid Fee-For–Service Recipients

Over the past ten years, there have been numerous studies of the degree to which ERs around the country are used for non-emergencies. Through the application of various methods and data sources, it has been concluded that anywhere from seven to 55 percent of all visits to ERs are for non-emergencies. While none of these studies focused solely on ER use by Medicaid recipients, at least one study found that Medicaid recipients were much more likely than persons who have private insurance to indicate that the ER was their primary source of care.

The results from DMAS' study of this issue indicate that in 2004, nearly 35 percent all Medicaid ER claims appeared to be for non-emergency care. However, this number has declined by 15 percent since 2002, when the rate was as high as 40 percent. Greater outreach efforts conducted by hospitals to reduce the incidence of patients who use the ER for routine care is probably a key factor influencing the observed decline.

Additional data are needed to determine with greater certainty, whether certain socio-demographic factors are more likely than others to impact the decision of Medicaid recipients to use the ER for routine care. Based on the data that are available, it appears that after controlling for other factors, females, legal citizens, infants, and young adults have significantly higher odds of using the emergency room for non-emergent care than their respective counterparts.

State Medicaid agencies have no authority over the procedures hospitals use to triage patients and divert those seeking routine care to a more appropriate setting. Moreover, because of concerns about violating federal law, many State Medicaid agencies have refrained from taking action to restrict access to ER care. Of the 32 states that participated in DMAS' telephone survey on this issue, only ten have established policies that are designed to discourage Medicaid recipients from using the ER for routine care.

DMAS presently operates a program that is designed to discourage the inappropriate use of the ER. Recipients who use the ER in this way are subject to be enrolled in the agency's Client Medical Management program. Recipients targeted by this program are assigned a case manager and receive materials that educate them on the appropriate use of the ER. However, resource limitations have greatly restricted the scope of the program, which presently serves less than three percent of those who use the ER for non-emergent care. If this program is to be expanded, more staff resources will be needed.

The Rate at Which ERs Are Used for Routine Care by Medicaid Recipients Has Declined but Remains A Problem

To conduct the analysis of ER use by Medicaid FFS recipients, the DMAS study team focused on the following questions:

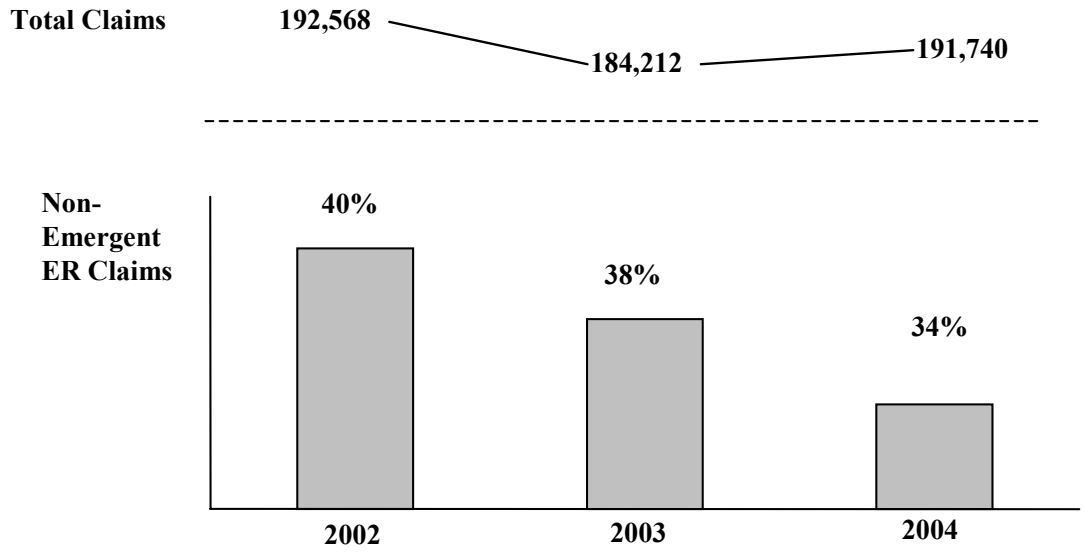
- How often have Medicaid FFS recipients used the ER for non-emergent care over the past three years;
- How do those recipients who use the ER for routine care compare to those who use it for exclusively for emergencies;
- Among which sub-groups of recipients are rates of non-emergent use the highest?
- What factors are the strongest predictors of non-emergent ER use among Medicaid FFS recipients?

