Frequent Users of Emergency Departments: Addressing the Needs of a Vulnerable Population in a Medicaid Waiver

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Executive Summary

Serious attempts to control health care costs must include efforts to rein in expenditures for high-cost Medicaid beneficiaries. In reforming California's Medi-Cal program, addressing the needs of a subset of high-cost beneficiaries, frequent users of avoidable emergency department (ED) visits, is critical to any waiver designed to improve outcomes and control costs.

California Department of Health Care Services data indicate that over 28,000 Medi-Cal beneficiaries who suffer from at least two categories of diagnoses (a chronic medical condition, a mental disorder, or a substance addiction disorder) visited the ED frequently in 2007. That year, these beneficiaries incurred over $400 million in acute care costs, more than $14,000 per beneficiary.[1]

While some beneficiaries were undoubtedly receiving care for unavoidable reasons, people who frequently use EDs for reasons that could have otherwise been avoided with primary, behavioral health, or other care, present with complex co-occurring chronic medical and behavioral health conditions. At the same time, they experience negative social determinants of health: poverty, homelessness or housing instability, unemployment, and social isolation.

Evidence-based strategies applied to Medi-Cal beneficiaries who are frequent users could avoid significant hospital costs. Based on conservative estimates, frequent users avoid hospital costs of $3,841 per beneficiary after one year and $7,519 per beneficiary per year after two years of receiving intensive interventions.[2] Taking into consideration the costs of programs designed to address the needs of frequent users, enrolling even 10,000 beneficiaries into these programs statewide could save the Medi-Cal program over $13.5 million per year within a two-year startup.

Other states' experiences prove that telephone and mail interactions, disease management or vendor-based approaches, and traditional medical home models, while sometimes successful for relatively compliant patients, do not work well in enrolling or reducing acute care use among frequent users. Frequent users require more intensive interventions. Programs that address social barriers to accessing appropriate care, as well as help frequent users coordinate their medical and behavioral health care, produce significant decreases in frequent users' consumption of hospital services.

Offering community-based case management, outreach and engagement strategies, transportation, linkage to permanent housing, and coaching toward self-directed care, a frequent user initiative operating in six geographically-diverse California counties helped frequent users who were Medi-Cal beneficiaries reduce their ED visits by 38% after one year and 60% after two years of enrollment, inpatient admissions by 17% after one year and 67% after two years, and the number of days spent in the hospital by 13% after one year and 69% after two years.[3]

The state is uniquely situated to align incentives to improve outcomes for frequent users. In fact, as California's budget crisis and the prospect of brokering a new waiver generate opportunities to reform the way care is delivered to beneficiaries, a vital component in reforming Medi-Cal should build on successes of frequent user programs. Adopting evidence-based strategies in addressing frequent users, rather than relying on programs proven *not* to reduce acute care consumption among this population, will help to control Medi-Cal costs and improve health outcomes.

Moving beneficiaries into managed care or into medical homes should mandate different models of care for different levels of need. Providing intensive services to frequent users for a specified period would allow the state to cushion baseline costs of a waiver, while also offering a mechanism for the state to achieve milestones in reducing avoidable acute or crisis care. To pay for these intensive services, a number of options exist:

- Directing a portion of up-front federal investment, as well as future realized cost savings, to match state, local, and philanthropic investment in frequent user programs;
- Carving out a portion of an expanded Health Care Coverage Initiative to provide incentives to fund frequent user programs in counties willing to pay for the non-federal match to treat uninsured frequent users in programs that also address the needs of Medi-Cal beneficiaries who are frequent users; and
- Recognizing county-funded frequent user programs as sources of non-federal match, while asking the federal government to contribute to the costs of these programs.

Introduction

Emergency departments (EDs) are the only healthcare resource that, by law, must serve anyone who walks through the door. They have become the resource a small group of people with barriers to appropriate health care use frequently. People who frequently use EDs for avoidable reasons face multiple barriers to accessing primary and behavioral health care, housing, even benefits to which they are entitled, contributing to disproportionate ED visits and hospital inpatient stays.[4]

In general, a small group of Medicaid beneficiaries account for a large share of Medicaid spending: a national study reported that 3.6% of Medicaid enrollees with per beneficiary annual costs of over $25,000 accounted for almost half of Medicaid spending.[5] Among this group of high-cost beneficiaries, frequent users consume significant acute care costs, while suffering poor health outcomes. ED treatment can cost two to three times more than primary care.[6] Historic trends of higher case severity and longer length of stays in the ED have increased ED costs.[7] Frequent users contribute to these trends. A recent report attracted national media attention when it identified nine Medicaid recipients who made 2,678 visits to Austin, Texas EDs from 2003 to 2008. Hospital costs for these nine individuals totaled $3 million in Medicaid and Medicare payments.[8]

In contending with challenges of high-need beneficiaries, California is no exception. According to California Department of Health Care Services (DHCS) data, 28,340 Medi-Cal beneficiaries visited the ED at least five times between January and December 2007 or eight times between January 2006 and December 2007 *and* had been diagnosed with at least two of the following: a chronic physical condition, a mental disorder, or a substance addiction disorder. These beneficiaries incurred costs of over $20 million in ED visits, over $360 million in inpatient stays, and over $16 million in ambulance services. More than 1,000 of these beneficiaries incurred costs of over $100,000 each during the course of the year.[9]

Not only do ED physicians often run costly diagnostic procedures to treat the severity of cases they now see, the ED is a resource-intensive setting not designed to manage chronic conditions.[10] Because EDs provide episodic, acute care, they are not designed to assist patients with the constellation of chronic medical conditions and social issues frequent users present. As a result, frequent users remain in poor, often deteriorating, health. Even when a frequent user accesses

primary care and community clinics, providers find it difficult to address frequent users' multiple psychosocial problems.

