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Mark D. Williams, Jr
Jennie Xu

100% GROUPS

Alvarado Emergency Medical Associates
Beach Emergency Medical Associates
Centinela Freeman Emergency Medical Associates
Central Coast Emergency Physicians
Coast Plaza Emergency Physicians
Emergency Medicine Specialists of Orange County
Glendale Adventist Emergency Physicians
Hollywood Presbyterian Emergency Medical Associates
Huntington Park Emergency Medical Associates
Napa Valley Emergency Medical Group
Newport Emergency Medical Group, Inc at Hoag Hospital
Orange County Emergency Medical Associates
Pacifica Emergency Medical Associates
Pacifica Emergency Providers, APC
Redondo Emergency Physicians
San Dimas Emergency Medical Associates
Shasta Regional Emergency Medical Associates
Sherman Oaks Emergency Medical Associates
Tarzana Emergency Medical Associates
Temecula Valley Emergency Physicians
Valley Presbyterian Emergency Medical Associates
Vituity Emergency Medicine Advocacy Physicians
While we may not have gone into medicine for the money, we still need to earn a wage that attracts the best and the brightest and EDs need to make enough to keep the lights on. The issue of reimbursement is uniquely important to emergency physicians because we are federally mandated by the Emergency Medical Treatment and Active Labor Act (EMTALA) to evaluate and stabilize all patients who present to our departments, regardless of their ability to pay. EMTALA codified the right to access emergency care and stabilizing treatment long before the Affordable Care Act (ACA). Prior to the 1986 law, patients could be turned away or unceremoniously dumped on public hospitals because of their inability to pay or insufficient insurance. The law applies when an individual has a medical emergency and they arrive at a hospital who has a contract with Medicare. At the same time the law created an unfunded mandate to provide emergency care.

We need to ensure that our total revenue will cover the cost of patients who cannot pay for their care. This is where payor mix is important as no ED could survive by caring for only uninsured patients.

As we all know, Medi-Cal reimbursement rates do not come close to covering the cost of providing emergency services. California has the highest Medicaid spending, but ranks among the bottom three states in Medicaid physician reimbursement rates. An ED visit in February of 2020 that’s billed using procedure code 99285 is reimbursed at $108.08, and a 99283 is reimbursed at only $44.60. That means we lose money on every Medi-Cal patient we treat; and one-third of all Californians are on Medi-Cal.

Payment amounts by commercial insurance payers are critical to the emergency care safety net. Commercial insurance payments are essential to offset losses suffered by treating patients on Medi-Cal and those who are uninsured. The discussions on balance billing often center on the out-of-network insurance marketplace. However, it is important to recognize the importance of the commercial insurance market in the context of the entire emergency care safety net. As you can see from the chart below, emergency physicians in California are relying on the payments from 26 percent of the patients they treat to...
make up for the loss in payments from the rest of the patients they care for. Unlike other physicians who can decide to cap the number of Medi-Cal, Medicare, or uninsured patients they choose to treat when it no longer becomes financially viable, emergency physicians must adhere to EMTALA and treat every patient; left to figure out how to balance the books later. Any cut in payment from commercial payers cannot be absorbed elsewhere and, therefore, directly impacts our ability to adequately staff EDs. Cuts in payments to EDs result in fewer emergency physicians on shift, leading to longer wait times and diminished access to quality care for patients.

The problem arises when health plans and insurance companies offer a contract built on unfair rates (not usual or customary) to emergency physicians who, logically, choose not to enter into contract with this plan or insurer. When that emergency physician is not contracted with an insured patient’s health plan or insurance company, the emergency services they provide to that insurer’s patient is considered out-of-network. That insurer often decides to reimburse the emergency physician less than what they were billed as there is no contract and no mandated obligation to pay what was billed. The difference in these costs (what the emergency physician bills the insurer for and what the insurer pays) is the balance bill. When this balance bill is shifted to the patient it is called a surprise bill. Another way to recoup the balance bill is to go through an Independent Dispute Resolution Process (IDRP), which aims to resolve claim payment disputes.

California ACEP has supported significant advocacy efforts to protect our patients from getting caught in the center of this battle between providers and insurance companies, while also advocating for fair payment of emergency physicians. Later in this issue, Dr. Andrea Brault describes the evolution of fair payment and how payers have responded. You can also read more about the proposed federal legislation in this issue’s Advocacy Update by Elena Lopez-Gusman and Kelsey McQuaid-Craig.

Bans on balance billing aren’t the only thing that could have a dramatic impact on our ability to practice emergency medicine. Since 2018, there have been numerous attempts by insurance companies, most notably Anthem, to deny coverage for ED discharge diagnoses they have deemed unnecessary, which clearly violates the prudent layperson standard. The prudent layperson standard prevents insurance companies from denying coverage to patients based on their final diagnosis. This protection was included in the ACA and has been California law long before the ACA. Identifying patients who don’t need emergency treatment is complex and can take multiple diagnostic tests and the expertise of an emergency physician. Insurers are engaging in multiple strategies to deny payments and it is another example of why we need to pay attention to reimbursement as emergency physicians.

