
CMCS Informational Bulletin

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SUBJECT: Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings

The Centers for Medicare & Medicaid Services (CMS) has been strengthening our collaborations with states in order to reduce costs, improve the patient experience, and improve the health of the populations we serve. As beneficiaries gain coverage as a result of the Affordable Care Act, utilization of services across the health care system is likely to increase, and states and CMS share a strong interest in reducing unnecessary hospital emergency department (ED) usage. In this changing environment, CMS is committed to partnering with states, plans, providers, and consumers to implement reforms that can appropriately address the needs of our beneficiaries more effectively and more efficiently.

Part I of this Informational Bulletin summarizes three strategies to deliver appropriate care in the most appropriate settings. In addition, since states have flexibility to develop payment methodologies or impose cost sharing for non-emergency use of ED services ([see 42 CFR 447.54](#)), part II of this Bulletin presents some of the evidence and regulatory issues with regard to distinguishing non-emergent from emergent use of the ED.

Background

Medicaid beneficiaries use the ED at an almost two-fold higher rate than the privately insured.^{1,2} This is not due to widespread inappropriate use of the ED amongst Medicaid beneficiaries, who tend to be in poorer health than the privately insured population; at least two studies found that the majority of ED visits by nonelderly Medicaid patients were for symptoms suggesting urgent or more serious medical problems.³ These studies estimate that non-urgent visits comprise only about 10 percent of all ED visits by Medicaid beneficiaries, and suggest that higher utilization may be in part due to unmet health needs and lack of access to appropriate settings. In this context, as most states have recognized, efforts to reduce ED use should focus not on merely reducing the number of ED visits, but also on promoting continuous coverage for eligible individuals and improving access to appropriate care settings to better address the health needs of the population.

¹Garcia et al. 2010. Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? CDC, NCHS Data Brief No 38. (NOTE: The percentages of Medicaid vs. privately insured enrollees with at least one emergency room visit in 2007 were: children under 17 years (27% vs. 17%); adults 18-44 years (38% vs. 17%); adults 45-64 years (39% vs. 16%.)

² Sommers et al. 2012. Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms. Center for Studying Health Systems Change.

³ [Garcia et al 2010](#); [Sommers et al 2012](#)

Part I: Strategies to Reduce ED Use

Based on CMS review of the literature, discussions with states, providers, and researchers, and findings reported on a CMS-supported Emergency Room (ER) Diversion grant program that operated in 20 states from 2008-2011,⁴ we have identified three key strategies to reduce inappropriate ED use.

Strategy 1: Broaden Access to Primary Care Services. Adequate access to health care settings aside from the emergency department is necessary, although not always sufficient. When there is limited capacity in the appropriate setting, there is nowhere to redirect the patient to avoid unnecessary ED use. Access, of course, needs to be evaluated from the perspective of the beneficiary—many have limited transportation options and often people cannot leave work for an appointment without losing pay or putting their job at risk.⁵ States and health systems have experimented with varying degrees of success in developing urgent care clinics, or ensuring the availability of clinics with expanded hours.

- **Medical and Health Homes.** Primary care medical and health homes typically have extended hours (weekends and evenings), same day appointments, 24/7 nurse advice lines, and continuity with one provider. In some models, patient navigators schedule appointments at primary care medical homes for frequent users. Some of these efforts have reduced ED use. For instance, Community Care of North Carolina reduced the ED visit rate by 16% for asthma, with a total savings to Medicaid and CHIP of about \$135 million.⁶

Medicaid can support these efforts via the Medicaid Health Home authority which includes enhanced federal financial support ([SMD: Health Home Core Quality Measures](#)), or under a state plan amendment for integrated care models ([Integrated Care Models](#)). Other states might build such a model into a section 1115 demonstration project.