Programs designed to remove barriers frequent users face in accessing appropriate care have succeeded in reducing frequent avoidable use of EDs. These programs implement a multidisciplinary approach that combines case management, transportation, medication monitoring, life skills, substance abuse treatment, and linkage to permanent housing (where appropriate) within a health team that includes physical and behavioral health care providers.

An 1115 waiver offers the state an opportunity to facilitate this patient-centered care.[11] Investment in this model can reduce use of more costly acute care, decrease charges for high-cost treatment, improve the lives of frequent users, integrate services for Medi-Cal beneficiaries and uninsured indigent childless adults, and increase the efficiency of the health-delivery system.

In addition to describing barriers to care frequent users face, this paper will report on evidence-based best practices in reducing crisis care. It will identify lessons learned from other states' attempt to curb costly health services among high-cost Medicaid beneficiaries. Finally, it will suggest options for addressing the needs of frequent users under the current system and a waiver.

Barriers to Appropriate Health Care

Frequent users generally do not visit the ED for vague or inconsequential complaints. They often require hospital admission due to the severity of uncontrolled chronic physical or mental illnesses. Unfortunately, hospitalization does not ameliorate the underlying chronic physical, mental, and societal barriers to obtaining appropriate healthcare. Many times, ED staff can identify frequent users who visit their hospitals, not only by the patients' frequency of visits, but also because of the staff's inability to address the patient's core challenges.

To confront these challenges, the Frequent Users of Health Services Initiative (the *Initiative*), a joint project of the California Health Care Foundation and The California Endowment, funded six programs designed to reduce avoidable frequent use of EDs. The Lewin Group conducted an independent evaluation of the six programs and found that participants enrolled in the *Initiative* used EDs and other acute services intensively, with each enrollee averaging annually:[12]

- 8.9 ED visits,
- 1.3 hospital admissions; and
- 5.8 inpatient days each.[13]

Insurance status was not a predictor of frequent ED use among participants. While many frequent users are uninsured, almost 40% of *Initiative* participants were Medi-Cal beneficiaries. [14] Uninsured frequent users share the characteristics of Medi-Cal beneficiaries who are frequent users: they are typically very poor, often homeless or unstably housed, living alone, poorly educated, and have chronic medical conditions. They are seldom dually eligible for Medicare and Medicaid, as most do not meet the eligibility requirements to qualify for Medicare.

The profile of patients enrolled in the six *Initiative* program sites varied, but 65% of all participants suffered from chronic diseases, commonly diabetes, cardiovascular disease, liver disease, asthma, and HIV/AIDS. Over half experienced substance addiction disorders and a third had been

diagnosed with a mental illness. A third of frequent users had two of these conditions, over a quarter, three or more conditions, and a tenth had at least four conditions. Almost half were homeless. Among *Initiative* participants in each of the six programs, the person who used the ED most frequently in all but one of these programs was homeless, all but one experienced a substance abuse disorder, and all but one had a severe chronic disease.[15]

New York's High-Cost Care Initiative, funded by the United Hospital Fund and the New York Community Trust, found similar profiles among high-cost Medicaid beneficiaries in New York. The usual source of primary care among these beneficiaries was the ED. Over two-thirds had chronic health conditions and nearly half had been diagnosed with multiple conditions. Two-thirds had also been diagnosed with a mental illness and about two-thirds suffered from a substance abuse disorder. About half had both. A third were homeless, and an additional 25 to 30% were unstably housed. In addition, the report listed social isolation, poverty, limited transportation, and an absence of community supports as contributors to their frequent ED and hospital use.[16]

Approaches That Minimize Inappropriate High-Cost Care

Recognizing that frequent ED users have multiple co-occurring conditions and psychosocial challenges, *Initiative* programs offered more than medical care. Though each program model differed, all employed community-based multidisciplinary care that included care coordination, referral to primary, behavioral health, and substance abuse treatment, transportation services, and outreach and engagement strategies essential to building trusting relationships with program participants. Staff met clients "where they were," partnering with EDs to identify frequent users and visiting EDs, shelters, sober living centers, and client homes to engage clients. Services were flexible and individualized, and delivered in a range of settings with a focus on enhancing participants' motivation to change harmful behaviors and supporting self-management of chronic conditions. Programs established partnerships to make housing available to homeless participants and provided supportive services needed to help people get and keep housing. Many uninsured frequent users were assisted in obtaining SSI and Medi-Cal benefits. The *Initiative* created unique opportunities for programs and their hospital partners to implement consistent strategies for patients with frequent and avoidable ED use, whether uninsured or enrolled in Medi-Cal. Though Foundation funding expired, four of the six programs continue with county and/or hospital funding.