The Rate at Which ERs Are Used For Routine Care. As noted earlier, for this study, DMAS staff were able to evaluate all hospital claims that have been paid for Medicaid FFS recipients over the past three years through the use of data from the agency's MMIS. All ER claims that were flagged for review (pended) and later classified as non-emergencies were used to calculate an ER non-emergency use rate – a representation of the degree to which Medicaid recipients used the emergency room for routine care.

Figure 1 reports the results of this analysis. As shown in FY 2002, hospitals submitted more than 192,500 claims for the care provided to Medicaid FFS recipients. This figure decreased slightly in FY 2003 (184,212), before nearly returning one year later to levels observed in FY 2002. Further analysis of these claims revealed problems with the degree to which Medicaid FFS recipients used the ER for non-emergent care. Specifically, in FY 2002, four out of every 10 ER claims submitted to DMAS were later determined to be for non-emergent care. One year later, this figure declined to 38 percent, decreasing further to 35 percent by the end of FY 2004.

Figure 1

Percent of Emergency Room Claims Submitted for Fee-for-Service Medicaid Recipients Whose Care Was Determined To Be "Non-Emergent"



Source: DMAS staff analysis of emergency room claims files from the agency's MMIS.

These results essentially tell two stories. First, with more than three of every 10 ER claims in FY 2004 classified as non-emergent, the data clearly indicate that too many Medicaid recipients continue to visit ERs when a trip to a primary care provider would have been more appropriate. While the cost implications to the State associated with this type of utilization have been minimized by the agency's claims review process, these visits likely remain a problem for ERs providing the care.

The second point worth noting is that the trend in ER use for routine care by Medicaid recipients is declining. Since FY 2002, the decrease in inappropriate ER use has been 15 percent. Increased efforts by ER staff in some hospitals to divert patients to primary care settings when appropriate has undoubtedly contributed to this trend. As will be discussed in more detail later in this report, using client outreach, hospitals such as VCU/HS have taken steps to link patients with primary physicians so that they will not routinely visit the ER for non-emergencies. As more hospitals across the State establish these programs, the Medicaid ER non-emergent use rate may continue downward.

Comparison of Recipients Based on ER Utilization Patterns. One objective of this study was to examine and compare the profiles of Medicaid recipients who use the ER for emergency care to those who do not. This was mildly complicated by the fact that a given recipient in Medicaid could have multiple ER claims for both emergency and non-emergent care.

In such instances, the claims data had to be summarized and reduced to one record per recipient. In reducing the claims file to the recipient level, the following decision rules were used:

- Recipients who had at least one ER claim for non-emergency services in FY 2004 were placed in the non-emergent care group.

- Recipients with only ER claims for only emergency services in FY 2004 were placed in the emergent care group.

This allowed the study team to compare and contrast the characteristics of these two groups. Figure 2 presents the results of this analysis. As shown, when the profile of Medicaid recipients who use the ER for emergent care is compared to those who rely on the ER for non-emergent services, only minor differences in the two populations are evident. Most notably, a larger proportion of those who used the ER for non-emergent care were female (64 to 57 percent).

The differences across the two groups for the other characteristics, while statistically significant, were minimal in size. For example, only four percent of all persons who used the ER for emergency care were non-citizens. Non-citizens, also referred to as Aliens, are only eligible for Medicaid-funded emergency services such as the treatment of an accidental injury or medical condition (including labor and delivery for pregnant women). By comparison, only two percent of those who use the ER for non-emergent care were non-citizens.