- **Alternative Primary Care Sites.** Given that two-thirds of emergency visits occur after business hours (weekdays 9 am - 5 pm), identifying primary care sites available after business hours is one strategy for improving appropriate access to health care services.⁷ The private sector estimates potentially \$4.4 billion in savings nationwide by increasing urgent care and retail clinic access for patients with nonemergency conditions.⁸

⁴ In these grants, states established alternative non-emergency service providers or primary care sites, used health information technology systems to improve the coordination of care, and conducted education and outreach programs to encourage beneficiaries to use the most appropriate settings. States reported similar lessons learned, but varied in their success in reducing ED use. For additional information see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/ER-Diversion-Grants.html>.

⁵ For a technical discussion of measurement of access, please see http://www.aspe.hhs.gov/health/reports/2013/medicaidaccess/rpt_medicaidaccessstudy.pdf

⁶ Steiner et al., 2008. Community care of North Carolina: Improving care through community health networks. *Annals of Family Medicine*. Vol 6, No 4 July/Aug.

⁷ Pitts et al, 2010. Where Americans get acute care: Increasingly, it's not at their doctor's office. *Health Affairs*. 29 (9):1620-1629

⁸ Weineck R. et al., 2010. Some Hospital Emergency Department Visits Could Be Handled by Alternative Care. RAND

These efforts typically begin by drawing these sites into the Medicaid program as providers and using public education, patient navigators, or nurse advice lines to educate beneficiaries about the use of these care sites. Ideally, the electronic medical record is interoperable between the beneficiary’s usual primary care provider and the urgent care setting. Some of these efforts have had marked success. In New York, the implementation of an urgent care center decreased ED utilization by 48% for adults with a visit to the clinic.⁹ Georgia established four primary care sites in rural, underserved areas with extended or weekend hours and hired case managers for redirecting frequent ED users covered by Medicare and/or Medicaid to the sites. Over a 3-year period, Georgia reported that the sites served about 33,000 patients at an estimated saving of \$7.3 million.¹⁰

Strategy 2: Focus on Frequent ED Users – “Super-utilizers.” Frequent ED users (often defined as individuals with 4 or more visits per year) comprise 4.5% to 8% of all ED patients across payors but account for 21% to 28% of all visits.¹¹ Targeting frequent ED users could improve quality and result in cost savings by increasing continuity and coordination of care.

Frequent ED users are more likely to have poor physical and mental health, no usual source of care, higher-than-average utilization of other health services, and be dissatisfied with their medical care.¹² While they may be a small group of people, they can account for a large share of costs. In Oregon, for instance, 50% of ED expenses in Oregon could be attributed to 3% of the Medicaid population (~16,000 individuals). Examples of state and local efforts include:

- Ambulatory Clinic on Site at ED. Minnesota’s Hennepin County Medical Center’s Coordinated Care Clinic (CCC), an ambulatory ICU clinic created to provide enhanced outpatient care to high utilizers of acute care, observed a 38% decrease in ER visits and a 25% decrease in hospitalizations in their client population over the first year of program participation.¹³
- Medicaid Health Homes and Community Interventions for Super-utilizers: Maine is addressing the needs of frequent ED users with Medicaid Health Homes. The health homes include both a patient-centered medical home primary practice as well as Community Care Teams, which are multidisciplinary care management teams that support the state’s highest need residents by providing individualized care plans, intensive care management, in home visits, health coaching, and connecting beneficiaries with appropriate community resources.¹⁴

⁹ Merritt et al, 2000. The Influence of an Urgent Care Center on the Frequency of ED Visits in an Urban Hospital Setting. *Am J. of Emerg Med.* Mar; 18 (2):123-5.

¹⁰ Owens C., 2012. Georgia Alternative Non-Emergency Room Diversion Project. Presentation to CMCS Quality Technical Advisory Group, July 25, 2012.

¹¹ LaCalle et al. 2010. Frequent users of emergency departments: The myths, the data and the policy implications. *Ann Emerg Med.* 56:42-48.

¹² Hunt et al, 2006. Characteristics of frequent users of emergency departments. *Annals of Emergency Medicine.* Vol 48: 1-8.

