COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)
www.dmas.virginia.gov

January 29, 2025

MEMORANDUM

TO: The Honorable Mark D. Sickles
Chair, Joint Subcommittee on Health and Human Resources

The Honorable R. Creigh Deeds
Vice Chair, Joint Subcommittee on Health and Human Resources

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: DMAS Measures to Manage Emergency Department Utilization and Cost in Virginia's Medicaid Program

This report is submitted in compliance with 304.HHH. of the 2023 Appropriations Act, which states:

The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services to implement a modified emergency room utilization program, consistent with the requirements necessary for approval by the Centers for Medicare and Medicaid Services, effective January 1, 2024. The department shall have the authority to implement this change effective January 1, 2024, and prior to the completion of any regulatory process undertaken in order to effect such change.

Should you have any questions or need additional information, please feel free to contact me at 804-664-2660.

CR/wf
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

DMAS Measures to Manage Emergency Department Utilization and Cost in Virginia's Medicaid Program

January 2025

Report Mandate:

Item 304.HHH. of the 2023 Appropriation Act states: "The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services to implement a modified emergency room utilization program, consistent with the requirements necessary for approval by the Centers for Medicare and Medicaid Services, effective January 1, 2024. The department shall have the authority to implement this change effective January 1, 2024, and prior to the completion of any regulatory process undertaken in order to effect such change."

Background

The Commonwealth of Virginia has sought to address inappropriate emergency department (ED) utilization and associated costs in Virginia's Medicaid program for many years. Efforts have included agency-led workgroups and legislative studies to research and analyze this issue and offer recommendations. While ED visits are necessary in many circumstances, the ED is a relatively high-cost setting to receive care. It is more cost-effective for the state if individuals receive care in a lower cost outpatient setting when appropriate and safe. Efforts to reduce ED utilization and cost are not unique to Virginia's Medicaid program and are often a focus for payers. A key challenge in addressing this issue in many states' Medicaid programs, including Virginia's, is that individuals with Medicaid do not have cost sharing for services. For Virginians with commercial health insurance, high copays act as a deterrent to using the ED unless it is necessary.

The Department of Medical Assistance Services (DMAS) has implemented a wide variety of programs with the aim of reducing ED utilization and costs. The primary recent examples are:

- **MCO Clinical Efficiency Program** – A financial incentive on Virginia's managed care organizations (MCOs) where a portion of their monthly capitation payments are 'withheld' and the MCOs can earn it back by reducing potentially preventable ED visits.

- **Emergency Department Care Coordination (EDCC)** – The General Assembly directed, and DMAS partially funds, the EDCC program. This technology platform provides real-time encounter data on every ED and acute inpatient visit to hospitals, Medicaid managed care organizations, commercial and Medicare health insurers, and participating outpatient providers. EDCC is targeted at addressing coordination of care for high-utilizing and high-needs individuals through effective data sharing. Participation and usage of the program has steadily increased every year since 2017 and the scope of data collection and

participation was expanded in Virginia code effective January 1, 2024.

These focused initiatives are supplemented by broader, programmatic efforts that include measures related to reducing ED use. These include implementing an array of evidence-based, outpatient Medicaid substance use services in 2019 called the Addiction and Recovery Treatment Services (ARTS) benefit. ARTS services were designed in part to provide treatment in more appropriate settings and reduce ED visits for individuals with substance use disorder. Additionally, Virginia's value-based purchasing program includes a performance measure for resident ED use. This program rewards nursing facilities with supplemental funding for their performance on five quality measures.

There have also been several legislatively directed changes to how DMAS and the MCOs reimburse hospitals for low-acuity ED visits.

- Prior to 2015, DMAS and the MCOs had the authority to pend certain ED claims and pay a reduced "triage fee" if a review of the claim indicated it met certain criteria.
- The 2015 Appropriation Act directed DMAS to discontinue this program.
- The 2020 Appropriation Act directed DMAS to develop a program that would automatically pay a reduced rate to hospitals for ED claims that met predetermined criteria.
- The program put in place was challenged in court and overturned. DMAS discontinued the program after the court decision.
- The 2023 Appropriation Act, signed in September of 2023, directed DMAS to "implement a modified emergency room utilization program, consistent with the requirements necessary for approval by the Centers for Medicare and Medicaid Services, effective January 1, 2024."