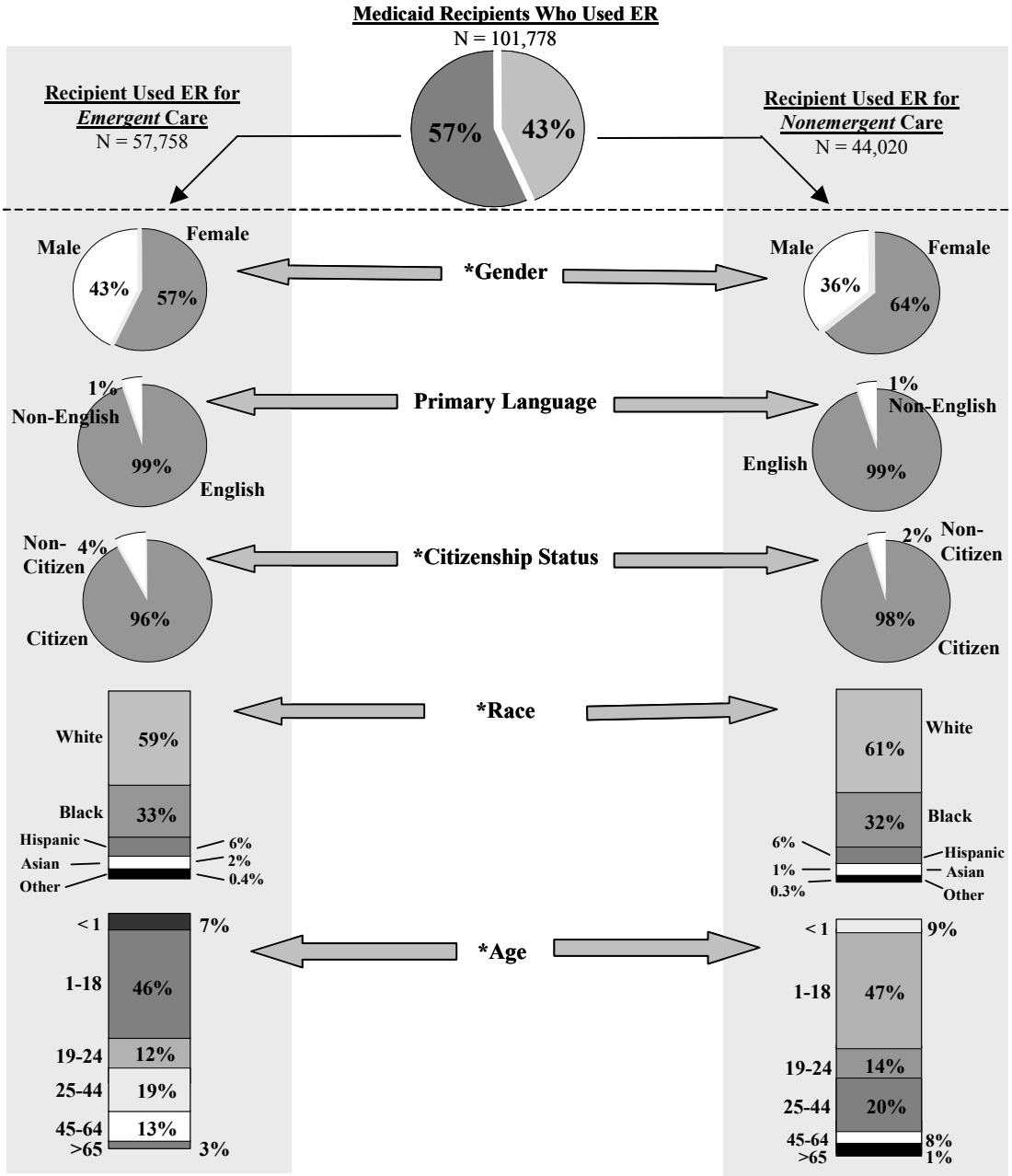
In terms of race, a slightly higher percentage of persons who used the ER for non-emergent services were white (61 to 59 percent). Differences across the remaining racial categories were negligible. Likewise, there were minimal differences in terms of the primary language and ages of Medicaid recipients.

The study team examined the distribution of these groups along two other factors -- type of locality and the density of providers in the locality. Because of the limited primary care provider network in many rural localities, it was believed that residents in these areas would be more likely to rely on ERs to receive routine health care. This is especially true in the southwestern part of the State. For this same reason, the study team believed that a larger proportion of Medicaid recipients who live in areas with a low density of primary care providers would represent a larger portion of the group that use ERs for non-emergent services.

For this study, locality type was created by ranking each jurisdiction based on the population density of the area. The top third of the localities with the largest population per square mile were considered “urban”, the middle third “suburban”, and the bottom third “rural”. A similar strategy was employed to develop the measure of provider density using the measure of population per primary care provider.

