

Reducing Medicaid Emergency Department Use: Increase Accessibility, Not Copays

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Date: October 27, 2014

Emergency department care, one of the most frequently cited drivers of health care costs, has become a major target for cost sharing policies. The stereotypical “frequent flyer” who uses the emergency department (ED) for every cough and snuffle has become a powerful, but unwarranted symbol of inefficient spending driven by poor patient decision-making.¹ Though often used to justify higher cost sharing on ED use, the common perception that ED overutilization drives wasteful spending is likely overblown, while the “solution” of raising copays does little to address the systemic factors contributing to the ED’s expanding role in our health care system.

Emergency Departments account for only 2% to 6% of all health expenditures.² “Inappropriate” ED use constitutes no more than a fraction of that small percentage.³

Even though ED utilization accounts for a small percentage of total health expenditures – and “inappropriate” ED use even less – the absolute dollar amounts are not trivial, roughly \$16 billion in FY 2012.⁴ Effective policies to reduce nonemergency ED use could improve care efficiency and potentially reduce costs. But raising ED copays is less effective than other approaches and has not proven to be effective at all in the Medicaid context. ED copays present a blunt barrier to care that shifts costs and blames patients.

¹ More accurately, frequent users symbolize a failure of effective patient-centered care coordination and lack of access to primary care, not a patient population that is abusing the system. While the most frequent users do account for a disproportionate share of ED expenditures, they are less likely to visit the ED with nonemergent symptoms. They are, in short, very sick. See John Billings & Maria C. Raven, *Dispelling an Urban Legend: Frequent Emergency Department Users Have Substantial Burden of Disease*, 32 HEALTH AFF. 2099, 2103 (2013).

² For various estimates of ED share of health expenditures, see Michael H. Lee et al., *Owning the Cost of Emergency Medicine: Beyond 2%*, 62 ANN. EMERGENCY MED. 498 (2013).

³ Peter B. Smulowitz et al., *Identifying Targets for Emergency Department Cost Reduction*, 61 ANNALS OF EMERGENCY MED. 293, 296 (2013).

⁴ This figure reflects 4% of the \$415 billion total Medicaid spending on services for FY 2012. See Henry J. Kaiser Fam. Found. (“KFF”), *Medicaid Moving Forward*, 8 (Jun 2014), <http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7235-07-medicaid-moving-forward2.pdf>.

This issue brief has two objectives:

- evaluate the efficacy of different approaches for reducing Medicaid ED utilization based on published literature and currently implemented best practice approaches; and
- review some of the problems related to ED co-pays, especially in the Medicaid context, and identify promising alternatives states have implemented to successfully reduce ED utilization while improving care coordination and quality.

ED Use Is Increasing, but Not Due to Indiscriminate Patient Choice

In the last two decades, ED utilization has increased substantially across all public and private health insurance. However, Medicaid is often singled out as a principle source of over-utilization.⁷ The policy of raising Medicaid ED copays as a “solution” implicitly faults a lack of health literacy or poor decision-making as the driver of overutilization, thus blaming Medicaid beneficiaries for ED “misuse.” This is misguided. Changes in ED utilization largely reflect system-wide structural factors, such as lack of available primary care providers and the ED’s evolving role as a “gatekeeper” and after-hours treatment option with increasing capacity to perform complex and comprehensive screenings and

A Word About EMTALA

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) underlies any discussion of ED utilization and public insurance. EMTALA requires emergency departments associated with any Medicare-participating hospital to screen and stabilize any individual who comes to the emergency department seeking care for a possible emergency without regard to her ability to pay.⁵ This singular law creates a key, if limited, safety net, guaranteeing access to emergency care for all individuals.

EMTALA strongly influences Medicaid’s emergency services coverage. Medicaid reimburses hospitals for care associated with the EMTALA requirements for both citizens and non-citizens, provided they would otherwise qualify for Medicaid.⁶ Moreover, Medicaid also uses EMTALA’s definition of an emergency medical condition. This definition clarifies what providers must do to meet their obligation to treat and stabilize a patient who comes to the hospital ED. In the managed care and cost sharing contexts, Medicaid law and regulations have added a prudent layperson standard to that definition to prevent beneficiaries from being unfairly charged for using the ED (discussed below). EMTALA is designed to ensure access to emergency screening and stabilization services; however, it does not address issues with who should pay for that care.