Evidence from Frequent Users of Health Services Initiative

The Lewin Group documented the following *Initiative* results, demonstrating significant decreases in ED visits, inpatient admissions, and hospital charges after one year participation:

ED and Inpatient Visits Aggregated Across Counties (N = 598)+

	PRE	POST	DIFFERENCE	% DIFFERENCE
ED Visits	4,799	3,380	1,419	30% decrease*
Inpatient Admissions	959	822	137	14% decrease*
Inpatient Days	4,299	4,200	99	2% decrease

*Statistically Significant +While Lewin reported significant decreases in charges, charges are not equivalent to costs and are not reported here.

These data include "super frequent users" who experienced catastrophic and often terminal illnesses while participating in the programs. Fourteen percent of the participants accounted for 84% of charges, which skewed data considerably. The remaining participants, therefore, had significantly greater reductions in ED use and inpatient days than reflected in overall program data.

Program successes were more striking after participants engaged in services for two years:

ED and Inpatient Visits Aggregated Across Counties, One Year Before and One and Two Years After Program Enrollment (N=241)+

Measure	Pre-Enrollment	One Year Post Enrollment	Pre-1 Yr. Post % Difference	Two Years Post Enrollment	Pre-Year 2 Post Difference
ED visits	2,471	1,608	35% decrease	965	61% decrease
Inpatient Admits	352	292	17% decrease	125	64% decrease
Inpatient Days	1,528	1,568	+3%	579	62% decrease

*Statistically significant. +While Lewin reported significant decreases in charges, charges are not equivalent to costs and are not reported here.

Medi-Cal beneficiaries similarly reduced ED visits and inpatient use significantly:

ED and Inpatient Visits and Charges for One Year Before and One and Two Years After Program Enrollment: Clients on Medi-Cal at Enrollment (N=141)+

Measure	Pre-Enrollment	One Year Post Enrollment	Pre-1 Yr. Post % Difference	Two Years Post Enrollment	Pre-Year 2 Post Difference
ED visits	1,771	1,093	38% decrease	720	60% decrease
Inpatient Admits	251	213	17% decrease	82	67% decrease
Inpatient Days	1,203	1,042	13% decrease	362	69% decrease

*Statistically significant. +While Lewin reported significant decreases in charges, charges are not equivalent to costs and are not reported here.

Moreover, the programs succeeded in stabilizing participants' lives. Data from the *Initiative* demonstrates that 69% of homeless clients became housed, 70% of uninsured clients were connected to Medi-Cal or county health services, and 35% of disabled clients without incomes became SSI recipients after receiving *Initiative* services for one year.[17]

Evidence from Other Frequent User Programs

Other programs intended to reduce frequent avoidable ED use incorporating similar models reported like benefits. San Francisco General Hospital (SFGH) published a research study comparing outcomes of frequent users randomly assigned to receive case management services to frequent users receiving usual care. The study reported a 40% reduction in ED costs within the first year. The savings in ED costs offset the full cost of the program, leading researchers to conclude, "Case management was associated with . . . statistically and practically significant reductions in ED utilization and cost."[18]

Two programs under New York's High-Cost Care Initiative offered care management, integrated service delivery, outreach, and collaboration with community-based social service organizations, as

well as data sharing among county and social service organizations. Preliminary findings from this model indicate that participants in the program decreased their ED use by 67% and their inpatient admissions by 45%, leading authors to conclude, "[T]o be successful, a service delivery model for high-cost Medicaid patients must embrace challenges . . . that, if ignored, would thwart traditional medical approaches to delivering acute care."[19]

Evidence from Similar Approaches Addressing Needs of Vulnerable Complex Populations

Some programs employ a similar multidisciplinary person-centered approach for populations with other complex health and psychosocial problems. People who cycle through other crisis systems have analogous risk profiles: they are often very poor and experience housing instability, receive poor healthcare, and face social isolation. Often, they are trapped in systems meant to respond to crisis, rather than the underlying challenges these individuals face.

A growing number of innovative homeless programs, for example, increasingly target or prioritize people for care using a "vulnerability index" that measures health fragility. The Boston Healthcare for the Homeless program conducted research identifying homeless people at greatest risk of death while on the streets. Risk factors that placed homeless people at greatest risk of mortality included more than three ED visits within a year, age (60 years or older), cirrhosis, renal disease or HIV/AIDS, or co-occurring psychiatric, substance abuse, and chronic medical conditions.[20]

For people with serious health problems who lack stable housing, programs that provide clients with whatever the client needs to maintain housing stability—often case management, linkage to primary and behavioral health care, life skills training, and other services, along with housing, the combination referred to as "supportive housing"—are similar to programs that provide clients with whatever is needed to maintain health stability. Supportive housing programs allow clients to decrease over-use of expensive emergency and long-term care services and offer research findings illustrative of future frequent user program outcomes:

- In preliminary findings from Chicago's Housing and Health Partnership, homeless patients offered medical respite and supportive housing spent 45% fewer days in nursing homes and 42% fewer days in hospitals, and made 46 fewer visits in EDs than patients in a randomly - assigned comparison group.[21]
- An evaluation published in the Journal of the American Medical Association of a Seattle program providing services linked to housing for homeless adults with severe alcohol problems revealed reductions in clients' medical expenses by 41% and sobering center use by 87%.[22]
- Among mentally ill Californians experiencing homelessness, supportive housing tenants reduced by 56% their number of ED visits and by 45% their number of hospital admissions. [23]