Advocacy efforts for fair payment of emergency physicians is critical. If fair payment is not addressed EDs across the state will not be able to keep the lights on. This will, in turn, affect remaining EDs that will be left caring for these additional patients. And once EDs across California become so overcrowded that overall access to emergency care is compromised, we will begin to see overall health in our communities decline. The safety net we provide will disintegrate.

While fair payment and balance billing have received most of the attention in recent years, there are other reimbursement topics that may affect us more personally and locally. In this issue Dr. Melanie Stanzer explains how our payments are tied to quality measures and how we may be financially incentivized or penalized based on the quality of care we provide to our patients through MACRA (Medicare Access and CHIP Reauthorization Act). Dr. Rodney Borger discusses the negative impact bundled Medi-Cal payments have on mental health treatment, which impacts all of our EDs. Elena Lopez-Gusman and Kelsey McQuaid-Craig outline the history of the Medical Injury Compensation Reform Act (MICRA) and new attempts to dismantle it through the ballot box. And finally, for those of you in academics, Dr. Lori Winston describes the efforts underway to support funding for Graduate Medical Education (GME).

Even for those of us who hate the idea of thinking of a patient encounter as a paycheck, the fact is that our legislators and voters hold the financial stability of our workplace in our hands. Only through robust advocacy and fair laws will we be able to care for patients without thinking about the dollar signs involved.
California ACEP has joined a broad and bipartisan coalition of doctors, community health centers, hospitals, local governments, public safety, business, and labor unions to fight a potential November 2020 ballot proposition drafted by an out-of-state trial attorney seeking to file more lawsuits against doctors and health care providers.

California’s successful Medical Injury Compensation Reform Act (MICRA) caps non-economic damages to ensure injured patients receive fair compensation while preserving access to health care by keeping doctors, nurses, and other health care providers in practice, and hospitals and clinics open. Currently, injured patients can receive unlimited payments for economic losses and past, present, and future medical bills.

You may be thinking, “Didn’t we just defeat a MICRA initiative on the ballot?” Yes, we did. While it was longer ago than it seems, Proposition 46 appeared on the ballot in California in 2014. In addition to other draconian provisions, like drug testing for doctors, Prop 46 sought to quadruple the cap on non-economic damages. A broad-based coalition was formed and mounted a strong campaign against the measure. Our members appeared in campaign materials and responded to dozens of media inquiries as part of this successful effort. On election day, the initiative was defeated in every single county in California.

Now, a single trial attorney is mounting a renewed effort to upend MICRA in a thinly veiled effort to benefit trial attorneys. At a time when the State is trying to expand access to care and decrease the cost of health care, this proposed initiative would do the opposite.

According to California’s nonpartisan Legislative Analyst’s Office (LAO) this misguided initiative will cost California taxpayers tens of millions “to high hundreds of millions of dollars annually” in health care costs. It will reduce access for those who need it most, including those who use Medi-Cal, county programs, safety net providers, and school-based health centers.

If this initiative is enacted by voters, medical lawsuits and payouts will skyrocket and someone will have to pay the price. That someone is consumers, taxpayers, and providers. By itself, raising the cap on non-economic damages, which is just a small portion of this overreaching measure, would result in a $1,100 increase in health care costs for a family of four. Unfortunately, the proposed initiative doesn’t stop there.

**THE INITIATIVE WOULD:**

- Completely eliminate the non-economic damage cap in cases of broadly defined “catastrophic injury,” which could be something as simple as a scar;
- More than quadruple the existing non-economic damage cap;
- Allow attorneys to be paid up front, forcing injured patients to take a lump sum payment rather than being compensated over time for their injuries;
- Considerably increase attorneys’ fees (in some instances more than double or triple what they are now) to be paid out of money intended for injured patients;
- Require trial attorneys to file “certificates of merit” declaring that the facts in the case have been reviewed by experts, but prohibits a judge from independently verifying the truthfulness of the statements in that document.

In 2014, voters were clear when they said No to Prop 46 and changes to MICRA that would have quadrupled the cap on non-economic damages. This measure goes well beyond what Prop 46 would have done and the cost to taxpayers would be far greater, as noted by the independent LAO.

Proponents of this measure must collect 623,212 valid signatures, which must be verified no later than June 25, 2020.

If the measure qualifies and is placed on the ballot in the November General Election, there will be many opportunities to take action and get involved. We will continue to keep you updated. To find out more information about the issue and how you can help educate your colleagues, patients, and neighbors, visit www.protectmicra.org.
Identify Your Revenue Opportunities

A typical ED group that appropriately increases its critical care by 2% collects an additional $50,000 annually.