⁵ 42 U.S.C. § 1395dd. See also Sara Rosenbaum, *The Enduring Role of the Emergency Medical Treatment and Active Labor Act*, 32 HEALTH AFF. 2075 (2013).

⁶ 8 U.S.C. § 1611(b)(1)(A). See also 42 C.F.R. § 440.255.

⁷ Douglas Holtz-Eakin & Michael Ramlet, American Action Forum, *Healthcare Reform and Medicaid: Patient Access, Emergency Department Use, and Financial Implications for States and Hospitals* (Sept. 2010), http://www.politico.com/pdf/PPM170_hcr_medicaid.pdf

treatments.⁸ Such screenings may be expensive, but they aim to reduce unnecessary (and far more expensive) hospital admissions.⁹ The ED's role in reducing even more expensive hospital stays cannot be overlooked. For example, emergency care and screening protocols developed for patients presenting with chest pain have safely reduced both total admissions and the time spent under observation in the ED.¹⁰

Medicaid beneficiaries historically use the ED at higher rates than privately insured individuals, but there is no clear evidence that ED utilization is increasing faster for Medicaid beneficiaries than for individuals with other types of insurance.¹¹ Medicaid enrollees are more likely to use the ED because they are less healthy as a population and because they typically face more barriers to accessing primary care. Lack of availability of primary care providers (PCPs) is a commonly cited contributor to increased ED use that cannot be blamed on beneficiaries.¹² For example, Oregon's recent Medicaid expansion added thousands of new enrollees. Provider networks for Oregon's managed care organizations did not keep up with added demand. State health officials attribute a coincident rise in Medicaid ED visits directly to the lack of primary care availability.¹³

Even when a beneficiary has a regular PCP, he may still be referred to an ED if the PCP is not available. In one survey, 82% of individuals who contacted their PCP prior to visiting the ED received recommendations to seek care at the ED.¹⁴ A steadily increasing proportion – now nearly half -- of all inpatient admissions pass through the ED.¹⁵ This systemic trend likely does not stem from sudden changes in patient behavior, but rather reflects the incentive structure of financial reimbursement policies for inpatient

⁸ Kristy Gonzalez Morganti et al., RAND Corp., *The Evolving Role of Emergency Departments in the United States*, 2 (2013),

http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR280/RAND_RR280.pdf.

⁹ Arthur L. Kellermann et al., *Emergency Care: Then, Now, and Next*, 32 HEALTH AFF. 2069 (2013). Inpatient hospital care comprises nearly a third of all healthcare costs. See Anne B. Martin et al., *National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year*, 33 Health Aff. 67, 70 (2014).

¹⁰ Jeremiah D. Schuur & Arjun K. Venkatesh, *The Growing Role of Emergency Departments in Hospital Admissions*, 367 NEW ENG. J MED. 391, 392 (2012); see also S. Bholasingh et al., *Safe Discharge from the Cardiac Emergency Room with a Rapid Rule-Out Myocardial Infarction Protocol Using Serial CK-MB_{mass}*, 85 HEART 143 (2001).

¹¹ Medicaid & CHIP Payment Advisory Comm'n ("MACPAC"), *Revisiting Emergency Department Use in Medicaid*, 2 (July 2014), http://www.macpac.gov/publications/MACFacts-EDuse_2014-07.pdf.

¹² Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60 ANNALS OF EMERGENCY MED. 4 (2012); Roberta Capp et al., *National Study of Health Insurance Type and Reasons for Emergency Department Use*, 29 J GEN. INTERNAL MED. 621 (2014).

¹³ Associated Press, *State Strains under Huge Medicaid Enrollment* (last visited July 29, 2014), <http://registerguard.com/rq/news/local/31911060-75/care-oregon-patients-medicaid-state.html.csp>.

¹⁴ Kristy Gonzalez Morganti et al., *supra* note 8, at 32.

¹⁵ *Id.* at 29-30.

care (which still reward hospitals for increasing admissions) and broader structural changes in health care delivery.