¹³ America’s Essential Hospitals. <http://www.naph.org/Homepage-Sections/Explore/Innovations/2013-Gage-Awards/HCMC-Coordinated-Care-Center-reduces-ED-uses-avoidable-hospitalizations.aspx>;

¹⁴ <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-24-2013.pdf>

CMS recently issued additional guidance on policies and best practices for high utilizer programs (<http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-24-2013.pdf>). The National Governors Association has also begun a collaboration across seven states around superutilizers.¹⁵

Strategy 3: Target needs of people with behavioral health problems: One particular group of high utilizers is people with behavioral health and substance abuse problems. About 12.5% of all ED visits across payors are due to mental health and/or substance abuse treatment needs.¹⁶ Some states and health plans have had dramatic success in improving health care and reducing overall ED usage by targeting the needs of this population. In many successful examples, case managers connect frequent ED users with behavioral health or social services that meet their needs or interdisciplinary clinics provide targeted services that are lower cost than the ED and more appropriately treat the behavioral health needs of patients. There are a number of examples of effective interventions for this population. For instance,

- **Medical Homes for People with Substance Abuse Problems.** In Indiana, WellPoint Health Plan medical homes for patients with high-service use decreased ED utilization by 72% and decreased controlled substance prescriptions by 38% in the 6 months pre- and post-program.¹⁷ Medical homes for people with substance abuse issues can also be a key intervention for super-utilizer programs as well – in Michigan, an integrated medicine clinic addressing super-utilizers with mental health and substance abuse needs decreased ED visits by over 50% among highest utilizers.¹⁸
- **Housing and Case Management Program.** In Illinois, a housing and case management program for patients who are homeless decreased ED use by 24%.¹⁹ In New York, case management and a mobile health clinic for IV drug users decreased ED use by 20%.²⁰ In Pennsylvania, a project linking patient navigators and persons with serious mental illness reported a 59% reduction in ED visits for individuals dually eligible for Medicare and Medicaid with the least serious acuity level and a 31% reduction in visits for individuals with the most serious acuity level.²¹

¹⁵ See <http://www.nga.org/cms/home/news-room/news-releases/2013-news-releases/col2-content/states-focus-on-reducing-health.html>, and resources from a recent conference at <http://www.nga.org/cms/home/nga-center-for-best-practices/meeting--webcast-materials/page-health-meetings-webcasts/col2-content/main-content-list/developing-state-level-capacity.html>.

¹⁶ Owens L et al. 2007. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults. Agency for Healthcare Research and Quality.

¹⁷ http://www.mhpa.org/MHPA_Updates_and_Health_Care_News/?MHPA_Responds_to_Bloomberg_Govt_Study_on_ER_Visits

¹⁸ <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-24-2013.pdf>

¹⁹ Sadowski LS et al. 2009 Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *JAMA*. May 6;301(17):1771-8.

²⁰ Pollack H et al., 2002. The impact of needle exchange based health services on emergency department use. *J Gen Intern Med*. May;17 (5):341-8.

²¹ Nauman D and Williamson J, 2012. Establishment of Alternative Non-emergency Services Providers In McKeesport Pennsylvania. Presentation to CMCS Quality Technical Advisory Group.

As an example of the broad multipronged strategies proposed in this Bulletin, Washington state initially proposed making different payments to emergency departments on the basis of non-emergency, as determined by a list of discharge diagnoses. In the face of some controversy, the state instead adopted a series of seven steps, including all of the three identified above. Within the first six months, the state reported a 10% reduction in Medicaid fee-for-service ED payments in this arena.²²

Part II: Differentiating Emergency and Non-Emergency Use of the ED

Current statute and regulations provide states with options for developing payment methodologies intended to encourage providers to direct patients to more appropriate care settings, or implementing cost sharing for beneficiaries based on a distinction between non-emergency and emergency use of the emergency department. These provisions, however, can be challenging to implement in light of the difficulty in distinguishing upfront what is and is not an emergency. This section of the Bulletin identifies some of the relevant considerations as states explore these options.