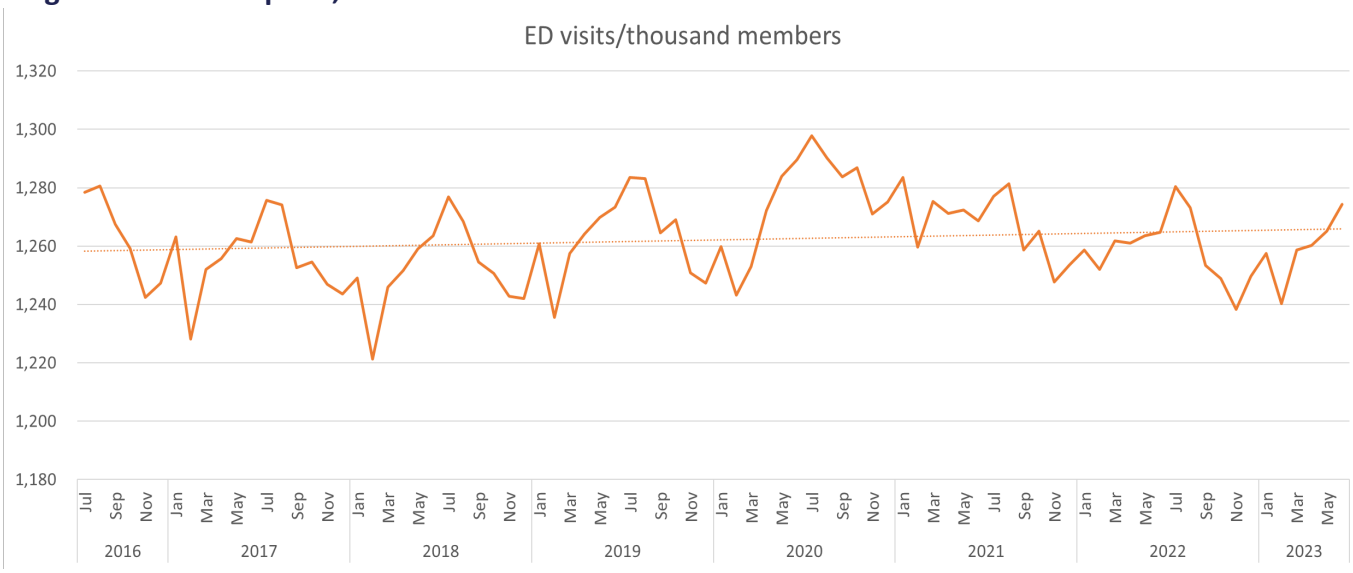
This final direction from the General Assembly led DMAS to take a broad, holistic review of its ED utilization programs and work with the impacted stakeholders to design additional initiatives.

Medicaid ED Trends

Long-term ED utilization and spending changes since 2016 in Virginia's Medicaid program align with broader medical trends, when adjusting for population. Utilization increased marginally from FY17 through FY23, in part due to the COVID-19 pandemic.