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Balance Billing Legislation

By Elena Lopez-Gusman & Kelsey McQuaid-Craig, MPA, CAE
Balance billing is a direct result of inadequate networks by insurers and should not be allowed. When health plans propose low contracted payment amounts it puts emergency medicine providers in a tough position. Some physicians decline to enter into unfair contracts with health plans when plans refuse to negotiate adequate reimbursement. This means that some patients may be “out-of-network” when they seek services in the emergency department (ED). And when health plans do not pay non-contracted providers fairly, physicians are forced to bill patients for the unpaid balances.

Patients should not face an additional bill; their insurance premiums should assure them access to physician services. However, a simple ban, without addressing the problem of inadequate contract rates by insurers, treats the symptom but not the disease.

As is commonly the case with many things Californian, we have a unique and somewhat odd health insurance and balance billing landscape. It is worth illustrating that landscape in order to better understand how possible Congressional action could impact our state laws.

California law regulating insurance products is bifurcated. The vast majority of health insurance products are governed by the Health and Safety Code, which is regulated and enforced by the Department of Managed Health Care (DMHC). A smaller number of health insurance products are governed by provisions of the Insurance Code and are regulated and enforced by the Department of Insurance (DOI) lead by the elected Insurance Commissioner. All HMOs are governed by the Health and Safety Code, as well as some PPO products, while a small number of PPO products are governed by the Insurance Code and DOI.

In the 2009 case Prospect v Northridge, the California Supreme Court ruled an implied contract between physicians providing emergency services and health plans governed by the Health and Safety Code. As a result of that implied contract, physicians providing emergency services and care to patients with those plans must accept payment from health plans, whatever the amount, and are barred from billing patients for any additional amount. Thus, as of January 2009, it has been illegal to balance bill a patient with a Health and Safety Code or DMHC regulated plan for non-contracted emergency services.

In 2015 Assembly Member Bonta introduced AB 533, which sought to ban balance billing in the remaining contexts; in other words, patients receiving non-emergency care with plans regulated by DMHC and patients receiving either emergency or non-emergency care with plans regulated by DOI. AB 533 would have banned balance billing when a patient sees an out-of-network physician at an in-network facility. As introduced, the bill did nothing to address the issue of fair payment for physicians, it simply banned balance billing. A 2017 study by Pao, et al. conducted after the Supreme Court ruling in Prospect found that when you ban balance billing without providing a mechanism to ensure fair payment of physicians, contract rates decline and reimbursement decreases, taking money out of the emergency care safety net.

Staff, Chapter leaders, and members engaged Assembly Member Bonta on this issue and participated in numerous stakeholder meetings in an attempt to find a fair solution for emergency physicians and patients. California ACEP strongly believes that patients should not be stuck in payment disputes between out-of-network providers and health plans and insurers. We have long held, dating back to SB 981 (Perata, 2008), that an interim payment standard and a mandatory independent dispute resolution process (IDRP) are necessary to ensure fair contracting, remove patients from billing disputes, and enable payers and providers to fairly dispute non-contracted claims. Simply put, a
balance billing ban must be coupled with a fair payment mechanism or health plans and insurers will be able to pay whatever they want without any recourse for appeal by physicians.

Emergency physicians are required by law to provide care to every patient who comes to the ED and therefore, unlike other physicians, they cannot opt out of providing out-of-network care if they are unable to agree on a contract with the health plan or insurer. They have no ability to avoid this situation.

Both patients and providers deserve protection from health plans and insurers who do not contract fairly to provide adequate networks. Patients do not choose where and when they will need emergency services and should not face post-care financial burdens for seeking emergency care. Likewise, emergency physicians are required to see every patient and, to meet that mission, need to be compensated fairly. Patients and providers should be protected from this cost-shift by imposing a fair payment standard on health plans and insurers. The payment standard for out-of-network services should be at a level which encourages contracting and results in the fewest number of appeals to the IDRP.

We tried to get our fair payment provisions amended into AB 533. In the final week of the 2015 legislative session, Assembly Member Bonta adopted the general framework of our proposal, but the interim payment was set extremely low – 125% of Medicare. Additionally, the design of the IDRP, as well as the basis for determining a fair payment, was left entirely in the hands of regulators. Despite the bill having the important goal of protecting patients from being involved in disputes between physicians and insurers about fair reimbursement, AB 533 chose health plans and insurers as the winners and physicians as the losers.

Due to the continued concerns raised by California ACEP, emergency services were exempted from the bill. AB 533 was eventually defeated on the final day of the 2015 legislative session. Negotiations continued over the winter and, in 2016, a new bill was negotiated and introduced. That bill, AB 72, also exempted emergency medical services and was signed into law.

That has been the state of the law for our members and their patients since 2017. With Congressional action looming, it remains unclear how that may change. At the time we wrote this article, there were several pieces of federal legislation seeking to address surprise billing.

Most recently, the House Ways and Means Committee passed H.R. 5826, a day after the House Education and Labor Committee passed out H.R. 5800 joining the Senate Health, Education, Labor, and Pensions (HELP) Committee proposal which has been pending since last year.