Figure 2

Demographic Characteristics of Medicaid Recipients Who Used Hospital Emergency Rooms for Emergent and Nonemergent Care (FY 2004)



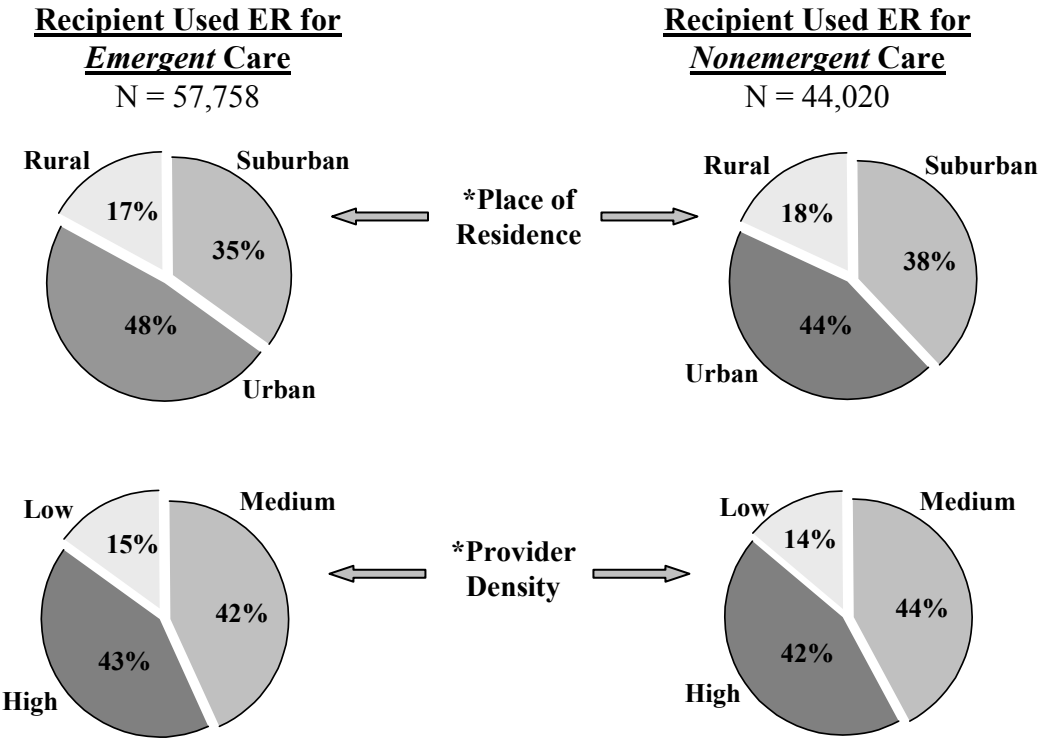
*Notes: The Chi-Square values for these indicators are significant at a level of .0001

Source: DMAS staff analysis of data from the Medicaid recipient and claims files.

Somewhat surprising, however, the study team found minimal to no differences in the distribution of the two groups for these variables (Figure 3). As shown, a slightly higher percentage of recipients who use the ER for emergent care are from urban areas (48 to 44 percent). Conversely, a slighter higher percentage of recipients who use ERs for non-emergent care were from suburban areas (38 to 35 percent). In terms of provider access, the differences were limited as well.

Figure 3

Place of Residence and Provider Density Variables for Virginia Medicaid Recipients
(FY 2004)



Notes: *This chi-square value for this indicator is significant at a level of .0008

Source: DMAS staff analysis of data from the Medicaid recipient and claims files.