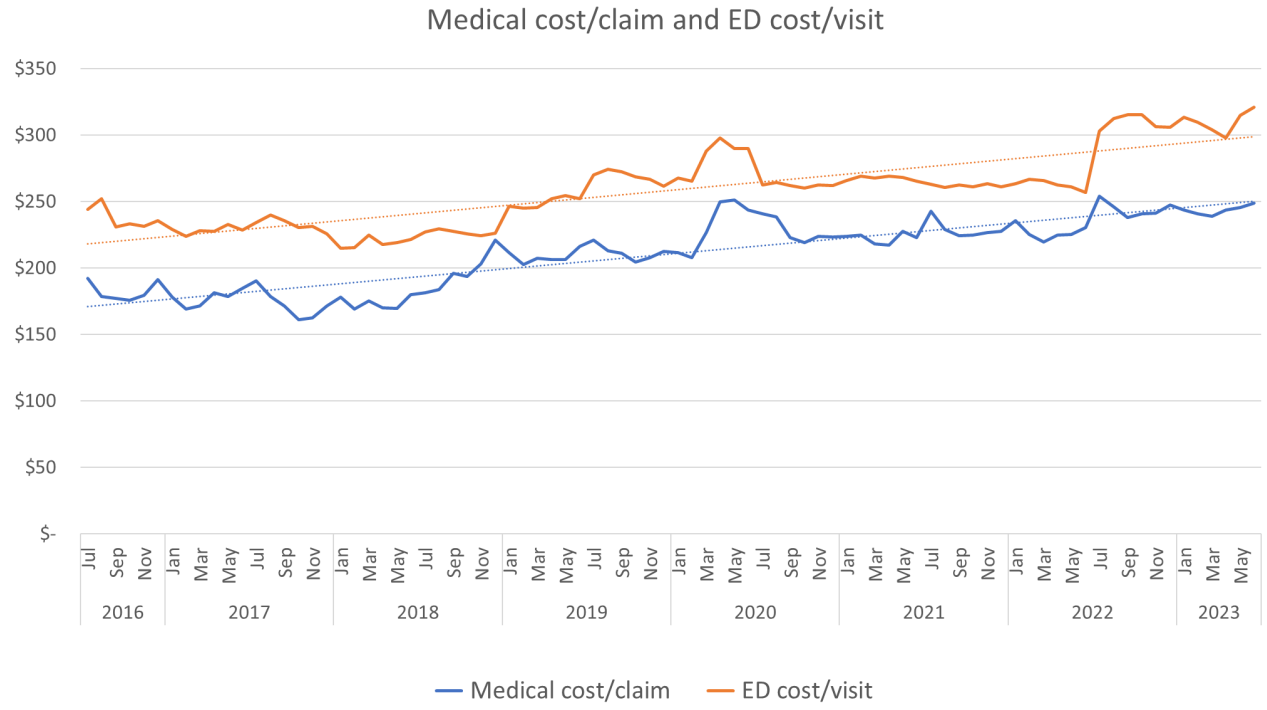
There is significant seasonality to ED use, with higher numbers of visits in the summer months, likely due to warmer weather and children being out of school.

Figure 1: ED Visits per 1,000 Medicaid Members



The cost per-visit for ED claims increased during this same time period, from about $230 per claim in FY17 to about $310 per claim in FY23 (Figure 2), following the trajectory of overall medical costs.

Figure 2: ED and Medical Cost per Claim, Medicaid Members



Recent data for the managed care population (representing 98.5% of all "full-benefit" Medicaid enrollees) shows an increase in cost per claim, but overall utilization remains somewhat flat. This is true in both the 'Acute' population, which is primarily low-income adults and children, and the 'Complex' population, which are individuals who are aged, blind, or disabled, including those needing long-term care (Table 1).

Table 1: MCO ED Utilization and Cost, FY22 – 24

	FY22	FY23	FY24
Acute Population			
PMPM	$16	$19	$21
Cost per Claim	$123	$144	$163
Claims per 12,000 Members	1,514	1,579	1,565
Complex Population			
PMPM	$22	$26	$31
Cost per Claim	$85	$100	$113
Claims per 12,000 Members	3,041	3,166	3,246

Virginia ED Utilization Rates Compared to Other States

Virginia Medicaid does have higher ED utilization rates than many other states that participate in a standardized set of measures known as the Healthcare Effectiveness Data and Information Set (HEDIS®). In Measurement Year 2022 (most recent available), Virginia ranked 22nd out of the 25 reporting states (using the *Ambulatory Care – Emergency Department Visits/1000* measure). This shows that while utilization has been largely steady, there is room for improvement. This underscores the importance of Virginia's current strategies to reduce ED utilization and the need to continue looking at additional methods.

Recent DMAS Actions to Address ED Utilization

In September 2023, DMAS conducted a comparative analysis of ED payment policies and practices in other state Medicaid programs to examine alternative options for reducing costs and improving quality of care for Medicaid members. In December 2023, DMAS conducted a data analysis of Virginia Medicaid members' ED utilization and cost in relation to overall Medicaid utilization and costs to identify any aberrant trends.

In June 2024, DMAS convened the first meeting of a workgroup representing hospitals and Medicaid managed care health plans to collectively analyze and review data, identify opportunities to reduce utilization and costs, and develop strategies to act on those opportunities.