ACEP has taken a support position on the Ways and Means legislation reporting that it takes the patient out of the middle, does not establish a federal benchmark payment, and provides for an open negotiation and mediation process that would allow insurers and physicians to resolve billing disputes. Unlike other proposals, the Ways and Means bill does not require a dollar threshold for mediation, providing emergency physicians and other specialties the ability to access the mediation process.

While certainly better than the other proposals pending in Congress, if enacted as-is it seems difficult to imagine how the Ways and Means legislation would not lead to lower reimbursement for emergency physicians in California. One of the standards for the mediator to use in arriving at a payment amount, is average contracted rates. We know that as EMTALA providers, unlike other specialties, emergency physician contracts are artificially low. Therefore, the mediation process is stacked against emergency physicians from the outset.

It appears that this legislation would be the standard for ERISA plans, as well as the standard in states for products where there is no payment methodology, which may include DOI regulated products for emergency care and services in California.

While ACEP does your federal lobbying and legislative efforts, California ACEP has been following this all very closely. ACEP has indicated they are continuing to work on changes to the Ways and Means legislation. We will continue to work with ACEP and to explore possible avenues for improvement in California law.

We realize this raises more questions than it answers, however, everything is very much in flux. We continue to work diligently on your behalf. To get up-to-date information about the Federal Surprise Billing efforts visit ACEP’s website at: https://www.acep.org/federal-advocacy/federal-advocacy-overview/acep4u-out-of-network/.
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CALIFORNIA ACEP'S ANNUAL CONFERENCE 2020

Education is targeted to Medical Students and Residents, but all are welcome to attend.

Friday, September 25, 2020
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Preposterous, you say? Well, perhaps for cardiac patients, but this is exactly what happens in California for another common ED presenting category, the emergency behavioral health patients. And that’s because in this state, rather than hospitals billing state Medi-Cal or managed health plans for acute psychiatric care, the purse strings for these Medi-Cal reimbursements are held by County Mental Health Departments. And if the County doesn’t want to reimburse you for psychiatric care, they don’t have to!

Medi-Cal for behavioral health care in California is divvied up to each county by something known as a ‘Carve-Out’. Essentially, the County Mental Health Departments set up their budgets annually with a block grant type of funding structure that doesn’t allow innovative programs to be funded on an as needed basis like all other emergency care. They can decide which hospitals, clinics, programs, and doctors they wish to contract with for Medi-Cal reimbursement and, if you don’t have a prior approved contract to deal with them, you don’t get funded. This especially hurts EDs, who are required by EMTALA law to evaluate and attempt to stabilize psychiatric emergencies just like other medical emergencies, but there is no guarantee of compensation for it. Instead, in many counties, Mental Health Departments have refused to reimburse hospital EDs despite the fact they may be caring for scores of psychiatric patients.
of patients each month, because they know the hospitals can't refuse the patients and they are getting these services for free.

Boarding of psychiatric patients in EDs is a major issue across the country, but multiple hospitals in California are effectively reducing the problem by creating hospital-based Crisis Stabilization Units (CSUs), Psych Observation Units, or Emergency Psychiatry Assessment, Treatment, and Healing (EmPath) Units. These programs, essentially a separate ED just for 5150-level psychiatric patients, typically feature individuals getting immediate access to psychiatric professionals and active treatment, which can result in 75% or more of 5150 patients becoming able to be discharged in a matter of hours, rather than waiting in the general ED to be admitted to an inpatient psychiatric bed. These hospital-based CSUs are high functioning with physician level care and should not be confused with the peer model CSUs that are in many communities that do not include 24/7 physician, nursing, and psychiatric care, which is why I prefer the name EmPath unit or Psych Observation Units.

When County Mental Health is on board with reimbursing these programs, everyone wins, especially patients who get timely and appropriate care to relieve their suffering – but these programs can also save millions of dollars per site per year for Medi-Cal, by avoiding huge numbers of costly inpatient stays. Several counties do reimburse these programs but despite their success a surprising number of County Mental Health Departments do not, at times with depressing results. One CSU which was displaying dazzling metrics – 81% of 5150 patients were being diverted from psychiatric inpatient admissions, and the staff was so well-trained in de-escalation that there had been zero uses of physical restraints on the unit from their first day – was told by their County Mental Health Department that they wouldn’t be receiving any reimbursement for their work, and should perhaps wait ‘a few years’ until the next County RFP for psychiatric services. As two-thirds of the 5150 patients were Medi-Cal, the unit couldn’t pay their bills and had to close completely.

And even in counties where there might be a contract for Medi-Cal reimbursement, the County Mental Health Department might cap the number of Medi-Cal patients the CSU can bill for. One California CSU has capacity for 20 patients, but the County told them they won’t be reimbursed for more than eight per day. Imagine being a 5150 patient stuck at a gurney in the back hallway of an ED for long hours, essentially undertreated and boarding, for merely the crime of being the 9th patient that day!