Higher ED copays or “better” education about “appropriate” ED utilization do not address any of these structural, system-level contributors to increased ED utilization. While there are undoubtedly some cases of individuals who default to the ED for basic care, such cases are hardly unique to Medicaid. One recent study shows that only about 10% of Medicaid ED visits involve truly “nonurgent” symptoms, a rate on par with private insurance.¹⁶ Billings’ and Raven’s analysis of frequent ED users (3 or more visits per year) finds that such individuals are generally very sick and use the ED appropriately.¹⁷ Furthermore, approaches to classify which individual visits represent “inappropriate overuse” are fraught and inconsistent.

RECOMMENDATION:

Focus efforts to improve ED efficiency on the systemic factors that drive utilization, rather than developing policies that primarily implicate patient behavior or education.

The Dilemma of Defining “Nonemergency”

The literature investigating ED utilization deploys a number of simple dichotomies to distinguish types of ED utilization: urgent/nonurgent, appropriate/inappropriate, emergency/nonemergency. But these seemingly straightforward distinctions stand on shaky evidentiary foundations. Medicaid law requires that before assessing an ED copay ED providers must screen the beneficiary, based on her history and presenting complaint, and determine that emergency care is not needed.¹⁸ To date, no dependable methodology exists to distinguish emergent from nonemergent conditions on a case-by-case basis. Triage systems based on trained professionals and published protocols, sometimes including vital sign measurements, have proven inconsistent and unreliable predictors of an actual emergency on an individual level.¹⁹ Alternatively, researchers

¹⁶ Anna S. Somers, Ellyn R. Boukus & Emily Carrier, Ctr. for Studying Health System Change, Research Brief No. 23, *Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms* (2012). Because “nonurgent” visits cost less than semi-urgent or urgent visits, they represent an even smaller proportion of total ED expenditures. See Robert M. Williams, *The Costs of Visits to Emergency Departments*, 334 NEW ENG. J MED. 642 (1996).

¹⁷ John Billings & Maria C. Raven, *supra* note 1.

¹⁸ 42 U.S.C. § 1396o-1(e)(1)(B).

¹⁹ Robert A. Lowe & Andrew B. Bindman, *Judging Who Needs Emergency Department Care: A Prerequisite for Policy-Making*, 15 AM. J. EMERGENCY MED. 133 (1997); Gail M. O’Brien et al., *“Inappropriate” Emergency Department Use: A Comparison of Three Methodologies for Identification*, 3 ACADEMIC EMERGENCY MED. 252 (1996); Maria C. Raven et al., *Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying “Nonemergency” Emergency Department Visits*, 309 JAMA 1145 (2013).

sometimes look retrospectively at claims data to evaluate how “urgent” or “emergent” a visit was based on discharge diagnosis codes. But again, the distinction is only valid at a population level and does not reliably predict individual cases. Furthermore, such retrospective methods fail to recognize that an individual decides to seek care at an ED based on severity of symptoms, medical history, the availability of alternatives, and sometimes advice from a primary care provider. They often cannot know ahead of time what the ultimate diagnosis will be.

This uncertainty stems from the fact that the “urgency” of a discharge diagnosis does not correlate well with the “urgency” of an initial chief complaint. Many complaints could lead to multiple possible diagnoses with varying levels of severity, so the diagnostic criteria alone fail to account for the uncertainties present prior to medical evaluation. For example, someone with severe abdominal pain may have “nonurgent” gas pains, severe food poisoning, or life-threatening acute appendicitis. Distinguishing between these diagnoses often requires screening, tests and expert evaluation. Because an individual’s decision to go to an ED depends on presenting symptoms *prior* to such screening, it is not reasonable to evaluate “nonemergency” use of the ED through retrospective discharge diagnosis data.²⁰

Perhaps the most cited diagnosis-based algorithm to distinguish “emergent” from “nonemergent” ED use is a population-based model developed by John Billings and colleagues at New York University.²¹ Billings explicitly states that this algorithm is *not* appropriate as a triage tool because it is based on population-level probabilities. For example, the algorithm suggests that for ED visits coded for “nausea with vomiting,” 59% were considered nonemergent, 24% emergent but treatable in primary care, and 18% required immediate ED care and were not preventable. How would a Medicaid beneficiary be expected to distinguish that her nausea was not in the 18% that required immediate ED care? Furthermore, the algorithm excludes approximately 40% of unclassifiable ED visits, including uncommon diagnoses, mental health and substance use disorders, accidents, and injuries.²² Billings himself notes that “appropriate” use of the ED also depends on factors such as provider availability and that, absent an available primary care alternative, individuals justifiably seek care in an ED.

