Emergency Departments, Medicaid Costs, and Access to Primary Care — Understanding the Link

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In December, 2011, Washington State’s Health Care Authority announced its intention to stop paying for emergency department (ED) visits by Medicaid beneficiaries “when those visits are not necessary for that place of service.”1 To identify unnecessary visits, the state proposed a list of approximately 500 diagnosis codes (see examples in the table). The proposed rule would apply to all Medicaid beneficiaries, irrespective of age, disability, or place of residence (such as a nursing home) — even if the patient, the child’s parent, or the nursing home staff believed that ED care was needed.

Previously, the Authority had sought to impose an annual three-visit limit on nonemergency ED use but was rebuffed by a state court ruling. The proposed rule would apply to all Medicaid beneficiaries, irrespective of age, disability, or place of residence (such as a nursing home) — even if the patient, the child’s parent, or the nursing home staff believed that ED care was needed.

On April 1, 2012, the day the new policy was supposed to take effect, Washington Governor Chris Gregoire suspended implementation in order to try a less drastic alternative worked out with the state’s hospitals and emergency physicians. The compromise plan calls for the rapid development and statewide adoption of an unspecified set of “best practices” to “reduce medical assistance expenditures through the reduction of unnecessary emergency department visits.” By July 1, hospitals accounting for at least 75% of ED utilization by Medicaid fee-for-service clients must submit legal attestations that they are complying with the plan. If they fail to do so, the Authority may proceed with implementing its policy of nonpayment for ED visits it determines to be nonemergency visits.

The motive for Washington State’s actions is clear enough. Since 2008, a total of 9.8 million Americans have lost employer-sponsored health insurance. As a result, Medicaid rolls have swelled by 7.5 million. Squeezed between rising expenditures and falling tax revenues, state governments are desperately searching for new ways to cut Medicaid spending. Given this fiscal challenge, the notion that many Medicaid beneficiaries overuse EDs was too tempting to ignore.

The genesis for the idea of denying payment for nonemer-
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PERSPECTIVE

Emergency ED visits are frequently traced to the research of John Billings, a professor of health policy at New York University. In the early 2000s, he developed an algorithm that used discharge diagnoses to identify ED visits that are “ambulatory care sensitive.” In his view, ambulatory care–sensitive visits fall into one of two groups: those that are “primary care treatable,” meaning that the problem could safely be managed in a doctor’s office, and those that are “primary care preventable,” meaning that the visit might have been averted if care had been provided sooner. An uncomplicated lower urinary tract infection would be considered “primary care treatable.” An asthma flare-up would be categorized as “primary care preventable.”

Unfortunately, policymakers have generally misinterpreted Billings’s findings. The fact that many ED visits could be managed in primary care settings does not mean that such care is available. In fact, Billings himself asserted that high rates of ED use for ambulatory care–sensitive conditions are a strong indicator of poor access to care—not poor judgment on the part of patients.

Two decades of research support this view. In 1994, research assistants posing as Medicaid patients telephoned a random sample of primary care doctors and clinics in 10 cities to determine whether Medicaid patients could get treatment for minor problems without visiting an ED. The callers were successful only 26% of the time. When office staff members were asked to suggest an alternative, the most common advice was no advice. The next most common recommendation was “Go to an ED.”

In 1996, researchers who were posted in 56 EDs nationwide interviewed 6187 walk-in patients over a single 24-hour period. When asked why they chose an ED for care, the vast majority of walk-in patients cited clinical reasons or preferences. Forty-five percent thought they had a medical emergency or were too sick to go elsewhere; 19% said they were sent to the ED by a health care professional.

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**Selected Diagnoses (with ICD-9 Codes) from the Washington State Health Authority’s List of “Nonemergency” Conditions.**

