



HBXX CHIP & Medicaid ER Use Amendments

First Step is to Improve Access to Patient-Centered Health Homes

A Utah Health Policy Project Fact Sheet (DISCUSSION DRAFT)

February 11, 2013

WHAT THE PROPOSED LEGISLATION DOES...

HBXX (Rep. M. Kennedy) creates penalties and incentives to promote appropriate use of the emergency room, including:

- Health plan authority to audit ER use and make lower payments to providers for non-emergent care;
- Use of savings to improve access to primary care;
- Measurement of appropriate ER use by enrollees in contracted health plans and publication of results;
- Higher copays for enrollees seeking care in ERs for non-emergent conditions; and
- Direct enrollment to health plans with better performance on ER use quality measures.

These measures may put the cart before the horse: Utah's Medicaid ACOs (accountable care organizations) are just getting started. Their first order of business should be to build health home teams and partnerships with community clinics to streamline access to primary care. The state can do its part to improve access to primary care, for example, by setting aside new medical school slots for students willing to deliver primary care in medically underserved areas (amending [Sen. J. Valentine's SB42](#)); by certifying and making it easier for community health workers to be paid through Medicaid; maximizing navigators and enrollment assister resources in health reform, and so on. Once these and similar proven measures are taken, payment incentives can follow.

ISSUES RAISED BY HBXX with **RECOMMENDATIONS**

The experience of other states is instructive: while the problem of people seeking primary or urgent care in the emergency room is straightforward, the solution is far more complex.

ISSUE: Use of savings to promote access to primary and urgent care is in keeping with the underlying intent of the bill. But the reason people often seek treatment for non-emergent conditions in the ER is because primary or urgent care is not accessible in their community.

RECOMMENDATION:

PROVEN APPROACHES TO ER DIVERSION

An **Oregon**-based accountable care initiative identifies so-called "frequent fliers" who visit the E.R. at least 10 times a year. Becky, a community health worker based in Bend, helps such patients connect with primary care at much lower cost to all payers. These and similar strategies have decreased emergency room visits by 49% during the first 6 months of 2012.

<http://www.oregon.gov/oha/pages/features/2011-1007-wilkinson.aspx>

A **Colorado**-based community health center E.R. diversion initiative focuses on 3 goals: 1) educate Medicaid clients about non-E.R. options; 2) make referrals to alternative non-E.R. care through use of outreach case managers; and 3) promote health homes as a permanent alternative to E.R. for Medicaid patients.

<http://www.hhs.gov/asl/testify/2011/05/t20110511a.html>

Utah was awarded an E.R. Diversion Grant from the Centers for Medicare and Medicaid in 2008. The grant was used to test a hypothesis: that Medicaid clients with access to a regular provider for primary care are less likely to use the emergency room for issues that are best addressed in primary care settings. The intervention, "Safe to Wait, assigns patients to PCPs and educates them about when it is appropriate to use the E.R. The project resulted in a 55% reduction in non-emergency use of the E.R. , suggesting a significant savings for Medicaid. For this reason the Department of Health decided to continue the program beyond the grant period.

http://health.utah.gov/opho/publications/hsu/10Jun_MedicaidER.pdf

- *Direct that the savings will be expended on the following prioritized list of primary care access improvement activities:*
 - *Public disclosure of health plan performance in relation to ER diversion and primary care access improvement quality measures;*
 - *Further diversion strategies by the health plans;*
 - *Further primary care access improvement strategies by the health plans;*
 - *Reimbursement for use of community health workers in improving primary care access as approved by CMS in other states; and*
 - *Maximizing Utah's participation in the federal health professional education loan repayment program.*
- *Require all Medicaid ACOs to participate in fully transparent primary care needs assessment activities that engage consumer groups and health system stakeholders.*
- *The amount of savings realized should be determined by the Department of Health based on claims and encounter data. Compliance with the bill's requirement that savings be spent on primary care access improvement activities should be verified through Department review of health plan financial reporting or audit.*

ISSUE: Higher copays for non-emergent ER use. Such measures are not likely to be approved by CMS, and this is because they have been shown to discourage people from seeking care *at all*. It's true that the Obama Administration recently released a few Federal Rule that gives states flexibility to charge higher co-pays for non-emergency use of the E.R., but the new rule only applies to individuals with household income >100% of the poverty level. This rule would only apply to the Medicaid expansion population—if or when Utah decides to implement this option.ⁱ

RECOMMENDATIONS:

- *Resources should be devoted to educating consumers about ER alternatives. Proven, cost-effective solutions like community health workers and navigators should be adequately funded and trained to connect patients to care in the right settings (also see legislation proposed by Sen. L Robles).ⁱⁱ*
- *As Utah Medicaid transitions to accountable care, determine the status of Utah's successful Safe to Wait initiative (see side bar, p. 1).*

ISSUE: Making public plan performance data in relation to ER diversion quality standards is essential to allowing market forces to help drive quality and cost growth reduction in Medicaid. The bill as written only permits limited public disclosure.

RECOMMENDATION: *Require the Department to publicly disclose health plan performance data in relation to the Department's ER diversion quality standards with any cost associated with disclosure paid out of ER diversion savings.*

ⁱ http://www.nytimes.com/2013/01/23/health/medicaid-patients-could-face-higher-fees-under-a-proposed-federal-policy.html?_r=0

ⁱⁱ <http://health.utah.gov/disparities/data/CommunityHealthWorkersInUtah2012.pdf>
<http://health.utah.gov/disparities/data/BridgingCommunitiesandClinics2012.pdf>