²⁰ See Arther L. Kellermann & Robin M. Weinick, *Emergency Departments, Medicaid Costs, and Access to Primary Care – Understanding the Link*, 366 NEW ENG. J. MED. 2141, 2142 (2012).

²¹ John Billings et al., Commonwealth Fund, *Emergency Department Use: The New York Story* (2000), <http://www.commonwealthfund.org/Publications/Issue-Briefs/2000/Nov/Emergency-Room-Use--The-New-York-Story.aspx>. See also David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children’s Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013); Arthur L. Kellermann & Robin M. Weinick, *supra* note 20, at 2142; Sallie Thieme Sanford, *A Systemic Approach to Diaper Rash, Chest Pain, and Medicaid in the ED*, 102 KY. L. J. 441, 445 (2014).

²² Jane Feldman, Washington State Hospital Administration, *The NYU Classification System for ED Visits: WSHA Technical Concerns*, 2 (Aug. 2010), http://www.wsha.org/files/169/nyu_classification_system_for_edvisits.pdf.

Despite Billings' admonitions to the contrary, at least one subsequent study "validated" the algorithm by applying it to *individual* visits.²⁵ These researchers classified a final diagnosis as "nonemergent" if the sum of the "nonemergent" and "emergent but treatable in primary care" categories exceeded 50%. The study would thus categorize "nausea with vomiting" as "nonemergent" even though an individual with those symptoms has an 18% chance of requiring immediate ED care and nearly 50% chance of requiring medical care within 12 hours. Far from validating the algorithm, this study design illustrates exactly why a population-level analysis cannot be meaningfully applied to an individual's decision to visit the ED.

The "prudent layperson" standard is designed precisely to avoid these problems associated with retrospective definitions of "emergency." This standard, though still subjective, more accurately accounts for the uncertainties inherent to an individual's decision to go to the ED. In short, it ensures that more ED visits legitimately qualify for payment by managed care plans.²⁶ Even so, "laypersons" still underestimate the severity of some conditions compared to trained ED physicians.²⁷ The Affordable Care Act (ACA) extended the "prudent layperson" standard to all health plans on the individual and group market, yet it remains unclear whether it

The Prudent Layperson Standard

The prudent layperson standard was originally adopted by states to prevent private health plans from denying payment for ED services based on discharge diagnosis.²³ Prior to its implementation, an individual who went to the ED with severe chest pain and a history of coronary disease – an entirely rational and appropriate decision – might find out (happily) that he was only experiencing heartburn, and later (unhappily) receive a denial of coverage from his health plan due to the "nonemergent" diagnosis. The prudent layperson standard has since been extended in federal law to Medicare, the Veterans Administration, private group and individual health plans and to Medicaid managed care and cost sharing.

CMS's Medicaid prudent layperson standard defines an emergency medical condition as experiencing "acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention" to seriously jeopardize or impair the individual's health (or, in the case of a pregnant woman, her health or the health of her unborn child.)²⁴

²³ Sallie Thieme Sanford, *supra* note 21, at 454.

²⁴ See 42 U.S.C. § 1396u-2(b)(2)(C) (managed care) and 42 U.S.C. § 1396o-1(e)(3) (cost sharing). See also 42 C.F.R. §§ 438.114 & 447.51.

²⁵ Dustin W. Ballard et al., *Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits*, 48 MED. CARE 58 (2010).

²⁶ Robert M. Williams, *The Prudent Layperson Definition: Will It Work for Emergency Medicine?*, 36 ANNALS OF EMERGENCY MED. 238, 239 (2000).