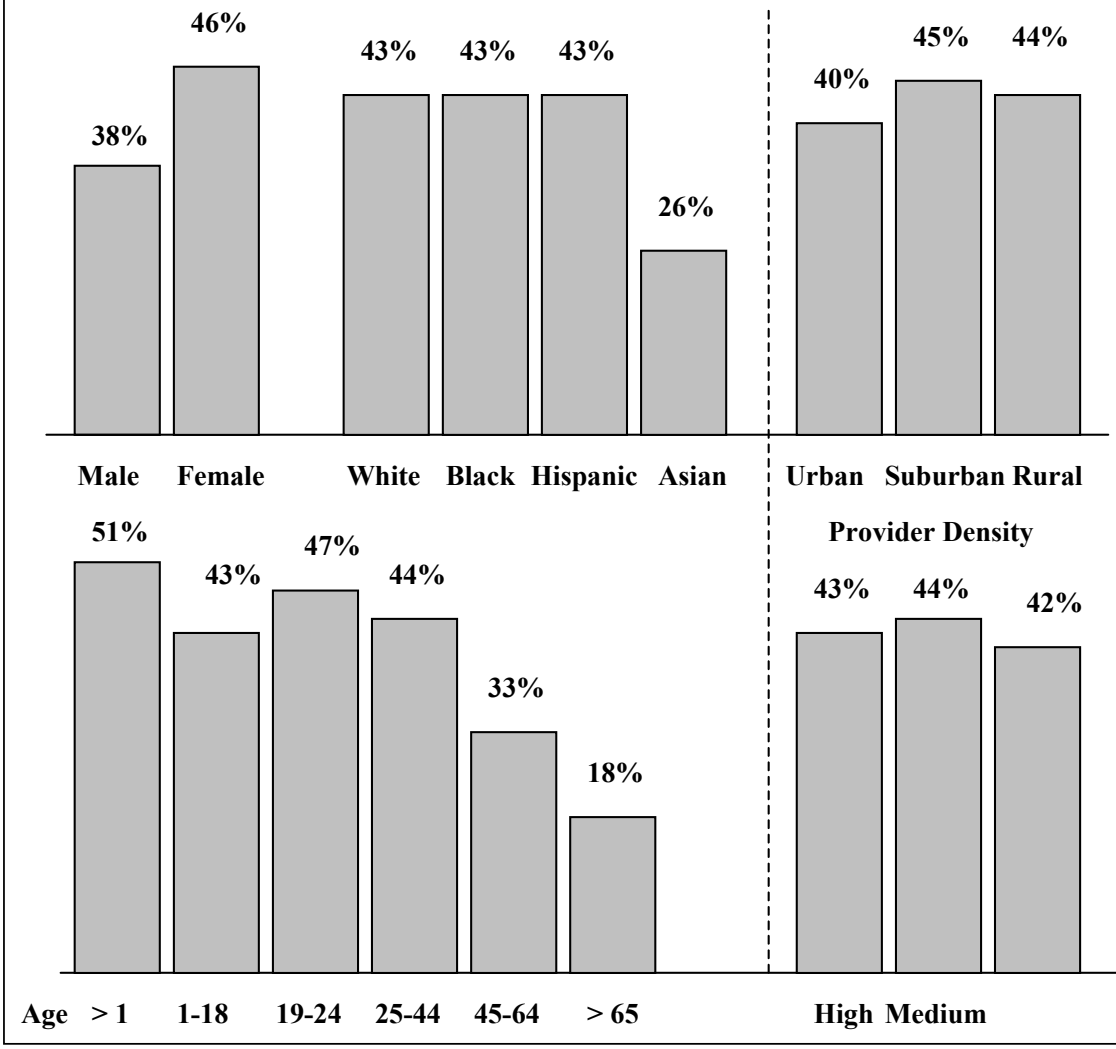
Factors That Impact The Use of ERs For Non-Emergent Care. The final question addressed in this analysis is whether certain recipient characteristics are associated with the use of ERs for routine or non-emergent care. This is an important analysis because, based on the results, it might be possible to more precisely identify those within the Medicaid FFS population who show a greater likelihood to use the ER for routine medical care. This would allow the agency to better target any efforts aimed at reducing this problem.

As a first step in this analysis, the rates of non-emergent ER use are separately reported for selected recipient characteristics. These ER non-emergent use rates are unadjusted, meaning that statistical controls have not been introduced to account for the effect of a given characteristic (e.g., recipient's race) while controlling for impact of other variables (e.g. recipient's age).

Figure 4 reports the unadjusted rates of non-emergent ER. The most significant variation in the rates is observed for the gender, race, and age of Medicaid FFS recipients. Specifically, 46 percent of all female Medicaid FFS recipients use the ER for routine care. This compares to a 38 percent rate for their male counterparts. The rate at which each racial group uses the ER for non-emergent care is more than 40 percent except for Asian Americans. Only 26 percent of this group uses the ER for routine care. Substantial age differences are also observed. While more than half of children under the age of one are taken to an ER for routine care, only 18 percent of Medicaid recipients over the age of 65 use the facilities for this purpose.