Community-Based Solutions Make Sense

Like supportive housing programs, *Initiative* projects succeeded in reducing ED visits and hospital admissions through a flexible, individualized, comprehensive strategy that addressed the health conditions and related needs of each patient. This strategy included case managers who,

- Relied on various data systems or ED staff identification of frequent users,
- Assessed physical and behavioral health conditions,
- Enhanced motivation to change risky behaviors (such as substance use),
- Reduced symptoms of mental illness or chronic conditions,

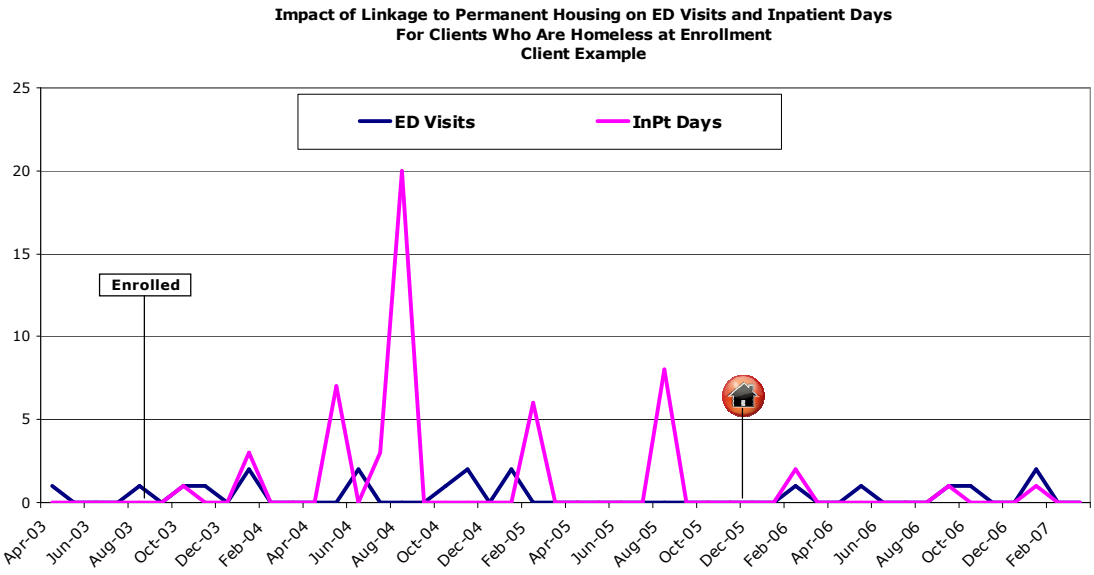
- Restored skills and functioning,
- Prevented crises that could lead to hospitalization, and
- Connected participants to affordable housing programs with ongoing supportive services.

In short, these programs were community-based programs that linked people to community resources. This linkage was essential for frequent users, who are generally distrustful of health care providers, are often homeless or unstably housed, and are struggling to survive. The SFGH study similarly found community-based case management to be critical to acute care reductions.[24]

Initiative programs offered care coordination that ranged from hiring licensed clinical staff to peer- or paraprofessional-driven interventions. Intensive paraprofessional or clinical staff services with transition to less intensive services produced the most dramatic reductions in crisis care. Care coordination meant finding solutions to multiple needs and integrating care across a myriad of systems.[25] Staff and program directors discovered that the following elements were critical:

- Forming a trusting relationship with the participant.
- Offering individualized services that connected people to and advocated for appropriate treatment in community clinics, with mental health professionals, and with substance abuse services, while engaging patients to participate in their care.
- Facilitating regular communication among physicians and clinicians working with the patient.[26]

Connection to housing proved to be a significant determinant of health status for the study's homeless participants. Living on the streets or in a shelter creates multiple barriers to adherence to medical regimens. Homeless people lack access to refrigeration for medications, their prescribed diets may be compromised by limited choices at food banks or shelters, and getting adequate rest is challenging when shelters close early in the morning. Exposure to heat and cold on the street, victimization, and exposure to contagious illnesses in shelters further compromise a homeless frequent user's fragile health. Rates of high risk behaviors (needle sharing, unsafe sex, trading sex for money or a place to stay) are also much higher when people are homeless. Placement in permanent housing significantly reduces risk behaviors and inappropriate health care.[27] Indeed, *Initiative participants who were homeless and connected to permanent housing reduced ED use by 34% and days in the hospital by 27%, whereas clients who remained homeless or lived in transitional housing reduced ED visits by 12% and increased their days in the hospital by 26%.*[28]



Most *Initiative* programs established community collaborations to link clients to resources like permanent housing. Program directors developed a sense of "collective accountability" within the community for frequent users, leading to cross-system approaches to addressing a variety of issues beyond "frequent emergency room use," like discharge planning, respite care, pain management, and case management improvements. [29]

Costs Saved

For Medi-Cal patients, *Initiative* participants' reduced hospitalization resulted in average costs avoided of $3,841 per beneficiary after the first year of participation in the programs and $7,519 per beneficiary per year at the end of the second year of enrollment.[30] These estimates do not include decreases in physician fees or ambulance transport costs, though one of the *Initiative* programs documented significant reductions in ambulance services. Within two years, these programs produced significant cost reductions to the Medi-Cal program and improved health outcomes. [31]