The Carve-Out even affects Managed Medi-Cal plans in a truly befuddling way. The Managed Medi-Cal program is typically responsible for all outpatient behavioral health care, but the billing reverts to the County Mental Health Department when an individual is admitted to an inpatient psychiatric bed. Thus, there are financial disincentives to providing quality psychiatric care in a CSU for these plans because it costs them zero once these patients are admitted!

Why do some County Mental Health Directors decline to pay for a hospital’s emergency psychiatric care? Some may believe that hospitals use a ‘medical model’, while they prefer their funding instead go to more ‘wellness’-oriented community care – yet those community programs still send all their patients to the ED who are acute, have substance intoxication or withdrawal issues, or are on 5150 status. Other leaders might simply be happy with the status quo, as they are getting ED care for these patients at no cost. This results in rationed, poor-quality care and increased boarding. We can and must do better for our patients. It is not unusual for patients to be held in EDs for many days awaiting hospital inpatient mental health care that could be better dealt with in an outpatient stabilization unit.

At a time when integration of physical and mental health is a major goal, this system makes no sense, and clearly adds to the stigma preventing people with psychiatric illnesses from seeking help. And when hospitals are required by federal law to treat behavioral emergencies the same as medical emergencies, singling out one type of patient for a completely separate, different (and uncertain) billing defies logic. We don’t treat our emergency patients only from the neck down and we shouldn’t have the head cut off reimbursement as well.

A simple solution to this issue would be returning all acute psychiatric care billing to general Medi-Cal, like all other emergency medical care in the state. Managed Medi-Cal should cover all hospital psychiatric services as well. Our Medi-Cal patients in need of emergency care shouldn’t be subject to the block granted budgets of a bureaucratic system that does not allow for fluctuations of need and immediate innovation, but instead should be included as a standard benefit along all other non-psychiatric urgent conditions. Doing so would lead to new programs, more prompt, targeted care for psychiatric emergency patients, reduced boarding, and open beds for non-psychiatric patients in the ED, all while saving millions of dollars overall for Medi-Cal. It’s time our state took a hard look on unifying emergency care for all patients under a single system of reimbursement and the state is doing exactly that.

If you have not heard, there is a major restructuring of Medi-Cal payment and coverage being discussed and mental health Medi-Cal funding revision is being considered under the CalAIM proposal. This initiative proposes, among other things, a restructuring of the payment methodologies in a very transformative manner and the details are currently being debated. We must insist and even demand on moving emergency psychiatric care and stabilization back into the standard benefit in the first phase of any reform. We owe this to our patients in order to reduce boarding and improve care for all that need emergency care.

DR. BORGER is a past Board Member of CalACEP. He is the Chairman of Emergency Medicine at Arrowhead Regional Medical Center and is a Board Member of Vituity.
The Evolution of Emergency Medicine’s Fight for Equitable Reimbursement

By Andrea Brault, MD, MMM, FACEP

Emergency medicine is vastly different from most other healthcare specialties, especially when you consider the payer mix and reimbursement process that has helped shape our business model. The majority of patient visits are made up of Medicaid, Medicare, and the uninsured — and compensation for these patients typically does not cover the cost of care. For most emergency departments (EDs), the only profitable visits are those covered by commercial insurance.

The impact of legislation isn’t always as intended.

State Legislators began taking an interest in emergency medicine reimbursement with efforts to ban Balance Billing. A very simplified example of this is when a provider bills for a service worth $350, but the commercial payer “allows” $200. The gap, or disputed amount, of $150 is the “Balance Bill.”

Ensuring that patients aren’t liable for this disputed amount makes perfect sense. But, because of legislation loopholes in some states, payers began lowering the amount they “allow” for some emergency services. If the provider disagreed with their payment, then it was up to the provider to sue the payer for a higher payment – a time consuming and expensive process for ED groups.

Aggressive payer trends have added downward pressure on ED reimbursement.

Federal Legislators then enacted the Affordable Care Act (ACA). The ACA wanted to protect patients when they were seen at an in-network hospital, but by an out-of-network (OON) provider. It specified that even if an emergency care provider had an OON status, the patient’s co-pay and co-insurance would still be the same as if an in-network provider had seen them.

But the language did not address the patient’s deductible. And, after the ACA was enacted, high-deductible health plans became much more commonplace.

Commercial payers found a new way to game the system with narrow networks.

According to a study by the Leonard Davis Institute of Health Economics, 72% of insurance plans have either small or extra small networks for hospital-based providers. And these narrow networks seem to be by design; some payers just aren’t interested in contracting with ED groups.

In another recent study, the Texas Medical Association found that one-quarter of physicians had approached a plan with which they were not contracted in an attempt to join the network — and almost a third received no response at all.

Surprise Billing is now the latest threat to the business model of emergency medicine.

Surprise billing is much like Balance Billing except that the cost is passed onto the patient in the form of a high-deductible, which makes this practice legal despite protections against Balance Billing. The resulting bill is then a surprise to the patient because they are often not aware of this financial responsibility.
States are starting to take action, but a Federal solution is also necessary.