Figure 4

Emergency Room Non-Emergent Use Rates For Selected Recipient Sub-Groups



Finally, the rate of non-emergent ER use for recipients from urban areas is lower than those from rural or suburban areas.

These differences raise a key question: After accounting for the influence of other factors, what recipient characteristics are most strongly associated with the ER utilization patterns of Medicaid recipients? Stated another way: Are certain recipient characteristics better indicators than others of which Medicaid participants are more likely to use the ER for routine care?

To address this issue, DMAS staff developed a logistic regression model using a dichotomous (1,0) dependent variable. This variable was constructed as follows:

1 = yes, the recipient used the ER for non-emergent care;
0 = no, the recipient did not use the ER for non-emergent care.

The use of regression analysis in this study was useful in two ways. First, with this statistical technique, a fuller explanation of the dependent variable is usually possible. In this case, the study team was able to discern which set of factors best explain the variation observed in ER non-emergent use rates. Second, the effect of any particular factor -- such as the age of the recipient – is made more certain because the confounding effects of other variables are removed.

The results of the analysis suggest that several variables -- the recipient's gender, citizenship, race, place of residence, age, and the number of providers in a locality -- appear to be significant factors in determining the probability that Medicaid recipients will use ERs for non-emergent care (Table 1).

A key statistic summarizing these results is the odds-ratio. This statistic, which is reported in Table 1, represents, on average, the odds that a Medicaid recipient with a specific characteristic (e.g., being female) will use the ER for non-emergent care after controlling for the other variables explicitly considered in the model. As shown, the odds that a Medicaid recipient living in an urban locality would use the ER were 83 percent of the odds that a recipient living in a rural jurisdiction would use the ER for non-emergent care. The odds that a recipient over the age of 65 would use the ER were only 39 percent of the odds that a recipient between the ages of 19 and 24 would use the ER. In addition, if the recipient was a female, the odds of using the ER for non-emergent care were, on average, 1.39 times greater than the odds that a male would use the ER for similar care. Finally, the odds that an infant would be taken to the ER for non-emergent care were 1.45 times the odds that a recipient between the ages of 19 and 24 would visit the ER for routine care.

In summary, these results mean that after controlling for other factors, Medicaid FFS recipients who are female, legal citizens, and either under the age of one or between the ages of 19 to 24 are much more likely to use ERs to receive routine care. Conversely, net of other factors, recipients who are Asian American or who live in urban areas are less likely to treat the ER as a primary care facility.

Table 1

Variables for the Multivariate Analysis of Factors Associated with Medicaid Recipients' Use of Hospital Emergency Rooms for Non-Emergent Care

Dependent Variable	Standardized Parameter Estimates	Odds Ratios	Level of Significance
Indicator of Whether the Medicaid Recipient Used the ER for Non-emergent Care (1 = Yes, 0 = No)			
Gender Variable			
Female*	**0.0884**	**1.39**	**<.0001**
Citizenship Variable			
Citizen*	**0.0333**	**1.46**	**<.0001**
Race Variable			
African-American	0.0073	1.03	0.0708
Asian*	**-0.0213**	**0.73**	**<.0001**
Hispanic	-0.0005	1.00	0.8896
Other Ethnicity	-0.0108	0.73	0.0030
Locality Type Variable			
Suburban	0.0107	1.04	0.0300
Urban*	**-0.0406**	**0.86**	**<.0001**
Age Variable			
< 1 year*	**0.0551**	**1.45**	**<.0001**
1 – 18 years	0.0103	1.04	0.0342
19 – 24 years*	**0.0213**	**1.12**	**<.0001**
45 – 64 years*	**-0.0707**	**0.66**	**<.0001**
> 65 years*	**-0.0836**	**0.36**	**<.0001**
Provider-Density Variable			
High Density	-0.0104	0.96	0.0142
Low Density*	**-0.0357**	**0.83**	**<.0001**

Notes: *Statistically significant at the 0.0001 level.

Source: DMAS staff analysis of MMIS recipient and hospital claims data.

DMAS' Program To Reduce The Rate At Which Medicaid Recipients Use Emergency Rooms For Non-Emergent Care Is Small In Scope

The final objective of this study was to collect information from other State Medicaid agencies, hospital providers, physicians, and Medicaid MCOs concerning possible strategies DMAS might use to slow the rate at which Medicaid recipients use the ER for routine care.