Medical Home and Disease Management Models in Other States

Medicaid disease management and medical home programs[32] are often successful strategies for improving outcomes and containing costs among Medicaid beneficiaries with uncontrolled chronic illness. Results from these models indicate that standard disease management or medical home programs with high patient-to-physician ratios may succeed for relatively compliant patients, but have failed to engage frequent users or impact their costs. Studies have found disease management programs have little capacity to provide in-person services.[33] Without funding to provide intensive services, disease management and medical home programs tend to enroll healthier populations and provide services that are less costly.[34]

Frequent users generally do not respond to standard low-intensity outreach. They do not return mailed questionnaires or call back case managers in response to messages. In fact, many frequent users do not have stable addresses or phone numbers. Standard disease management or medical home programs frequently do not have the capacity to link beneficiaries to housing, substance abuse, or other locally-controlled resources essential for a frequent user's recovery. Nor do most mainstream providers have the expertise to deal with the multi-dimensional social and environmental issues that impede frequent users' ability to access treatment. On the other hand, some states have developed more flexible advanced health care/medical home models for people who face multiple psychosocial barriers to care.

Difficulties Engaging Vulnerable Populations

Several state programs have failed to meet enrollment targets through traditional large vendor-based disease management programs. New York's Care Management Demonstration Program offered vendor-provided telecare services to high-cost Medicaid beneficiaries through six regional sites. All sites, particularly non-local contractors, failed to meet enrollment targets due to difficulty engaging the population. According to the New York Department of Health (DOH), none of the sites achieved reductions in Medicaid costs. Similarly, Iowa eliminated targeting of beneficiaries with high acute care use when its telephonic and mail outreach enrolled 17 beneficiaries.[35]

Evidence shows that traditional forms of care management do not result in cost savings or help to contain costs for the high-need population. Washington began a disease management program in 2002 that offered traditional call-in and nurseline services to Medicaid beneficiaries. The state contracted with McKesson, but terminated the contract and restructured the program after four years, once the state determined that the vendor experienced significant difficulties enrolling and engaging patients, particularly patients with complex psychosocial needs. According to state evaluations, the program did not result in any significant cost savings, though the vendor reported savings. Likewise, Indiana's Chronic Disease Management Program, which offered nurse care managers to help patients set self-management goals and foster relationships with primary care providers, has not produced significant cost savings for beneficiaries with any of the identified diseases except for congestive heart failure.[36]

New Approaches

Several states are now investing in programs that offer intensive services to Medicaid beneficiaries who have multiple conditions and frequently use acute care. Working with the Center for Healthcare Strategies, Washington recently developed a Kings County pilot targeted at frequent users of acute care with complex psychosocial needs. The state has engaged a local non-profit contractor to provide community-based multidisciplinary services, akin to the *Initiative* programs. The state expects to expand the program to a second site. The state has secured agreement from the Centers for Medicare and Medicaid Services (CMS) to pay the contractor a capitated rate.[37]

Predictive Modeling

States and some health plans are beginning to use predictive modeling to identify persons with complex conditions who are at risk for incurring high healthcare costs. In states that have implemented innovative care management strategies, a focus on high-cost, high-need Medicaid beneficiaries has identified patients with chronic disease and co-occurring behavioral health conditions who had been difficult to locate or engage in appropriate care. An algorithm that includes data on prior hospital admissions, ED visits, chronic diseases, multiple co-morbidities, and patient characteristics (age, gender, and, if possible, homeless status and social isolation) could identify patients with the greatest need for intensive interventions.[38]

Differentiated Approaches Offering Targeted Interventions

States are increasingly stratifying programs, offering intensive interventions to beneficiaries who have multiple barriers to care, and more modest interventions for beneficiaries who need assistance managing chronic conditions. These states often engage in risk-screening or predictive modeling to identify appropriate interventions.[39]

South Carolina has credited this stratification for their successes in reducing by nine percent their Medicaid ED claims from 2003 to 2006. The state connects each beneficiary with a primary care physician who is part of a Care Coordination Services Organization (CSO). While most beneficiaries receive consumer education, CSOs provide frequent users with more intensive case management, including linkage to services beneficiaries need to maintain health stability.[40]

Last year, New York's DOH issued a Request for Proposals for a Chronic Illness Demonstration Program. DOH plans to stratify their Care Management and Chronic Illness Demonstration programs, offering call-in or nurse-line services for some beneficiaries and face-to-face locally-based multidisciplinary services to beneficiaries with psychosocial complexities. For the latter, DOH will use predictive modeling to identify the target population by frequent ED visits, hospital admissions, diagnostic criteria, and patient characteristics. The demonstration program will operate through five community-based programs that will pair licensed professionals with paraprofessional case managers, providing capitated rates of approximately $3,400 per year, per beneficiary. Contractors will be expected to produce health and cost outcomes that compare favorably to a control group. In the second and third years of the contract, contractors will be at risk for contributing to a risk fund for each patient whose costs exceed the average costs of the control group. During the same period, contractors who show aggregated beneficiary expenses below 85% of the expenses of the control group will receive bonuses from savings.[41]

Taking a different approach, Pennsylvania has implemented a patient-centered chronic care model to provide community-based multidisciplinary team services to link patients to community resources.[42] At the same time, Pennsylvania's Medical Assistance program has integrated physical and behavioral health services for people with co-occurring serious mental illness and physical health conditions in three regional pilots. One pilot links the state's ACCESS Plus, an enhanced primary care case management program, with additional community-based behavioral health partners.[43] CMS approved a shared reinvestment strategy that invests savings from implementing managed care into behavioral health programs implemented in eight counties.