<table>
<thead>
<tr>
<th>Diagnosis (ICD-9 Code)</th>
<th>Risk</th>
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<tr>
<td>Hemophthalmos except current injury (360.43)</td>
<td>Causes range from subconjunctival hemorrhage (frightening but generally benign) to potentially vision-threatening disorders.</td>
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<tr>
<td>Corneal disorder due to contact lens (371.82)</td>
<td>Corneal abrasions are very painful and require testing to identify the cause; corneal ulcers produce similar symptoms and can lead to vision loss if immediate treatment is not received.</td>
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<tr>
<td>Mucopurulent conjunctivitis (372.03)</td>
<td>Can represent a serious infection caused by staphylococcus, gonococcus, or other bacteria.</td>
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<tr>
<td>Acute suppurative otitis media (with and without drum rupture) (382.00 and 382.01)</td>
<td>Symptoms include severe pain, mild to very high fever, and hearing loss; without treatment, can lead to local extension of infection, scarring, adhesions, and structural ear damage.</td>
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<tr>
<td>Acute bronchitis (466.0)</td>
<td>Cannot be reliably distinguished from pneumonia without a chest x-ray.</td>
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<tr>
<td>Disorders of menstruation and other abnormal bleeding from genital tract (626.8 and 626.9)</td>
<td>Can signal dangerous complications of unrecognized pregnancy, such as ruptured ectopic pregnancy or incomplete miscarriage; requires pregnancy test, careful physical examination, and sometimes diagnostic ultrasonography.</td>
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<tr>
<td>Headache (784.0)</td>
<td>Severe headaches require careful evaluation to rule out meningitis, encephalitis, subarachnoid hemorrhage, and other intracranial pathology.</td>
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<tr>
<td>Spontaneous ecchymoses (782.7)</td>
<td>Can signify life-threatening thrombocytopenia, vasculitis, or rickettsial infection.</td>
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<tr>
<td>Sprains of various types (840–848)</td>
<td>Require careful examination and often x-rays to rule out fracture.</td>
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<tr>
<td>Contusions of various types, including multiple sites (920–924.9)</td>
<td>Frequently a sign of assault; multiple contusions may indicate abuse. An x-ray may be needed to rule out fracture.</td>
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<tr>
<td>Authority-requested psychiatric examination (V701)</td>
<td>Law enforcement officers and others often bring psychiatric patients to ED for immediate evaluation; many inpatient psychiatric facilities will not accept referrals without a “medical clearance” examination. Many office-based providers do not provide these services.</td>
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*ICD-9 denotes International Classification of Diseases, 9th Revision.*
Getting follow-up care after an ED visit can be challenging as well. In 2005, research assistants posing as patients telephoned 499 randomly selected primary care practices and clinics in nine U.S. cities. Claiming that they had been seen in an ED the night before and had received a diagnosis of one of three serious problems (pneumonia, hypertension, or possible ectopic pregnancy), callers requested follow-up care. When they said they were covered by Medicaid, only one third could secure a timely appointment.

Billings hoped that his algorithm would be used to evaluate the performance of primary care systems and assess promising interventions to improve access to care. He never intended it to be used to judge individual decisions to seek care. Ironically, the population-based tool he designed to improve access to care is instead being used to restrict it.

Perhaps the Authority's actions will encourage Medicaid beneficiaries to forgo nonemergency ED visits and instead forge enduring relationships with primary care providers. If that happens, it will be a good thing. Unfortunately, acutely ill patients aren't particularly adept at determining the level of care they need. Even experienced triage nurses get it wrong: 3 to 5% of patients whose condition is classified as "nonurgent" at the ED triage desk require immediate hospitalization. If the Authority's efforts inadvertently cause more Medicaid beneficiaries to delay or forgo needed care, they could worsen outcomes and increase costs.

Perhaps the Authority assumes that the state's hospitals will keep treating Medicaid beneficiaries anyway, since the federal Emergency Medical Treatment and Active Labor Act requires EDs to evaluate and stabilize all in need, without regard for the patient's ability to pay. Then, if the ED workup reveals that the patient's cough and fever were due to acute bronchitis instead of pneumonia, or that a painfully swollen ankle was severely sprained rather than fractured, payment can be denied. "Retrospective denials" of this sort are so unfair that Congress included "prudent layperson" language in the Affordable Care Act (ACA). As a result, health plans, including Medicaid managed-care organizations, can no longer deny payment of a claim if the patient or the parent of a pediatric patient reasonably believed that the problem required treatment in an emergency department. Although it is questionable whether the prudent-layperson provision in the ACA extends to enrollees in fee-for-service Medicaid, one thing is clear: for millions of low-income Americans, not only is the ED a reasonable choice — often, it is the only choice.

If the compromise measure falters and Washington State's Health Authority goes forward with its nonpayment policy, other states could quickly follow suit. If that happens, the resulting spike in uncompensated care costs will probably accelerate an already alarming national trend in ED closures. Everyone's access to emergency care could be affected.

Clearly, something must be done to stop the hemorrhaging of state budgets. But ill-considered actions could make things worse. Medicaid was created to ensure that the poorest of the poor have access to care. Rather than confronting the challenge of inadequate access to primary care, Washington State's Health Care Authority is attempting to restrict access to ED care. Instead of blocking the doors to the ED, policymakers in Washington State and elsewhere should draw the proper lessons from Billings's research and unlock the doors to primary care.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the RAND Corporation, Santa Monica, CA.

This article (10.1056/NEJMp1203247) was published on May 16, 2012, at NEJM.org.


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