To meet this study requirement, DMAS staff conducted telephone surveys of other Medicaid agencies and contacted the five managed care organizations that contract with Medicaid to request information on the strategies these organizations use to curb the use of ERs for non-emergent care services. DMAS also met with staff at the Virginia Commonwealth University Health System (VCU/HS) to discuss a program the hospital has implemented to reduce non-emergent ER use. Finally, the Virginia College of Emergency Physicians (VACEP) was also contacted for input on this issue.

Policies Of Other State Agencies. DMAS staff conducted surveys of Medicaid agencies in 50 states. The purpose of the survey was to determine whether other agencies had adopted any policies or programs designed to limit the degree to which Medicaid FFS recipients use the ER for non-emergent care. A total of 32 states responded to the survey. Of those responding, only ten -- 31 percent -- had developed any policy or programs concerning this issue. Three of the nine states perform retrospective reviews similar to DMAS and will reduce payments for ER claims submitted for non-emergency procedures.

The remaining states actually monitor the emergency room use of Medicaid recipients and will perform outreach activities when there is evidence that recipients are using the ER for routine care. The most elaborate program is operated by the state of Maine. Staff at the Maine Medicaid agency conducted an analysis of the top five non-emergency diagnoses that are traditionally treated in the ER. These were persistent coughing, earaches, bronchitis, sore throats, and upper respiratory infections. On a quarterly basis, staff identify patients who have presented themselves in the ER for any of these diagnosis two or more times in a quarter. Those patients are sent letters reminding them their provider's office is available 24 hours, seven days a week to treat these conditions. Nurses on staff at the agency will also call the patient's home to ascertain whether the family is facing barriers that prevent them from using their primary care physician. Finally, primary care providers are expected to provide 24-hour coverage to support this program and they receive an incentive payment for doing so.

Strategies Used By MCOs in Virginia's Medicaid Program. Each of the five MCOs that contract with the Virginia Medicaid program monitor and work with beneficiaries in some manner to minimize the use of ER for routine care. As shown in Table 2, at least three of the MCOs establish limits on the number of non-emergency ER visits it will allow before an intervention is triggered. As shown in Table 2, these thresholds range from as few as one visit per month to as many as five visits in a quarter. Once a beneficiary is identified as a non-emergent ER user based on an analysis of utilization patterns, at least two of the MCOs will initiate patient contacts and provide educational information on the appropriate use of ER services. These contacts are typically conducted via the telephone or through mailings. One of the MCOs targets its efforts only on persons who are diagnosed with Asthma.

Table 2

Summary of Strategies Used By MCOs In The Medicaid Program

Strategies	Anthem	Optima	Southern Health	Unicare	Virginia Premier
Identify Frequent Users	5 visits in a quarter	1 or more non-emergent visits per year	Yes	Yes	2 or more visits in 1 month or 3 visits in a quarter
Educational Information			Pamphlet on what is an emergency	Developed Program for Asthma	Yes
PCP Contact			Contact PCP to advise them of patient's use and to ensure follow up		Copy of letter sent to participant
Outreach	Outreach workers	More than 2 ER visits Customer Service Rep. Contact for Education More than 3 ER visits Home visit for education More than 4 ER visits Nurse home visit	Letter to recipient which refers to PCP for certain programs Refers to nurse call line for Medicaid, Education on benefits and how to access transportation to primary care physician Referral to Client Medical Management if needed	Asthma program includes home visits,	Phone/letter Home visit if no phone or letter is returned or continued ED visits
Denial of Payment		For non-Medicaid beneficiaries. Decision by Medical Director			

All five MCOs indicated that extensive outreach efforts are employed to curtail this problem if previous interventions do not decrease emergency department visits. The intensity of these outreach efforts will vary based on the frequency with which beneficiaries are misusing ER services. One of these plans will refer participants to medical management program if educational interventions are not helpful. Additionally, one MCO indicated that for its non-Medicaid population, payment for claims submitted for non-emergent ER services could be denied.