Meeting the Needs of Frequent Users Under the Current Medi-Cal System

Perverse Incentives Provide Barriers to Appropriate Care

Medicaid payment mechanisms have traditionally favored hospital care. Medicaid covers many components of community-based care as optional benefits and reimbursement is often limited, even though community-based care is generally less expensive and can contribute to controlling long-term costs.[44] California's current financing structures for Medi-Cal and health care for people who are uninsured are extremely fragmented and complex, and the current system provides disincentives to investments in the type of flexible, multidisciplinary, intensive services needed to remove frequent users from the acute care cycle.

Fragmentation in financing and delivery systems for medical, mental health, and substance abuse treatment creates significant obstacles to integrating health care for people who have co-occurring conditions that contribute to avoidable use of hospital EDs and inpatient stays. Even though policymakers agree that evidence demonstrates the effectiveness of frequent user program models, policymakers do not agree about how the state and counties should share financial burdens, risks, or rewards. County mental or behavioral health care departments have some capacity to pay for case management or treatment services, but, with limited resources, these systems prioritize serving people with the most severe mental disorders. The programs that might deliver flexible services for frequent users are rarely funded from the same budgets that pay for hospital care, making it nearly impossible to align incentives to achieve reductions in ED use.

The current Medi-Cal Hospital Demonstration waiver seems to have added to this complexity. The state currently pays the non-federal cost of Medi-Cal reimbursements for outpatient care for Medi-Cal beneficiaries. [45] On the other hand, a beneficiary who is frequently admitted to a public hospital does not directly impact the state's budget, and as a result, the state has little financial incentive to redirect frequent ED users out of the hospital and into more appropriate care.

Challenges also exist in relationships between payment mechanisms and costs in the service delivery system. For example, a Medi-Cal beneficiary who decreases ED visits or inpatient stays may impact a hospital's uncompensated care, without corresponding reductions in costs to operate the facility.

Though California's current financing and delivery systems do not create incentives for the creation, expansion, or replication of programs that reduce frequent avoidable hospital use, 2009 brings renewed focus on health care reform at the national and state levels and a growing awareness of the critical need for reforming payment mechanisms and delivery systems to produce better outcomes and increase access to care while controlling the growth in health care expenditures, particularly for people with complex health problems. A reformed approach to addressing the needs of frequent users offers the promise of cost controls, as well as avoiding long-term institutional-level care among a population that will be increasingly likely to use nursing homes in future years as the population ages and becomes more disabled.

New Frequent User Program

California could take steps to implement a statewide frequent users program for Medi-Cal beneficiaries. The state could certify community-based programs that meet specified standards—an infrastructure that has the capacity to provide services proven to decrease ED use, community linkages, evidence-based criteria for identifying clients, experience meeting the needs of people who have psychosocial risk factors, and provision or partnership with a multidisciplinary medical/mental health team—as "frequent user programs."

The state could choose among several approaches for providing Medi-Cal reimbursement for effective programs for frequent users. Though the state would not, under the current waiver, benefit from decreased inpatient hospital days in public hospitals, the state could design systems to allow the state and counties to share costs and savings, depending on the option the state chooses. For example, the state could partner with counties interested in contributing a non-federal share of costs. For other counties without county hospitals, the state could pay non-federal costs.

Reimbursement Options

The state could use a number of mechanisms to obtain federal contributions through Medicaid reimbursements for a frequent user program:

- Medi-Cal Administration: DHCS or a contractor could subcontract with local entities using administrative funds. Administrative funds may limit the range of services available for reimbursement, but this approach would require less federal scrutiny, could be implemented quickly, and would allow the state to shift savings from acute care into administrative costs on a per beneficiary basis to fund ongoing services.

- 1915(i) State Plan Amendment (SPA): Section 1915(i) of the Social Security Act allows states to offer home and community-based services to a number of beneficiaries. Reimbursable services include care coordination, financial management, peer support, supported employment, assertive community treatment, and transportation. 1915(i) would allow the state to target specific services to specific populations.
- Primary Care Case Management (PCCM): A PCCM SPA permits a state to offer capitated rates to an entity that provides case management/care coordination services. The primary care case manager must include a licensed professional, who can employ or partner with a paraprofessional to offer *Initiative*-type services.
- Rehab Option Coverage for Assertive Community Treatment Teams: A number of state Medicaid programs reimburse for Assertive Community Treatment (ACT) services to patients meeting specific profiles. ACT teams, which include paraprofessionals and licensed clinicians, provide a wide range of medical and psychosocial services and the mechanisms of ACT are very similar to existing frequent user programs. States most often cover these services under the Rehab Option, and medical necessity criteria may target benefits to people with serious mental illness who frequently use psychiatric hospitals or crisis care, though the Rehab Option could also be used to cover others with complex health problems and functional impairments.
- Allow Federally-Qualified Health Centers (FQHCs) to Include Paraprofessional Services in Payment Rate: A DHCS audit concluded that costs for non-licensed case managers could not be included in an FQHC's payment rate, significantly restricting the ability of FQHCs to provide care coordination to vulnerable populations who are difficult to engage in a clinic setting. The state could seek clarification from CMS that FQHCs may include in their payment rate the services of non-licensed paraprofessionals who provide care outside of the clinic setting, which would allow case managers to identify clients in EDs (and in other non-clinical settings).