²⁷ These conditions include acute abdominal pain and hemiparesis, or weakness on one side of the body. Mark I. Langdorf et al., *Patients' vs. Physicians' Assessments of Emergencies: The Prudent Layperson Standard*, IV CAL. J. EMERGENCY MED. 75 (2003).

applies in all Medicaid contexts, particularly fee-for-service (FFS).²⁸ Several states have exploited this apparent loophole. At one point, Washington proposed limiting or denying Medicaid payment for “nonemergency” ED use in FFS based on diagnosis lists derived from Billing’s algorithm.²⁹ Other states, such as Arkansas, simply claim that nonemergency services in the ED are not covered and that beneficiaries can be billed for inappropriate use.³⁰ These policies raise two questions:

- May a state may deny coverage for otherwise covered treatment based solely on the setting in which services are provided?
- If yes, must the state agency apply the prudent layperson standard to distinguish what is a non-emergency service and notify patients of the potential costs prior to treatment?

RECOMMENDATION:

Given its broad applicability in other publicly funded programs, CMS should apply the prudent layperson across all Medicaid contexts. Moreover, CMS should not allow state Medicaid agencies to restrict payments for nonemergency ED services unless and until a validated predictive method exists to fairly and reliably distinguish nonemergent from emergent visits based on the prudent layperson standard.

Copays for Nonemergency Medicaid ED Visits Do Not Work

Medicaid only allows copays for “nonemergent” ED visits, which distinguishes it from ED copays in many private individual and employer-sponsored plans that typically charge copays for anyone not admitted to the hospital.³¹ As noted above, before charging a copay, Medicaid ED providers must first screen the individual to evaluate the severity of her symptoms. Then, if the symptoms are not deemed emergent, the provider must “provide the individual with the name and location of an available and accessible alternative non-emergency services provider” that charges lower or no copays.³² Setting

²⁸ See ACA § 10101(h), codified at 42 U.S.C. 300gg-19a(b). The standard previously applied in the context of Medicaid managed care. 42 U.S.C. §§ 1396u-2(b)(2) The cost sharing statute links the prudent layperson standard to managed care, but current cost sharing regulations apply the prudent layperson standard to any Medicaid ED copay. 42 U.S.C. § 1396o-1(e)(3); 42 C.F.R. § 447.51. In the Medicaid FFS context, regulations mandate, but do not clearly define, coverage for emergency services. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930(c). See also Sallie Thieme Sanford, *supra* note 21, at 455.

²⁹ Sallie Thieme Sanford, *supra* note 21.

³⁰ Ark. Medicaid, *What to Do in an Emergency* (last visited Oct 17, 2014), <https://www.medicaid.state.ar.us/InternetSolution/consumer/emergency.aspx>.

³¹ See 42 U.S.C. 1396o(a)(2)(D). For the Medicaid copayment definition of “nonemergency,” see 42 U.S.C. 1396o-1(e)(4)(A) and 42 C.F.R. § 438.114.

³² 42 C.F.R. § 447.54(d)(2). See also 42 U.S.C. §§ 1396o-1(e)(1),

aside the concerns about the accuracy of triage systems to determine “nonemergent” conditions, the cost of administering the required screening and referral may well exceed the revenue from collecting ED copays (up to \$8 for most Medicaid beneficiaries) plus any savings from “diverted” ED care.³³ In 2008, the Texas Health and Human Services Commission funded a cost-effectiveness study for implementing a nonemergency ED copay in its Medicaid program. The consultant, Health Management Associates, projected that costs would outweigh savings by \$900,000 to \$2.8 million dollars over two years, mostly due to administrative expenses for identifying appropriate alternative providers.³⁴ It recommended against implementing the ED copay.

Given these costs and constraints, it should come as no surprise that a recent multi-state analysis found that implementing copayments for nonemergent ED use had no discernible effect on ED utilization (emergency or nonemergency) for Medicaid enrollees.³⁵ Another study of ED copay increases in Alabama’s Children’s Health Insurance Program (CHIP), a public insurance program targeted to low-income minors, found no reduction whatsoever in low-severity ED use following the implementation of a \$20 surcharge for nonemergency ED visits.³⁶

Even in the context of employer-sponsored insurance (ESI) – where copays generally apply regardless of urgency – questions remain about copays’ impact on “appropriate” ED use. Several studies of ESI *do* suggest that higher ED cost sharing selectively reduces ED utilization for less urgent symptoms without increasing adverse health outcomes.³⁷ For example, Wharam et al. found that when employers switch to high deductible health plans with substantial increases in patient out-of-pocket costs – on the order of hundreds of dollars per visit – ED use declined by 10% relative to controls.