Many states have now enacted (or are in the process of enacting) legislation to protect consumers against Surprise Billing. Some states, New York in particular, have implemented legislation that successfully protects patients, includes a specific payment standard for high frequency/low dollar claims, and establishes a mechanism for billing disputes. Other states, unfortunately, have passed legislation without any dispute resolution process and no minimum benefit standard.

What we see now is a patchwork of legislation to ban Surprise Billing, each with different rules and priorities. But state legislation typically involves products regulated by the individual state and, therefore, would not include one of the most common forms of coverage: employer-sponsored health plans (ERISA plans). These plans follow federal rules, leaving patients and providers confused and frustrated.

Federal solutions are now being proposed to protect patients from these OON high deductibles, and there are two competing approaches under debate.

- One option would follow the path of New York, where providers and health plans work through a dispute resolution process. This approach levels the playing field.
- The other approach would instead set a rate based on the median in-network reimbursement for that service in the same geographic area. If this approach wins, it will devastate our industry, especially rural and at-risk institutions – because it would drive down even the contracted rates.

Advocacy is now more important than ever.

The business model of emergency medicine is both complicated and unique. And it’s up to us – the providers and partner stakeholders – to educate lawmakers about the potential impact of proposed legislation. The future of emergency medicine reimbursement will depend on our continued advocacy and collective voice.

DR. BRAULT is President & CEO of Brault Practice Solutions, is the Immediate Past-Chair of the Emergency Department Practice Management Association (EDPMA), and is a Past President of CalACEP.
LOCAL REIMBURSEMENT
SUCCESS STORIES

By Kelsey McQuaid-Craig, MPA, CAE

Photo Credit: San Bernardino County Medical Society

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fforts to secure fair payment don't just occur at the state or national level. The following are two examples of important efforts by local emergency physicians to secure much needed funds for the emergency care safety net.

SAN BERNARDINO COUNTY MADDY FUND:

Thanks to the hard work of Rodney Borger, MD, FACEP, past CalACEP Board Member and current Chair of the San Bernardino County Medical Society EMS Committee, physicians in San Bernardino County received additional funding from their county’s Maddy Fund. Dr. Borger led the charge to secure reimbursement through adjustments to 2018 underpayments to physicians from the Maddy Fund. The pictures on this page show Dr. Borger with the physician groups who received additional funding.

The Maddy Emergency Medical Services (Maddy) Fund was established to reimburse providers, hospitals, and emergency medical services for uncompensated care. CalACEP is proud to have established and defended the Maddy EMS Fund.

CENTRAL COAST MEDI-CAL CUTS:

In October 2019, the Central Coast Alliance for Health (CCAH), the local Medi-Cal managed care organization, proposed making substantial cuts to reimbursement for emergency physicians to offset their $35 million annual deficit. In its proposal, CCAH stated that it was targeting emergency physicians for the cuts because reimbursement reductions would not affect access to care for their enrollees, because emergency physicians had to treat them regardless due to EMTALA.

Local emergency physicians in Monterey, Santa Cruz, and Merced counties quickly mobilized and voiced opposition to the proposal. Thanks to their quick mobilization, the vote by the CCAH Board was tabled at the October meeting. Following multiple meetings with the CCAH Finance Committee and CCAH Board, local physicians received word that there would not be a cost reduction strategy brought to the CCAH Board that would target one specialty. CCAH stated they wanted to implement a policy that keeps their provider network intact.

Their new proposal incorporates elements to address high in-patient costs, with substantially reduced focus on reimbursement for all providers. Three different proposals will be refined and brought to the CCAH Board for further discussion in March. The vote on their cost reduction strategies will occur at the April meeting.

If you would like help with your county’s Maddy Fund or another local reimbursement issue, please contact the CalACEP office at info@californiaacep.org.
Cast Your Vote!

2020 CALIFORNIA ACEP BOARD OF DIRECTORS ELECTION

ONLINE • MAY 15-31, 2020
Brief Overview

You may have heard about MIPS and MACRA. It sounds important but what does this mean to you?

MACRA (Medicare Access and CHIP Reauthorization Act of 2015) is the federal legislation approved in 2015 that reauthorized CHIP (Children’s Health Insurance Program), eliminated the sustainable growth rate formula, and created a new payment policy called the Quality Payment Program. Instead of previous payment programs’ focus on fee-for-service, this program focuses on value-based service. The transition also coincided with the conversion to electronic medical records, meaning that information like wait times, medications given, labs, and imaging ordered is becoming more readily available.

The Quality Payment Program is divided into the Advanced Alternative Payment Model, which includes accountable care organizations and bundled payment plans, and the Merit-Based Incentive Payment System (MIPS). To us emergency physicians and advanced practice providers, MIPS is the most important component. As a result of MACRA, our payments are now tied to quality measures. If physicians/PAs/NPs do not meet these criteria, a provider or site can be penalized financially. If these measures are successfully met, there is a potential for a financial bonus. Furthermore, these quality measures can be publicly reported giving patients, employers, and others access to see how you are doing relative to preset standards of care.

