Corporation for Supportive Housing
1330 Broadway, Suite 601
Oakland, CA 94612
T 510.251.1910
F 510.251.5954
www.csh.org

Improving Health and Health System Outcomes by Redirecting Medi-Cal Resources

Problem

A small percentage of Medi-Cal recipients are disproportionately driving costs, impacting our health care system. In 2003, 60% of all Medi-Cal expenditures funded services for only 5% of enrollees.[1] Currently, Medi-Cal is reimbursing fees for emergency room visits and other urgent care, some of which could be prevented through less costly case coordination and non-medical services, which also stabilize and improve beneficiaries' overall health.

A significant percentage of people emergency departments identify as ***frequent users of health services*** are Medi-Cal beneficiaries. These individuals have multiple needs and confront difficulties navigating the healthcare system. However, Medi-Cal restricts reimbursement for the multidisciplinary approaches—coordination of health, mental health, and substance abuse treatment—that decrease emergency department visits and hospital stays.

Hospital emergency departments and community clinics have the interest to provide these Medi-Cal beneficiaries with multi-disciplinary services, but may not always have the means, as often these costs are not reimbursed.

Potential Solution: Medi-Cal State Plan Amendment

The state could receive federal matching funds for multidisciplinary services to frequent users through a State Plan Amendment. With this option, the state would draw federal matching funds to provide frequent users with multidisciplinary, coordinated care across a continuum of services.[2] However, the state would be required to change its Medicaid plan.

Background

Frequent users of health services make multiple visits to hospital emergency departments to access treatment for conditions better addressed with earlier or primary care. Patients have complex, unmet needs and face barriers in accessing housing and medical, mental, and substance abuse treatment, all of which can contribute to frequent emergency department (ED) visits:

- Two-thirds of frequent users have untreated physical conditions: diabetes, cardiovascular disease, cirrhosis, respiratory conditions, seizures, hepatitis C, HIV, and chronic pain;
- Over half suffer substance abuse disorders;
- Over a third have mental illness;
- Almost half are homeless;
- More than a third has three or more of these conditions.[3]

The small proportion of people who are frequent users use public health services disproportionately. One county found that 4% of people served in their public health system accounted for 38% of the cost of publicly funded mental health services.[4] A San Francisco General Hospital study reported that homeless patients comprised 24% of all emergency room patients and 19% of all inpatients, and indicated that many homeless people accessing care through these expensive systems were frequent users.[5]

Frequent users average:

- 8.9 ED visits each annually, with average annual charges of $13,000 per patient;
- 1.3 hospital admissions annually;
- 5.8 inpatient days each, with average annual charges of $45,000 per patient.[6]

Achieving Better Results

Programs incorporating case management as part of a multidisciplinary team approach report cost benefits. A San Francisco General study reported a substantial reduction in emergency department costs within the first year of offering case management, leading researchers to conclude, "Case management was associated with . . . statistically and practically significant reductions in ED utilization and cost."[7] Early results from The Frequent Users of Health Services Initiative[8] programs have shown that a multi-disciplinary, coordinated care approach can reduce emergency department visits and costs, while improving the stability and quality of life for patients.[9]

Appropriate services not only reduce costs, but lead to better health outcomes. In San Francisco, multidisciplinary case management services targeted to frequent users resulted in a 50% reduction in homelessness and a 25% reduction in substance abuse.[10] Data from Frequent Users of Health Services Initiative programs demonstrated that 67% of homeless clients became housed, 70% of uninsured clients became insured, and 35% of clients without incomes became SSI recipients.[11] Similarly, a University of Washington study showed patients receiving substance abuse treatment alone were more likely to receive outpatient treatment for other health conditions and less likely to develop acute conditions. While the treatment cost an average of $2,300, it saved $2,510 in overall Medicaid costs in one year. The researchers concluded that the substance abuse treatment virtually paid for itself.[12] This conclusion is applicable to providing appropriate services to frequent users as well.

A State Plan Amendment could help sustain existing programs that provide this multidisciplinary approach, as well as spur the development of new programs in counties tackling the challenge of overcrowded emergency rooms and repeated and avoidable use by a small population of Medi-Cal beneficiaries.

---

[1] MaCurdy, Thomas, et. al. "Medi-Cal Expenditures: Historical Growth and Long Term Forecasts." Public Policy Institute of California, June 2005.

[2] This proposal would define frequent users as people who visit the emergency department on five or more occasions in one year or eight or more occasions in two years, and who experience two or more of the following barriers to treatment during the course of this period: a serious or chronic physical condition, mental illness, substance abuse, or homelessness.

[3] The Lewin Group, "Frequent Users of Health Services Initiative Evaluation: Interim Findings on Program Outcomes, and ED & Hospital Utilization and Charges." July 2007. A San Francisco-focused study found 81% of frequent users to be homeless. Shumway, Martha, Ph.D., et. al., "Cost Effectiveness of Clinical Case Management for ED Frequent Users: Results of a Randomized Trial." *Am. J. Emergency Med.* April 2007.

[4] Chandler D., "Capitated Assertive Community Treatment Program Savings: System Implications," *Adm. Pol'y Mental Health.* Sept. 2002.

[5] Kushel, Margot, et. al., "Emergency Department Use Among the Homeless and Marginally Housed: Results from a Community-Based Study." *Am. J. Public Health.* 2002; Salt, S., "Hospitalization Costs Associated with Homelessness in New York City." *N. Engl. J. Med.* 1998.

[6] The Lewin Group, "Frequent Users of Health Services Initiative Evaluation."

[7] Shumway, Martha, Ph.D., et. al., "Cost Effectiveness of Clinical Case Management for ED Frequent Users."

[8] The Frequent Users of Health Services Initiative, funded by The California Endowment and the California HealthCare Foundation, is a five-year, six-project initiative focused on decreasing avoidable emergency department visits and hospital stays through developing more responsive systems of care. www.csh.org/fuhsi.

[9] The Lewin Group, "Frequent Users of Health Services Initiative Evaluation."

[10] Okin, RL, et. al., "The Effects of Clinical Case Management on Hospital Service Use Among ED Frequent Users." *Am. J. Emerg. Med.* 2000.

[11] The Lewin Group, "Frequent Users of Health Services Initiative Evaluation."

[12] This study targeted people receiving General Relief, rather than frequent users of health services. Wickizer, Thomas, et. al., "The Effect of Substance Abuse Treatment on Medicaid Expenditures Among General Relief Welfare Clients." University of Washington, The Milbank Quarterly, Vol. 84, No. 3. 2006.