Recommendation of Physician Associations. The members of VACEP commented on the problem of non-emergent use of emergency departments. Their recommendations can be summarized as follows:

- Increase/improve client education in basic health care, emphasizing the importance of preventive and routine care.
- Increase the number of primary care physicians so that preventive and routine care is more readily available and convenient for the client.
- Identify Primary Care Physicians (PCPs) in managed care organizations that are not providing access for assigned clients and change the system to reimburse based on per patient encounters rather on the number of assigned clients.

VCEP staff report that there are some practice plans whose beneficiaries -- both Medicaid and non-Medicaid -- use ERs for non-emergent care at rates of less than two percent. This they contend is evidence of what a properly managed MCO or PCP can achieve with their patients.

Diversion of Non-Emergent Cases. One of the more aggressive approaches used to minimize the rate at which patients' access the ER for routine care is implemented by staff at the VCU/HS. This program, which was initiated in November 2000, requires hospital medical staff to review medical information on patients who have visited the ER and identify those who appear to be using this setting for primary rather than emergency care. Based on this assessment, medical staff will conduct outreach activities that have both an educational and care management component. Staff will explain the role of the ER to these patients but also make efforts to connect them to a primary care physician. Over time, VCU/HS officials believe that this program plays a key role in limiting ER non-emergent use rates.

The hospital is currently evaluating the results of their efforts at diversion using an algorithm developed by The Commonwealth Fund, the New York University Center for Health and Public Service Research, and the United Hospital Fund of New York. The algorithm was developed with the advice of a panel of ER and primary care physicians and was based on an examination of more than 6,000 ER patient records. Based on this review, each case was classified into one of the following categories:

- Non-emergent - The patient's initial complaint, vitals signs, medical history, and age indicated that immediate medical care was not required within 12 hours.

- Emergent/Primary Care Treatable - Treatment was required within 12 hours, but care could have been provided in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan).

- Emergent/ER Care Required But Preventable Or Avoidable - Emergency care was required based on the complaint or procedures or resources used, but the emergent nature of the condition was potentially preventable or avoidable if timely and effective primary care had been provided (e.g., flare-ups of asthma, diabetes, or congestive heart disease).

- Emergent/ER Care Needed - Not Preventable Or Avoidable - Emergency care was required and primary care treatment could not have prevented the condition (e.g., trauma, appendicitis, or heart attack).

Since the program was implemented almost four years ago, VCU/HS has evaluated its ER cases using the just described algorithm. The results of their efforts indicate a decreasing trend for non-emergent and emergent/primary care treatable visits in the ER.

DMAS' Client Medical Management Program (CMM). DMAS currently operates a similar medical management program that targets some of the Medicaid FFS recipients who use the ER for non-emergent care at least three or more times in a three-month period. Once identified, the recipient can be enrolled in CMM. While in this program, the recipient is assigned a case manager and is educated on the appropriate use of the ER. Attempts are also made to find the recipient a primary care physician (PCP) to limit future occurrences of the problem.

Staff who work in this program indicate that it is sometimes difficult to find a PCP for these recipients because they are generally noncompliant with treatment and do not participate with follow up visits to the PCP. In fact staff note that they have discovered instances where PCPs have given after hour instructions for recipients to go to the ER.

While this program holds some promise, it is too small in scope to significantly impact non-emergent ER use rates statewide. Presently, CMM has approximately 1,000 participants, which is less than three percent of the recipients who use the ER for routine care on an annual basis. If DMAS is to expand this program, more staff resources will be needed.

ATTACHMENT 1

2004 Virginia Acts of the Assembly

Item 322 G. The Department of Medical Assistance Services shall report on the degree to which hospital emergency rooms are being used by Medicaid fee-for-service clients for non-emergency care, and identify actions that could be taken to limit inappropriate use of this treatment setting. In conducting its review, the Department shall: (i) assess recent trends in emergency room use by Medicaid fee-for-service enrollees; (ii) estimate the incidence of Medicaid clients using the emergency room for non-emergency care; (iii) identify effective actions taken by the organizations participating in the Department's managed care program as well as other state Medicaid programs to limit inappropriate use of the emergency room; (iv) consult with physicians and hospitals in assessing and developing programs that direct patients to primary care settings; and (v) recommend actions that can be taken to ensure emergency room usage by Medicaid fee-for-service clients is appropriate and medically necessary. The Department shall report its findings and recommendations to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees by November 1, 2004.