MIPS consists of four performance categories: quality, cost, improvement activities, and promoting interoperability. Each category has an assigned percentage weight and the total score is the sum of the weight of each of the four categories. Quality points (45% of total) are obtained through reporting six measures over a 12-month period. For the cost category (15%) you do not have to submit any additional data; it is calculated by CMS using administrative claims data consisting of the Medicare Spending Per Beneficiary (MSPB) measure and the Total Capita Cost measure. For 2020, there has been an addition of 18 new episode-based measures; however, none of these apply to emergency medicine. To get the improvement activity points (15%) you can choose either: two high-weighted activities; one high-weighted activity and two medium-weighted activities; or four or more...
medium-weighted activities from a list of activities created by CMS to improve clinical practice. If reporting as a group, at least 50 percent of clinicians in the group have to participate in this activity. Promoting interoperability (25%) is the category from which most emergency physicians are exempt, as its purpose is related to the use of electronic health records and most emergency physicians are already using the hospital’s electronic health record. You can view the quality measures and improvement activities on the qpp.cms.gov website.

How do you report quality measures?

You can use billing claims, electronic health records, registries (such as CEDR, CMS Web interface), and the CAHPS for MIPS survey.

ACEP has created a Qualified Clinical Data Registry called CEDR (Clinical Emergency Data Registry) to help report measures, as well as to help identify quality measures best suited for emergency physicians.

What is new for 2020?

There is an increased data completeness requirement from 60% of Medicare Part B patients to 70%, as well as QCDR measures, MIPS CQMs, and eCQMs from 60% to 70% sample of clinician’s or group’s patients across all payers for the performance period.

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
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</thead>
<tbody>
<tr>
<td>Performance Threshold</td>
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<td>45</td>
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<tr>
<td>Performance Threshold</td>
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<tr>
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<td>15%</td>
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<tr>
<td>Promoting Interoperability</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Looking towards the future

For 2021

- The performance threshold is increased to 60 points
- The additional performance threshold for exceptional performance is 85 points

DR. STANZER currently serves on the CalACEP Board of Directors. She is also the Director of Compliance & Government Related Services and the Director of Reimbursement, Coding & Quality for Emergent Medical Associates.
In 1996, the government implemented the GME funding cap that limits the amount of money a hospital can receive for training residents. Federal GME funding comes through direct medical expenses (DME) and indirect medical expenses (IME). DME includes things like resident salaries and benefits, faculty and coordinator costs, etc. IME is a complicated equation that uses the resident to Medicare bed ratio to support hospitals for the generally increased costs associated with training residents (they sometimes order more tests or open more central line kits). Many other states have implemented GME funding on top of federal dollars. Up until recently, California’s only state funds for GME were from the Song Brown Act which supports GME training in primary care – family medicine, internal medicine, obstetrics, and pediatrics.

While training residents will likely not add to a hospital’s bottom line, there is inherent value. Value in the quality of care delivered and value in physician recruitment. Some studies highlight that teaching institutions have lower mortality rates compared to nonteaching hospitals. When a hospital transitions to becoming a teaching institution, more doctors are at the bedside caring for patients. The biggest bang for the buck for a teaching hospital is the successful long-term strategy benefits of physician recruitment. About 50% of residents will stay within a 30-mile radius of where they trained. That percentage is even higher if the resident is originally from that area. Considering it costs upwards of $30-$50k to recruit one physician, that kind of pipeline is golden for an aging medical staff in an underserved area. GME training is also good for physician retention. Teaching is a very fulfilling endeavor to physicians and educating residents makes for a more enjoyable work environment.
In 2016, the voters of California passed Proposition 56, a tobacco tax with $38 million earmarked for developing new residency positions in primary care and EM. The funding is administrated through the University of California with a 15-member advisory board organized through Physicians for a Healthy California (trustees for the California Medical Association). CalACEP is one of the organizations represented on the advisory board to help decide how to fairly distribute this funding across specialties throughout the state. The advisory board spends a significant amount of time educating themselves on California physician workforce needs, defining underserved areas, and brainstorming creative ways to encourage graduates to remain in primary care rather than subspecialize. EM is lucky regarding the latter because we almost always continue working in the ED, even if we earn additional credentials in fellowships like EMS, toxicology, etc. Through state funding programs like CalMedForce, it is important for California to train physicians in the areas that we need them and to create a physician workforce that is representative of our patient population.

Awards for year two of CalMedForce have recently been announced and 12 emergency medicine residency programs will share $7.1 million. The advisory board continues to do work to maximize the impact of this much needed funding. Some of the additional revenue from Proposition 56 is also being directed to CalHealthCares, a loan repayment program to incentivize physicians to participate in Medi-Cal and to practice in underserved areas.