³³ Only beneficiaries with incomes above 150% FPL may be charged more than \$8. 42 C.F.R. § 447.54(b). Maryland abandoned a nonemergency ED copay for this reason. See Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use of Emergency Departments*, 29 HEALTH AFF. 1643 (2010). See also below Section III.F. An evaluation of Indiana’s Medicaid ED copay showed that nearly two thirds of beneficiaries who used the ED reported never being charged a copay, suggesting that many providers do not bother collecting from patients. Indiana Family and Social Services Admin., *Healthy Indiana Plan Section 1115 Demonstration Annual Report, 2012*, 65 (2013), http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf.

³⁴ Health Management Associates, *Co-pays for Nonemergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis*, 3 (May 2008), http://www.hhsc.state.tx.us/reports/HospitalEmergencyRoomsAnalysis_0708.pdf.

³⁵ Karoline Mortensen, *supra* note 33.

³⁶ CHIP requires a prudent layperson standard, but the study does not detail how providers evaluated for “nonemergency” visits. David J. Becker et al., *supra* note 21.

³⁷ John Hsu et al., *Cost-Sharing for Emergency Care and Unfavorable Clinical Events: Findings from the Safety and Financial Ramifications of ED Copayments Study*, 41 HEALTH SERVICES RES. 1801 (2006); J. Frank Wharam et al., *High-Deductible Insurance: Two-Year Emergency Department and Hospital Use*, 17 AMER. J. MANAGED CARE e410 (2011); Dahlia K. Remler & Jessica Greene, *Cost-Sharing: A Blunt Instrument*, 30 ANNUAL REV. PUBLIC HEALTH 293 (2009); Joe V. Selby et al., *Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization*, 334 NEW ENG. J. MED. 635 (1996).

The ED and Communicable Disease

The ED is a critical first-line node in the nation's communicable disease response system. Implementing harsh ED copays might discourage infected individuals from seeking timely care and thus hamper efforts to control outbreaks. On top of that, recent evidence indicates that training and planning for possible outbreaks in many hospitals may be inadequate.³⁸ The Centers for Disease Control and Prevention (CDC) continues to develop and revise recommended protocols for the screening, isolation and treatment of patients with various diseases to address these problems.³⁹ State and federal Medicaid programs should not exacerbate them by adding any new barriers to care. Heightened and mandatory ED copay provisions always represent flawed policy, but they would be particularly damaging before CDC's updated communicable disease protocols are adequately tested and implemented throughout the nation's hospitals. HHS should certainly not approve any ED copays beyond what is currently authorized by the Medicaid Act.

Low-severity repeat ED visits declined by 36%.⁴⁰ However, although the authors correctly report no significant decline in high-severity ED visits, the study's small sample size for such visits makes statistical significance nearly impossible to achieve. In fact, high severity ED visits among enrollees with lower incomes declined by 25% (compared to a 1.3% decline for higher income enrollees).⁴¹ While not technically "significant," the findings suggest that increased copays may discourage unnecessary *and*

necessary ED care, especially for low-income enrollees. An older study of ED cost sharing in employer plans showed significant reductions in ED visits for symptoms in nearly all categories (including "often an emergency").⁴² Such results suggest that high ED copays may indeed contribute to delayed or abandoned care that might negatively impact the health of some individuals.

³⁸ See Diana Hunt, Dallas Morning News, *Dallas Hospital May Face State Inquiry on Ebola Patient's Handling*, (updated Oct. 11, 2014), <http://www.dallasnews.com/news/metro/20141010-texas-health-presbyterian-may-face-state-inquiry-in-ebola-case.ece>. A recent survey of registered nurses across 31 states identified serious deficiencies in training and preparedness. Over 80% of respondents reported their hospital had not communicated any policy regarding preparations for receiving potential Ebola patients. Nation'l Nurses United, *National Nurse Survey Shows Hospitals Still Not Prepared for U.S. Ebola Patients* (last visited Oct. 14, 2014), <http://www.nationalnursesunited.org/press/entry/national-nurse-survey-shows-hospitals-still-not-prepared-for-us-ebola/>.