Meeting 1 – June 24, 2024

During the first meeting, the workgroup hosted presentations of data on ED utilization from DMAS, health plans, and the Virginia Hospital and Healthcare Association with the aim of leveraging the participants' data capabilities to understand challenges with ED utilization and identify potential areas of focus. Participants discussed what data points or metrics each group monitors and analyzes to gauge performance related to ED utilization. The group discussed identification of readily available data to inform the ongoing discussion of strategies to reduce ED utilization.

Some observations from the data included:

- ED visits tend to increase on weekdays during business hours, especially Monday and Tuesday.
- Medicaid ED utilization is higher than other payer types in Virginia (including and especially among high utilizers).
- Pediatric ED utilization and upper respiratory conditions were drivers of potentially preventable ED visits.

Meeting 2 – July 24, 2024

At the second meeting, DMAS reviewed past recommendations, including the findings of a 2021 DMAS workgroup and the 2022 Joint Commission on Health Care study. DMAS presented additional data analysis on Virginia compared to other states, characteristics of high utilizers, cross-payer comparisons, and population-specific analyses. The group discussed what type of strategies to focus efforts on, and in particular what populations to target. Potential populations considered were high utilizers; individuals with chronic conditions for which ED is the appropriate setting, but that, with better upstream management, could be prevented from advancing to the stage of needing intervention in the ED; and children and young adults with respiratory conditions. The group decided to focus on reducing ED visits for low-acuity respiratory conditions.

The meeting concluded with a charge to the workgroup participants to come to the next meeting prepared to share proposed strategies and key performance indicators (KPIs).

Meeting 3 – August 22, 2024

For the third meeting, each Medicaid MCO presented on its proposed strategy to address ED utilization, with a focus on reducing ED visits for low-acuity respiratory conditions. The group discussed the best next steps and a decision was made to move forward with these strategies, with a focus on convening to share learnings and best practices and monitor each plan's key performance indicators over the course of the following year.

DMAS Planned Actions in 2025

DMAS plans to continue and build on all of these initiatives into 2025 and state fiscal year 2026. Before DMAS can implement additional programs to reduce low-acuity use of emergency departments, it is important to understand the data and what factors result in such utilization. One new addition in the coming year is that DMAS will analyze total ED utilization and spending across both fee-for-service and managed care, and set a program-wide target for these metrics. This will provide important insight into how the various programs that address the challenge from different perspectives are working together to impact ED use overall. This tracking won't enable DMAS to determine the cause of any changes, as broader population service delivery factors can't be adequately controlled for, but it will provide a program-wide focus on the issue.

As part of this effort DMAS will continue to track its existing programs, particularly the clinical efficiency withholds for potentially preventable ED visits, the EDCC program, and the new initiatives targeting low-acuity respiratory ED use. These programs will be tracked and discussed quarterly with the hospital and MCO stakeholders, and additional insights will be added from new stakeholders when necessary.

Appendix – ED Utilization Workgroup Participants

Aetna Better Health

Ira Bloomfield

Joel Gray

Corey Pleasants

Anthem

Hillary Whonder-Genus

Catherine Silva

Natalie Feldman

Molina Healthcare

William Phipps

Ann Vaughters

Sentara Healthcare

Allison Raines

Jamie Talbott

Michael Genco

United HealthCare

Tameeka Smith

Pamela Andrews

Janine Woldt

Virginia Association of Health Plans

Doug Gray

Heidi Dix

Virginia Hospital and Healthcare Association

Brent Rawlings

David Vaamonde

Julie Dime

Abraham Segres

Emily Lafon

Jay Andrews

Craig Connors

Mary Washington Healthcare

Christopher Newman

UVA Health

Michael A. Williams

Ballad Health

Paula Masters

Casey Carringer

Office of the Secretary of Health and Human Resources

Lanette Walker

DMAS

Lisa Price-Stevens

Jeff Lunardi

Andrew Mitchell

Olufemi Obembe

Dan Plain

Jason Rachel

Katie Linkenauger

Marina Hench

Hope Richardson

Allie Atkeson

Brian Campbell

Karl Loewe

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.