How A New Waiver Could Address the Needs of Frequent Users

The Medicaid waiver provides the best opportunity to implement an effective, integrated program. Though the state could now implement a frequent user program for Medi-Cal beneficiaries, such a program would not reimburse for services for uninsured frequent users or offer the flexibility or integrated service model a frequent user program instituted under a waiver would offer.

In formulating a waiver, the federal government has traditionally required a state to prove budget neutrality to the federal government, which would require the state's "with-waiver" costs to be equivalent to baseline ("without waiver") costs (costs for serving the current population in addition to the state's Disproportionate Share Hospital allocation).[46] A frequent user program would not only create a cushion for the baseline cost calculation, the state could offer the program as a means of achieving "with waiver" savings. While creating frequent user programs would entail up-front investment, the programs would allow the state to achieve milestones in acute care savings and would help the state prove budget neutrality over the life of the waiver or on a per capita basis.[47]

Meeting the Goals of Reform

A statewide frequent user program would meet the goals of a waiver. First, since frequent user programs achieve federal goals for reform, existing locally-funded program could attract federal funding match for these services to the state. Second, most current frequent user programs are operated through safety net clinics or hospitals. A frequent user program would strengthen the

ability of safety net providers to reach this population and allow for a more flexible use of funds for overcoming frequent users' barriers to care, strengthening the safety net. Some safety net clinics already offer a wide range of services, including mental health, chronic disease management, outreach, transportation, translation services, and insurance enrollment assistance. A small but growing number also integrate behavioral health care with primary care.[48] Partly for these reasons, Medicaid beneficiaries who receive care through community health clinics are 22% less likely to have preventable hospitalizations than other Medicaid patients.[49] Third, as frequent user programs throughout the state have demonstrated, these programs improve health outcomes and remove barriers to appropriate health care access. Finally, a frequent user program would be able to integrate newly covered Medi-Cal populations. In fact, *Initiative* frequent user programs established strong partnerships between hospitals and community-based services, removing barriers that result from systems fragmentation, and ensuring continuity of care to uninsured patients, as the programs provided the same level of care to beneficiaries and to uninsured people.

Innovative Differentiated Medical Home Approach

Whether the state elects to enroll beneficiaries into managed care or into medical homes, the state should match beneficiary need with intensity of services provided. Frequent user programs incorporate principles of an advanced medical home model, as they incorporate a whole person orientation, they create an integrated coherent care plan in partnership with patients, they provide enhanced access to care, and they encourage provider linkages with community-based resources.[50] A report from the Medicaid Institute in New York concluded that achieving goals of improving health outcomes and reducing Medicaid spending requires identifying patients at risk for high future costs through predictive models and changing the way providers deliver services to reduce reliance on acute care through services that address behaviors and social problems that act as barriers to accessing appropriate care.[51]

A program offering these services to frequent users should combine the following elements:

- Data integration to identify frequent users of ED and/or inpatient care, and vulnerability assessments to identify those with the greatest risks of mortality or avoidable hospitalizations;
- Outreach and engagement strategies to meet frequent users "where they are," to create trusting relationships with health care/medical homes, and to educate and support patients to self-manage their care and reduce risks;
- Flexible, individualized, client-centered services;
- Services that are integrated to address co-occurring health conditions and disorders, as well as link participants to community-based supports;
- Community-based care coordination offered in a range of settings that connects clients to services needed, including permanent housing, to achieve and maintain health stability; and
- Sustained engagement and early intervention to prevent or manage health crises.

With a waiver that offers an incremental approach to implementation, a frequent user program—or any program that provides multidisciplinary services to people who face psychosocial barriers to care—should be a high priority in controlling costs and improving health outcomes.

Like other states that are in the process of rethinking health care, California should develop a stratified approach to addressing the needs of those with unmanaged chronic conditions. The state could use predictive modeling to identify need. For many with unmanaged chronic conditions, the state could offer a chronic care model that provides a moderate-level of services to assist patients

in self-managing their conditions. For others with multiple barriers to appropriate care, the state could contract with or reimburse for services offered through recognized community-based frequent user programs that already integrate care for multiple populations, such as Federally Qualified Health Clinics, community clinics, hospital-provided outpatient clinics, Coverage Initiative programs, and Social Health Maintenance Organizations, as well as spur the creation of new frequent user programs through incentives.

Baseline Costs

Though the state has not financed frequent user programs to date, frequent user programs will give California an edge in negotiating baseline costs with CMS. The state could identify existing frequent user programs as an example of innovation that has allowed the Medi-Cal system to control long-term costs for thousands of beneficiaries and uninsured people statewide.

