Development of an All-Cause Emergency Department (ED) Utilization Measure for Medicaid Beneficiaries – NOSORH Comments

Introduction

On November 8, 2021, the Centers for Medicare and Medicaid Services (CMS) released a call for public comment on a project titled, *Development of the All-Cause Emergency Department (ED) Utilization for Medicaid Beneficiaries Measure*. This call for comment seeks input that would help identify areas of improvement for the measure. The project is being managed by the Lewin Group.

The National Organization of State Offices of Rural Health (NOSORH) submits these comments and recommendations on the proposed measure to CMS and the Lewin Group. NOSORH was established in 1995 to assist State Offices of Rural Health (SORH)s in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities build effective health care delivery systems.

In preparing these comments NOSORH drew upon discussions with multiple SORHs. NOSORH trusts that its comments will contribute meaningfully to the development of practical measures related to ED utilization by Medicaid beneficiaries. NOSORH notes that CMS has committed itself to addressing the health disparities of different groups, including racial/ethnic minorities, age cohorts, gender groups, poor people and LGBTQ+ populations. NOSORH's comments do not specifically discuss how CMS might modify this measure to address the health disparities of these populations. NOSORH understands, however, the importance of health disparities, and believes that its recommendations can be further targeted to key populations.

NOSORH stands ready to assist CMS and the Lewin Group in further exploration of this topic.

Overview

NOSORH believes that a measure of trending and relative emergency department (ED) utilization can be useful in assessing a state Medicaid program's ability to ensure preventive and primary care. Failure of a Medicaid program to assure an adequate and accessible network of providers for Medicaid beneficiaries can lead to increased unnecessary use of ED resources. Preventive and primary care network adequacy is particularly important for rural areas and shortage areas. NOSORH believes, however, that a *single* measure looking at all-cause ED utilization may be too broad, and that more discrete monitoring and analysis could have greater usefulness - particularly for the purpose of improving state Medicaid program performance.

NOSORH notes that some changes in ED use are linked to factors beyond a Medicaid program's control. The impact of the COVID-19 pandemic on ED utilization is a stark

reminder of this fact. Notwithstanding, NOSORH believes that alternative measures of ED utilization linked to factors within a Medicaid program's purview would be beneficial.

NOSORH believes that the focal point of ED utilization measurement should be on two factors:

- **Inappropriate use of ED resources** - i.e., use of ED for non-emergent reasons where outpatient resources could be utilized; and
- **Preventable ED utilization** – i.e., use of ED for emergent reasons where appropriate use of outpatient services could have prevented an emergent situation.

Presented below are several possible modifications that could be made to the proposed measure which NOSORH believes would better address these two factors.

Recommendations

- **Emergency/Non-Emergent ED Utilization**: **NOSORH suggests that Medicaid differentiate the measurement of *emergent* and *non-emergent* diagnoses in ED utilization.**

  Discussion: This type of differentiation would be an excellent first step in measurement of the *inappropriate use of the ED*. It would provide a good baseline for Medicaid program efforts to reduce ED utilization for non-emergent reasons. The indicators would also provide performance measurement of the *adequacy* and *accessibility* of each Medicaid program's ambulatory care network.

- **Behavioral Health, Alcohol-Related and Substance Use Disorder ED Utilization**: **NOSORH suggests that Medicaid differentiate the measurement of behavioral health, alcohol-related, and substance abuse disorder related diagnoses in ED utilization.**

  Discussion: These diagnostic categories represent a significant percentage of all ED visits. A recent study suggests that most of these visits are unnecessary, and could be prevented if there was adequate and accessible outpatient services:

  https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.jsp

  Differentiating these diagnostic categories from other medical diagnoses will assist Medicaid programs in identifying needs for targeted program responses. Potential responses could include establishment of Medicaid-supported SBIRT (Screening, Brief Intervention, and Referral to Treatment) or similar programs.

- **Shortage Area ED Utilization**: **NOSORH suggests that Medicaid differentiate the measurement of ED utilization by Medicaid beneficiaries in designated Health Professional Shortage Areas (HPSA) and non-designated areas.** This differentiation should include Medicaid beneficiaries located in either *geographic* or *low-income* HPSAs.

Discussion: HPSAs defined for geographic areas are designated regions which have inadequate primary care supply which meets *less than half* the demand of the area's population. Most patients in these areas will not be able to receive the outpatient services they require and will be at higher risk of inappropriate and preventable use of the ED.

Similarly, low-income HPSAs are designated regions which have inadequate primary care supply for the low-income population – those below 200% of the Federal Poverty Level – meeting less than half the demand from the low-income population. This population includes Medicaid eligible individuals. The lack of accessibility may be due to the refusal of local providers to accept Medicaid patients or the lack of provisions for care to the uninsured. This population is at higher risk of inappropriate and preventable use of the ED.

The recommended differentiation of measurement can provide Medicaid programs with insight into potential structural changes and payment incentives which could reduce inappropriate and preventable ED utilization.

- **Rural vs Urban ED Utilization: NOSORH suggests that Medicaid differentiate the measurement of ED utilization by Medicaid beneficiaries in rural and urban areas.**

  Discussion: Visits to rural and critical access hospital (CAH) emergency departments (EDs) have risen 50% in the US in the last 10 years. Much of this increase has been attributed to demand for acute, unscheduled care. This growth reflects the safety net role of EDs in US rural communities, which disproportionately experience primary care shortages. A recent study explores the extent of this issue and its impact:

  https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786354

  It would be useful to measure the differences between rural and urban community ED utilization. This would provide insight into how Medicaid programs might address the structural issues underlying rural/urban disparities.

- **Ambulatory Care Sensitive (ACS) ED Utilization**: **NOSORH suggests that Medicaid differentiate the ED utilization attributed to a defined set of ambulatory care sensitive diagnostic codes.**

  Discussion: This approach would be similar to the analysis of ACS *hospitalizations*. A set of key diagnostic codes could be identified where improved preventive and primary care could reduce preventable ED utilization. These measures could provide data for multiple Medicaid program responses.

  There are several resources which could be used in defining a set of ACS diagnostic codes for ED utilization. The Agency for Healthcare Research and Quality (AHRQ) is an excellent source for alternative lists of ACS diagnostic codes:

  https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html

It should also be noted that Medicaid program interventions designed to reduce preventable ED utilization need be not limited to *medical* responses. In its analyses AHRQ has identified *dental emergencies*, including dental pain, abscesses and infections as a major diagnostic category for ED admissions. A Medicaid program intervention designed to reduce preventable ED utilization for these diagnoses could consider expansion of dental coverage for adults, and potential structural changes addressing dental care shortages. Similarly, the diagnostic category for *injuries caused by falls/slips* are forms a significant percentage of ED utilization, particularly for elderly and disabled Medicaid beneficiaries. Medicaid program interventions designed to prevent falls/slips would need to address home safety and other social determinants.