The Medicaid statute and implementing regulations preclude cost sharing for emergency services, while permitting cost sharing (within limits) for non-emergency use of the ED. Before a beneficiary can be charged for a non-emergency visit to the ED, the hospital is required to assess the individual clinically. If it is determined that the individual does not need ED services, before cost sharing can be imposed, an accessible and available alternative provider must be identified, and a referral to coordinate scheduling must be provided. The final rule published in July 2013 retains flexibility for states to adopt methods to distinguish non-emergency services in a manner consistent with applicable statute and regulations.

States are also permitted to vary payments to providers, as long as payments are “consistent with efficiency, economy and quality of care” and are sufficient to ensure access to services similar to the access for the general population. A number of states have adopted payment strategies to reduce inappropriate ED use. Under one such strategy, the state will provide lower levels of payment for a non-emergent visit to the ED, as determined retrospectively by chart review, or based on a coding algorithm. CMS and states will need to ensure that a state’s ED payment strategy does not impede care and that safeguards are in place to provide for care outside of the ED setting.

States that propose either cost sharing or payment strategies should demonstrate sufficient access to services outside of the ED and consider expanding care through medical homes or other arrangements that improve linkages between patients and providers.

Clinical issues in differentiating emergency and nonemergency use of the ED

²² Washington State Health Authority, at http://www.washingtonhealth.hca.wa.gov/press_release/implementing-emergency-room-best-practices-improves-care.html. The seven steps are: 1) Track emergency department visits to reduce “ED shopping”; 2) Implement patient education efforts to re-direct care to the most appropriate setting; 3) Institute an extensive case management program to reduce inappropriate emergency department utilization by frequent users; 4) Reduce inappropriate ED visits by collaborative use of prompt (72 hour) visits to primary care physicians and improving access to care; 5) Implement narcotic guidelines that will discourage narcotic-seeking behavior; 6) Track data on patients prescribed controlled substances by widespread participation in the state’s Prescription Monitoring Program; and 7) Track progress of the plan to make sure steps are working.

For purposes of making valid differentials in payment or cost sharing, states must establish a reasonable, clinically-based method to distinguish emergency from non-emergency visits. The application of this method must occur after a hospital has fulfilled its Emergency Medical Treatment and Labor Act (EMTALA) obligations (see below), but before any further evaluation or treatment is provided, in order to ensure that the patient has a chance to seek other care without paying the cost sharing. Where the policy is to provide a differential payment rate or implement cost sharing, the application of the method should occur after a hospital has fulfilled its EMTALA obligations, but before any further evaluation or treatment is provided, in order to allow the provider an opportunity to ensure that the patient is directed to an appropriate non-emergency setting.

Different methods have been used to distinguish emergent from nonemergent care before a full evaluation is done; however no two methods appear to agree. The Billings algorithm, which is often cited, provides very different results from the triage determination of non-urgent care that is done at the time of an ED visit, and still other methodologies differ from both of these.²³ A study in JAMA in March 2013 underscored this challenge.²⁴ The study compared the “presenting complaint” (the patient’s first complaint when they arrive to the ED) to the final discharge diagnosis (the final diagnosis after a full evaluation is done) and found significant overlap between emergencies and non-emergencies whether using presenting complaints or discharge diagnoses as the tool for differentiation.

Relevant Statutory and Regulatory Issues

Regardless of state laws or Medicaid health care delivery arrangements, hospital providers that participate in the Medicare program are bound by EMTALA, found at sections 1866 and 1867 of the Social Security Act and implemented at 42 CFR 489.20 and 489.24. EMTALA requires such hospitals having emergency departments to provide a medical screening examination to every individual who “comes to the emergency department” seeking examination or treatment, and, when necessary, stabilizing treatment by qualified medical personnel or appropriate transfers for any individual determined to have an emergency medical condition.²⁵ States will want to be sensitive to

²³ For instance, in the Billings algorithm, a certain percentage of final diagnoses of abdominal pain are assigned to the urgent category because analyses will show that a certain portion of patients may come to the ED complaining of pain that could be a heart attack but after a workup determine that the cause was abdominal pain. Another percent of abdominal pain is assigned to the nonurgent category—a patient might present with obvious heartburn, and so the final diagnosis of abdominal pain would be nonurgent. But for any single diagnosis of abdominal pain, it is impossible to determine through the Billings algorithm whether this is urgent or nonurgent—only at an aggregate population level.