³⁹ Manny Fernandez, Sabrina Tavernise and Richard Fausset, New York Times, *C.D.C. Rethinking Methods to Stop Spread of Ebola* (Oct. 13, 2014), http://www.nytimes.com/2014/10/14/us/dallas-nurse-ebola-patient.html?_r=0.

⁴⁰ J. Frank Wharam et al., *Emergency Department Use and Subsequent Hospitalizations among Members of a High-Deductible Health Plan*, 297 JAMA 1093, 1097 (2007).

⁴¹ *Id* at 1098.

⁴² Joe V. Selby et al., *supra* note 37, at 638.

RECOMMENDATION:

States should avoid Medicaid ED copays. Push states to study the cost-effectiveness of administering an ED copay prior to implementation. In states that nonetheless apply an ED copay, ensure the agency adequately monitors whether ED providers fulfill their responsibilities to screen beneficiaries and, when necessary, refer them to accessible and available alternative providers. Advocate for evaluations that track the costs as well as the impacts of the ED copay policy on both utilization and health outcomes.

Better Alternatives to Improve Cost Efficiency of ED Utilization

Best practices to improve the cost efficiency of Medicaid ED utilization typically do not include copayments for nonemergency use. More proven policies to reduce ED use among Medicaid enrollees eliminate barriers to primary care rather than increase cost sharing.⁴³ If primary care alternatives are not actually accessible and available to enrollees, an ED copay simply adds insult to injury.

Logically, reducing expenses in the ED should start with identifying and streamlining the more expensive ED practices. ED copays, even if they worked, only target a minority of all ED visits that, due to their reduced severity, are less costly than an average ED visit.⁴⁴ Smulovitz et al. suggest instead focusing efforts to boost efficiency by using ED screens to reduce or shorten costly hospital admissions for intermediate level complex conditions like diabetic complications, abdominal pains or pneumonia. Such hospitalizations account for a far larger proportion of overall health expenses than “nonemergent” ED visits.⁴⁵ They suggest increasing alternatives to hospital care or developing new “rapid rule-out” ED protocols for these complex conditions to identify patients who -- after appropriate diagnostics and screenings -- can be safely released and referred to follow-up care without an inpatient stay. Evidence already demonstrates how such ED protocols have achieved savings (without sacrificing quality) for individuals with chest pain.⁴⁶ New protocols would apply to all ED patients, regardless of insurance status, and could increase efficiency without requiring copays.

⁴³ For example, one program in Michigan identified hundreds of high frequency ED users and provided them with intensive case management and care coordination. A subsequent review of 300 participants found ED use declined by 64% after one year. Agency for Healthcare Research and Quality (“AHRQ”) Healthcare Innovation Exchange, *Coordinated, Intensive Medical, Social, and Behavioral Health Services Improve Outcomes and Reduce Utilization for Frequent Emergency Department Users* (Oct. 23, 2013) <https://innovations.ahrq.gov/profiles/coordinated-intensive-medical-social-and-behavioral-health-services-improve-outcomes-and#veryTop>.

⁴⁴ Robert M. Williams, *supra* note 16; see also Peter J. Cunningham, Ctr. for Studying Health System Change, *Nonurgent Use of Hospital Emergency Departments*, Testimony before the U.S. Senate Health, Education, Labor and Pensions Committee Subcommittee on Primary Health & Aging, 1, 11 (2011), <http://hschange.org/CONTENT/1204/1204.pdf>.

⁴⁵ Peter B. Smulowitz et al., *supra* note 3, at 296.

⁴⁶ *Id.* at 297; Kristy Gonzalez Morganti et al., *supra* note 8, at 52.

