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Preventing Long-Term Healthcare Costs by Revising Medi-Cal Eligibility

A Statewide Challenge

- Many individuals who **frequently use emergency department (ED) and inpatient hospital services** are **uninsured and have multiple needs,** according to the Frequent Users of Health Services Initiative.[1]

- They often suffer from **chronic and acute medical conditions, mental illness, substance abuse**, and **homelessness,** or have a combination of these conditions.

- Only people who are disabled, age 65 or older, pregnant, or have dependent children are eligible for Medi-Cal. **Proving disability requires multiple appointments and extensive medical documentation,** often difficult for frequent users who lack the stability needed to maintain appointments, keep regular contact with medical providers, or retain personal medical histories.

- Frequent users who are uninsured and lack access to a regular source of medical care are particularly at risk of becoming **permanently disabled and in need of expensive, long-term care** in skilled nursing facilities.

- Currently, **2% of Medi-Cal beneficiaries are responsible for 40% of Medi-Cal costs**—a large proportion of high-cost beneficiaries are receiving expensive nursing home, ED, and hospital care.[2]

- **In the meantime, hospitals are consistently burdened with covering costs of care** for the uninsured, who may be disabled, homeless, and mentally ill patients.

A Solution

Extend Medi-Cal eligibility to a small population of ED frequent users.[3] This solution could reduce avoidable use of emergency rooms, decrease the demand on county resources, improve health outcomes for frequent users, and potentially decrease long-term Medi-Cal costs.[4]

Background

Frequent users average:

- 8.9 ED visits each annually, with average annual charges of $13,000 per patient;
- 1.3 hospital admissions annually; and
- 5.8 inpatient days each, with average annual charges of $45,000 per patient.[5]

Frequent users of health services have multiple needs:

- Two-thirds of frequent users have untreated physical conditions, such as 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; and
- More than a third have three or more of the above conditions.[5]

Frequent users also impact scarce community resources. Hospitals, particularly financially precarious county hospitals, take on the burden of expensive emergency and inpatient care for uninsured people forced into crisis care.[6] One county found that 4% of people served in their public health system accounted for more than a third, 38%, of the costs of publicly-funded mental-health services.[7]

Achieving Better Results

Revising Medi-Cal to allow eligibility for frequent users of health services makes fiscal sense in the long term. Frequent users' untreated medical conditions could generate higher costs to the state in the long-term, both in acute inpatient and in skilled nursing facility costs, when these individuals become Medi-Cal qualified by age or disability. A Harvard study of Medicare beneficiaries found that previously uninsured adults experienced significantly worse health conditions and used more medical services once eligible for Medicare than previously insured beneficiaries. Researchers concluded, "Providing earlier health insurance coverage for uninsured adults, particularly those with cardiovascular disease or diabetes, may have considerable social and economic value . . . by improving health outcomes."[8]

Revising Medi-Cal eligibility will help stabilize the lives of homeless frequent users. Housing alone often does not result in housing stability among frequent users. Homeless frequent users need access to appropriate health and support services to maintain housing stability and stay out of hospital emergency rooms. Homeless people offered these services with housing experience a 56% reduction of emergency department use and a 37% reduction in hospital inpatient days.[9]

Revising Medi-Cal eligibility will improve counties' abilities to address community needs.

- Last year, hospitals spent more than $8 billion in services without compensation.
- Uncompensated care has contributed to the closure of 65 emergency rooms in California since 1997.
- County hospitals are particularly affected, as counties not only provide healthcare to uninsured residents, they often house trauma and burn centers.
- Expanding Medi-Cal eligibility, with ensuing greater access to primary and preventive healthcare for those using significant high-cost care, would reduce unnecessary ED use and thus decrease ambulance diversions.

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[1] 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.

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

[3] Under this proposal, frequent users would be defined as people who visit the emergency department on five or more occasions in one year or on 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.

[4] This option would require the state to obtain a waiver from the federal government, to prove cost neutrality to the federal government, and to change the state Medicaid Plan.

[4] The Lewin Group, "Frequent Users of Health Services Initiative Evaluation: Interim Findings on Program Outcomes, and ED & Hospital Utilization and Charges." July 2007.

[5] The Lewin Group, "Frequent Users of Health Services Initiative Evaluation: Interim Findings on Program Outcomes, and ED & Hospital Utilization and Charges." July 2007.

[6] State law requires counties to provide care under the Welfare and Institutions Code, § 17000.

[7] Chandler D., "Capitated Assertive Community Treatment Program Savings: System Implications," *Adm. Policy Mental Health.* Sept. 2002,

[8] McWilliams, Michael, M.D., et. al., "Health of Previously Uninsured Adults After Acquiring Medicare Coverage." *J. Amer. Med. Assoc.* Vol. 298, No. 24. Dec. 26, 2007 (emphasis added).

[9] Burt, Martha, Ph.D., & Martinez, Tia, J.D., "Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults." *Psychiatric Services,* Vol. 57, No. 7. July 2006.