²⁴ Raven et al, “Comparison of presenting complaint vs. discharge diagnosis for identifying “nonemergency “emergency department visits. *JAMA*, March 20, 2013.

²⁵ Under EMTALA, an emergency medical condition is defined as acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that, in the absence of immediate medical attention, could reasonably be expected to place the health of the individual or an unborn child in serious jeopardy, or result in serious impairment of bodily functions or serious dysfunction of any bodily organ or part. In the case of a pregnant woman having contractions, the definition also means there is inadequate time to affect a safe transfer or that transfer may pose a threat to the health or safety of the woman or unborn child. In addition to these requirements for providers under EMTALA, Medicaid regulations at 438.114 governing coverage provided by managed care organizations (MCOs) require them to cover services needed to evaluate or stabilize an emergency medical condition, defined somewhat differently than under EMTALA as ‘a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine,

the potential that methodologies intended to affect provider or beneficiary behavior in the ED, if not designed properly, could create provider EMTALA compliance issues.

Under EMTALA, all individuals who present to the ED at Medicare-participating facilities must be treated the same with respect to services required under EMTALA, regardless of their ability to pay and/or their payer (private, public, or uninsured) status. Providers cannot lawfully withhold or delay EMTALA screening or services for a class of individuals on the basis that they are Medicaid beneficiaries. Generally, hospitals must fulfill their obligations to an individual under EMTALA prior to employment of any processes required by a specific payer. For example, the following practices are likely to conflict with EMTALA requirements: use of special registration procedures for Medicaid beneficiaries prior to the hospital's fulfillment of its EMTALA obligations; or requirements for hospitals to consult with Medicaid staff or vendors as part of the required screening examination or for determination of what stabilizing treatment is needed, e.g., whether an admission is required, or whether a transfer, which is appropriate under EMTALA, is allowable by the Medicaid program.

It is also important to note that Medicaid regulations at 42 CFR 440.230, implementing benefit standards for the program, require that benefits be sufficient in amount, duration and scope. This regulation also requires that services, including outpatient hospital services, be furnished without arbitrary limits based on diagnosis, type of illness, or condition. As such, hard caps on annual visits to hospital EDs are not approvable because they restrict outpatient hospital services furnished by hospital EDs, which treat acute and immediate conditions.²⁶ In addition, the unintended consequences, both in terms of care provision to beneficiaries, and financial impact to hospitals, are high.

Conclusion

CMS is very supportive of efforts to ensure that appropriate care is delivered in the most appropriate settings. Successful strategies to reduce inappropriate ED use can have the enhanced benefit of improving care and lowering costs.

Experience and research suggests that narrow strategies to reduce ED usage by attempting to distinguish need on a case by case basis have had limited success in reducing expenditures to date, due in part to the very reasons for higher rates of utilization by Medicaid beneficiaries including unmet multiple health needs and the limited availability of alternative health care services.

However, broader strategies - such as expanding primary care access, “superutilizer” programs, and targeting the needs of people with behavioral health and substance abuse issues -- appear to have

could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.’ Providers are expected to comply with the EMTALA definition and requirements, regardless of the coverage provided by a Medicaid MCO or any other payer.

²⁶ A “soft cap” is distinguished from a “hard cap” in that additional services will be covered with prior or special authorization.

considerable promise for addressing unmet health needs as the underlying causes of high ED utilization. We have identified in this Bulletin several strategies for reducing inappropriate use of ED services, and are eager to work with states and providers interested in implementing these approaches.

We hope this information is helpful and we welcome additional examples of best practices or innovative strategies in this area. For more information, please contact Stephen Cha, MD, CMCS Chief Medical Officer at Stephen.Cha@cms.hhs.gov.