Other approaches target the most frequent ED users. Billings and Raven recommend screening for likely frequent users and then targeting specific case management services to improve their health, coordinate their care and reduce the likelihood they will need emergency services going forward.⁴⁷ In this vein, one Cleveland hospital created a Medicaid care coordination program targeted at 18,000 frequent hospital users who were previously uninsured. A nurse assigned to each enrollee helped schedule appointments and ensure medication adherence. After nine months, ED use in the group dropped by 60% while PCP visits increased. The hospital came in under-budget by \$150/month per enrollee.⁴⁸ Emergency Medical Services initiatives in Texas and San Diego similarly identified and provided extra support to frequent 911 callers and saved millions of dollars annually due to reduced ambulance and ED costs.⁴⁹ The promise of such approaches may be limited due to the fact that most “frequent users” do not remain “frequent users” for more than a year or two.⁵⁰ This targeting method thus requires an effective screen to identify new patients “at risk” of becoming frequent users and provide them with needed care coordination.

The state that has most aggressively implemented systemic reforms to improve Medicaid ED efficiency is Washington – the same state that originally proposed denying Medicaid payment for “nonemergency” ED diagnoses. In 2013, Washington dropped its original proposal and instead implemented seven “best practices” that address the root causes of high ED utilization:

1. Establish a communication system between Emergency Departments to help identify frequent users and share information about their prior ED visits;
2. Create and disseminate lists of frequent ED users to hospital personnel to flag when to use the inter-ED communication system;
3. Adopt a standardized care plan for frequent users to improve care coordination and integrate with the communication network. Set follow-up appointments with a primary care provider within 3 or 4 days of each ED visit;

⁴⁷ John Billings & Maria C. Raven, *supra* note 1.

⁴⁸ Sarah Jane Tribble, Nation’l Pub. Radio, *A Hospital Reboots Medicaid to Give Better Care for Less Money* (Aug. 5, 2014), <http://www.npr.org/blogs/health/2014/08/05/336317359/a-hospital-reboots-medicaid-to-give-better-care-for-less-money>.

⁴⁹ AHRQ Healthcare Innovation Exchange, *Data-Driven System Helps Emergency Medical Services Identify Frequent Callers and Connect Them to Community Services, Reducing Transports and Costs* (June 4, 2014), <https://innovations.ahrq.gov/profiles/data-driven-system-helps-emergency-medical-services-identify-frequent-callers-and-connect>; AHRQ Healthcare Innovation Exchange, *Trained Paramedics Provide Ongoing Support to Frequent 911 Callers, Reducing Use of Ambulance and Emergency Department Services* (updated June 3, 2014), <https://innovations.ahrq.gov/profiles/trained-paramedics-provide-ongoing-support-frequent-911-callers-reducing-use-ambulance-and#htdi>.

⁵⁰ MACPAC, *supra* note 11, at 6.

4. Set strict guidelines for narcotics prescriptions and train ED physicians in enforcing the guidelines;
5. Increase enrollment of ED providers in Washington's Prescription Monitoring Program;
6. Set up a feedback loop in hospitals that designates hospital staff to review ED utilization reports and issue recommended changes; and
7. Develop materials to educate patients on appropriate ED use.⁵¹

After one year of implementation, nearly 100 hospitals actively participated in the ED communication network, and ED visits declined by 10%.⁵² The state anticipates further reductions in ED utilization due to the implementation of a medical homes program and the restoration of adult dental care services to its Medicaid program in January 2014.

RECOMMENDATION:

Instead of ED copays, efforts to improve the efficiency of ED use should center on facilitating access to primary care, providing more effective patient-centered care coordination, developing ED screens that safely reduce preventable hospitalizations, and increasing communication between EDs and hospitals.

Conclusion

Systemic approaches to reducing ED inefficiencies pragmatically focus efforts on the true drivers of ED utilization and costs. Rather than singling out and blaming beneficiaries for poor judgment, these initiatives acknowledge that EDs often represent a last resort safety net for individuals who have otherwise fallen through the cracks of our fragmented health care system. Providing better care coordination, access to primary care, and systems to communicate between providers all help improve cost efficiency without creating new financial barriers that could lead beneficiaries to delay or forgo needed care. These best practices should be the first place states look when attempting to improve the efficiency ED care and utilization.

⁵¹ Washington State Health Care Authority, *Report to the Legislature: Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation* (Mar. 2014), <http://www.hca.wa.gov/Documents/EmergencyDeptUtilization.pdf>.

⁵² *Id* at 4. The report notes that other factors, such as the transition of some beneficiaries from FFS to managed care, may have played a role in reducing ED utilization.