Sources of Financing Frequent User Programs in a Waiver

In crafting a new waiver, the state will not only need to identify sources that can generate federal matching funds, it will also need to identify sources of long-term savings. To pay for a differentiated advanced health care/medical home model that includes reimbursement for frequent user programs, the state should consider one or more of the following options:

- *Directing Portion of Up-Front Investment and Future Cost Savings to Frequent User Programs:* The state could ask the federal government to make an up-front investment in innovative programs likely to produce costs savings, and allow for these savings to be captured and redirected to ongoing funding in future years. The state can carve out a portion of up-front federal funding to pay interested hospitals, clinics, and counties to create the infrastructure needed to provide appropriate services to frequent users, matching local and/or state funding for medical home models. Funding for new and existing frequent user programs would allow the state to meet milestones under the waiver for decreased ED visits, inpatient admissions, number of days spent inpatient, and ambulance transports, as well as make the case to the federal government that the state is pursuing the Obama Administration's longer-term reform goals of controlling costs, increasing access to care, and improving the quality of care. Indeed, frequent user programs are one of the few models proven to reduce avoidable use of EDs and inpatient hospitalizations. Medi-Cal beneficiaries in *Initiative* programs were able to reduce their acute care costs by an average of $3,841 after the first year of participation in the programs and $7,519 per year by the end of the second year of enrollment, with a two-year startup.[52] The state could allow additional per member costs or request aggregate funding to achieve milestones in reductions in acute care use among a specified number of enrollees.
- *Expand Health Care Coverage Initiative to Include Frequent User Programs for Uninsured People:* The state could request additional federal funds to expand the Health Care Coverage Initiative (HCCI) and carve out a portion of these resources to provide incentives to counties interested in continuing to fund existing or create new frequent user programs. Under the 2005 hospital waiver, the federal government provided $180 million per year for the last three years of the waiver term to create HCCI for people who are uninsured. Based on a competitive application process, the state selected 10 counties to participate. The state required counties to implement medical homes. A UCLA Center for Health Policy Research team recommended expansion and enhancement of HCCI to, among other things, improve care coordination and identify high service users to, "focus more intensive care coordination and self-management

support services on these high-need patients," which the researchers concluded would improve outcomes and "maximize cost-effectiveness."[53]

- *Use Existing Frequent User Programs As Source of Non-Federal Match:* Multiple frequent user programs (in addition to the *Initiative* programs) currently exist in California. These local programs subsist on payments from public (and some private) hospitals or counties that see the value in producing better health outcomes and diverting people from acute care. Programs do not currently receive federal matching funds for many of the services they provide. The state could request federal match for these programs, which would allow the programs to serve a greater number of frequent users.
- *Method of Controlling Costs for Expanding Eligibility:* If the state waiver includes expansion of Medi-Cal eligibility to indigent childless adults, this population will include a significant number of people with chronic health conditions complicated by co-occurring behavioral health challenges, many of whom have relied on hospital EDs for care. Frequent user programs should become an integral element in demonstrating an ability to control costs for any new population of beneficiaries.

Other Elements in Waiver Needed to Facilitate Frequent User Care

To maximize the state's ability to achieve the goals of a waiver, the state should include the following provisions in a waiver concept paper:

- Allow for reimbursement of same-day physical and mental-health encounters in the same facility, which would promote integrated care, reduce missed appointments, improve patient outcomes, and reduce avoidable crisis care.[54]
- Permit reimbursement or rate-setting that includes outreach to frequent users, including paraprofessional staff working at hospitals or with ED staff to identify frequent users, and case management in a patient's home (or other settings) to engage frequent users.
- Obtain federal funding for improvements in health information technology to allow for tracking and data collection across hospitals and between EDs and frequent user clinics/programs.
- Request a relaxation of Deficit Reduction Act requirements for proof of identity and citizenship. Many frequent users, particularly those who are homeless, have great difficulties producing the documentation required.

Provider Payment

Several states are now implementing new methods of provider payment to incorporate care management and increase preventive care. A frequent user program could implement provider incentives based on patient outcomes. Current payment systems could be adapted to finance community health services team models that integrate care for medical and behavioral health conditions, providing a person-centered health care home. Achieving this integration of primary care, behavioral health care, and linkage to social services necessitates an alignment of financial and policy incentives.[55] The state could offer providers bonuses for practices that lower total healthcare expenditures for patients and bundled payments to hospitals to cover costs of hospital care and post-discharge care with incentives to reduce ED visits following discharge. The state could also provide a case rate for care management/coordination services layered with an FQHC-like prospective payment system for medical and behavioral healthcare services that can be billed by identified codes. Additionally, the state could allow providers who reduce patient acute care

costs to receive a portion of savings.[56] The state could alternatively implement risk-sharing with capitated case rates for community-based frequent user programs.

For the few frequent user beneficiaries enrolled in County Organized Health Services or managed care plans, the plans could contract with community-based programs to offer *Initiative*-type services. The state could fund services for frequent users enrolled in managed care by providing federal match to managed care plans partnering with frequent user programs. The state could require the plans to use reserves or secure local funds to pay non-federal share of costs. Along with lower acute care costs, access to federal funds would offer incentives for managed care plans to subcontract with frequent user programs.

Conclusion

Though frequent users represent a small segment of the current Medi-Cal and uninsured population, they drive a large share of public costs. A new Medi-Cal waiver offers California the opportunity to move beyond current disincentives to providing better health care to these individuals and controlling overall spending for this population. Moreover, it offers an opportunity to improve health outcomes for our most vulnerable residents. For these reasons, any state effort to control costs and improve outcomes for high-need beneficiaries must include intensive interventions directed at frequent users to succeed. Transforming the way care is delivered to this group of individuals is a critical first step to fulfilling the goals of any reform.

Endnotes

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