

NCCEP Access to Care Committee

Situation

Policies and procedures need to be implemented that ensure that all the residents of North Carolina continue to have access to high quality acute care services whenever needed. In response to this urgent need, the North Carolina College of Emergency Physicians has created the Access to Care Committee (NCCEP ATCC).

Background

NC faces a 3 billion budget deficit in 2011. Most providers (including ED providers) took a 9% cut in Medicaid reimbursement rates in 2010 and face an even greater reduction in the future unless policies and procedures are implemented immediately to reduce spending. Many Medicaid recipients are forced to turn to the ED for primary care services, and this trend will greatly increase when/if provider reimbursement is further reduced as many more providers will no longer be able to afford to treat Medicaid patients in their practices. Health care delivery as mandated by PPACA is projected to increase the number of Medicaid patients in NC ~600,000 by 2014. NC is projected to have a declining number of PCP's over the next decade (as most states are facing).

Assessment

The healthcare environment for the practicing EM physician continues to deteriorate in NC. ACEP's Report Card on the State of Emergency Medicine gave NC an "F" for the professional liability climate. Multiple factors make it increasingly problematic to retain and recruit highly qualified EM physicians. Many groups have placed a moratorium on hiring additional physicians due to increasing overhead and declining reimbursement. Emergency departments remain the most cost and time effective place for the medical screening exams (MSE) for most of the possible undifferentiated emergency medical conditions (EMC's) that acutely ill and injured patients have. At the same time, we need to find the most cost effective venue for non-EMC's to be evaluated. Further development of acute mental health services (such as the evolving LME network) need to be identified and implemented immediately to reduce the staffing and financial burden that has been placed on ED's across the state due to prolonged boarding (sometimes a week or longer) of these patients. Creative solutions to these problems must be developed and implemented by DHHS and the house of medicine in NC.

Recommendations

- Medicaid reimbursement for EM services should be restored to the levels paid early in 2010 and needs to be maintained at a level that will ensure the ongoing EM safety net our EM physicians provide for the residents of NC.
- To ensure the broadest ongoing participation of primary care practitioners (PCPs) in the state, primary care office codes (99201-99215) need to be preserved at current levels. Failure to do so will result in the termination of many PCPs from Medicaid, leaving many of the underserved of NC few places to go to meet their primary care needs. Preserving

existing reimbursement for all specialty office visit codes (99201-99215) will also serve to ensure ongoing access of Medicaid patients for specialty office care.

- Access to the NC Medicaid Portal needs to be fully implemented and utilized in all our ED's. The clinical information available in Portal needs to be expanded this year to include results of recent evaluations for the same or similar patient presentations to greatly reduce the current high frequency of duplicating expensive evaluations (especially imaging). Alternatively, EDP's could contact healthcare professional gatekeepers who have full access to the clinical information available in Portal to relay to EDP's. It is essential to maximally utilize and develop Portal access to reduce utilization and cost for NC Medicaid beneficiaries. Access to imaging studies and/or their reports will save millions of dollars annually through the marked reduction of ordering duplicative studies. Access to an enhanced Portal clinical database would save additional millions annually due to reduction in duplicative evaluation and management services.
- Another Portal functionality that could result in the savings of additional millions of dollars will involve identifying chronic pain patients who have high ED utilization and coordinating their care to reduce ED visits, redundant imaging, and overuse of prescription drugs. Most importantly, this will result in greatly improved mental and physical health for these patients as the parenteral use and prescribing of controlled substances will decrease for this patient population.
- Another related recommendation is for NC DHHS to consider identifying the top 1% (or so) of those with the highest utilization of Medicaid resources, and assign caseworkers to respond to all unscheduled healthcare visits in real time to assess the need for that service (EMTALA concerns acknowledged).
- Alternative networks of health care need to be further developed for patients for whom an EMC does not exist, or needs prompt follow up once an EMC has been stabilized. Increased access to primary care practices, urgent care centers, FQHC's, and other free or low cost community health centers should be utilized for all patients needing prompt follow up after being seen and stabilized in an ED or for those who have been determined that not EMC exists after having a MSE performed.
- Work to establish legislation/regulations that will find reasonable locations outside the ED for all patients with mental health conditions needing further mental health evaluation after they have been medically stabilized/cleared in an ED.
- All stakeholders need to work collaboratively to bring about substantive liability reform for all providers who provide EMTALA mandated care.
- States (including NC) should not continue to absorb the unfunded mandate of EMTALA as dictated by the federal government. States as well as their medical societies and professional organizations need to work collaboratively to bring about EMTALA reform.