Editor’s Note: CalACEP supported Proposition 56 and has advocated on behalf of EM residencies getting their fair share.

DR. WINSTON currently serves as the Vice President of CalACEP and serves on the Proposition 56 GME advisory board.

REFERENCES

INTRODUCTION: Case management is an effective, short-term means to reduce emergency department (ED) visits in frequent users of the ED. This study sought to determine the effectiveness of case management on frequent ED users, in terms of reducing ED and hospital length of stay (LOS), accrued costs, and utilization of diagnostic tests.

METHODS: The study consisted of a retrospective chart review of ED and inpatient visits in our hospital's ED case management program, comparing patient visits made in the one year prior to enrollment in the program, to the visits made in the one year after enrollment in the program. We examined the LOS, use of diagnostic testing, and monetary charges incurred by these patients one year prior and one year after enrollment into case management.

RESULTS: The study consisted of 158 patients in case management. Comparing the one year prior to enrollment to the one year after enrollment, ED visits decreased by 49%, inpatient admissions decreased by 39%, the use of computed tomography imaging decreased 41%, the use of ultrasound imaging decreased 52%, and the use of radiographs decreased 38%. LOS in the ED and for inpatient admissions decreased by 39%, reducing total LOS for these patients by 178 days. ED and hospital charges incurred by these patients decreased by 5.8 million dollars, a 41% reduction. All differences were statistically significant.

CONCLUSION: Case management for frequent users of the ED is an effective method to reduce patient visits, the use of diagnostic testing, length of stay, and cost within our institution. [West J Emerg Med. 2018;19(2)238-244.]

INTRODUCTION

Frequent users of the emergency department (ED) represent a complex group of patients who overuse ED resources. This group accounts for as many as 28% of all ED visits, with the number of annual visits by this group continuing to rise.1-4 Frequent users of the ED are defined as patients making four or more ED visits per year; however, some “ultra”-frequent users may make 20 or more visits per year.2-8 It has been well established that ED frequent users increase healthcare costs and contribute to ED and hospital crowding.

While the reasons underlying frequent ED visits are often complex and may represent failure of the healthcare system to provide for patients with complex needs, ED frequent users incur significant charges and time for treatment and testing as a part of their evaluation and treatment. Additionally, as a part of each ED visit, evaluation, and treatment, patients spend time occupying EDs bed and using hospital services such as phlebotomy and radiology.5,7,9-14 ED bed time and hospital resources are a valuable commodity, particularly as ED visits continue to rise nationwide, making the reduction of such resources by ED frequent users a desirable goal.

Case management, as defined by the Case Management Society of America, is a “collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.”15 Given the complex medical and
social needs of ED frequent users, case management has been extensively used in this group of patients, with multiple studies showing successful reducing in the use of ED services and cost of care in the ED. A 2017 systematic review identified 31 different studies of interventions to decrease ED visits by frequent users. However, despite the large number of studies published, there has been little research on the effect of ED case management for frequent users on length of stay (LOS), either in the ED or in the inpatient setting. To the best of our knowledge, this is the first study to evaluate the effect of case management on ED, inpatient, and total hospital LOS for all types of visits by ED frequent users.

The goal of this investigation was to explore the effect of ED case management in frequent users of the ED on LOS, both in the ED and the inpatient setting. To better understand the impact of case management in this population, we also chose to look at the effect of this intervention on ED and hospital charges as well as utilization of hospital services. We hypothesized that ED case management would reduce ED visits, admissions, ED LOS, inpatient LOS, charges, and diagnostic studies.

**METHODS**

We conducted this study at a 225-bed hospital in a suburban area, with approximately 56,000 ED visits per year. The surrounding healthcare community consists of a variable mix of county-run primary care clinics and private practice physicians – in both primary care and specialty care. There are few free clinics in the surrounding area. Two other hospitals are within 30 miles of our institution, one of which is a county hospital.

The study consisted of a retrospective chart review of ED and inpatients visits by patients in our hospital’s Emergency Department Recurrent Visitor Program (EDRVP), comparing the visits made in the one year prior to enrollment in the program, to the visits made in the one year after enrollment in the program. This study was considered exempt by our hospital’s institutional review board.

The EDRVP is run by an ED social worker or registered nurse (RN), with emergency physicians, social workers, ED RNs, chemical dependency providers, behavioral health RNs, case managers, and representatives from local insurance providers. At monthly meetings, members of the EDRVP discuss approximately 10 patients who have been referred to the program. If a care plan does not appear to be working to address frequent ED visits or a new issue has come up for the patient causing recurrence of heavy ED use, the patient’s case and care plan is re-visited at the next meeting. If a truly urgent or emergent issue arises, the staff will correspond via secure email or in person to address it and develop new care plans or revisions to existing care plans. The program was developed initially in 2006 by ED staff at our hospital to address increasing visits by frequent users. As the program has grown, additional hospital staff and services have been recruited to assist us with the growing number of patients requiring case management, and to meet newly identified needs of patients in the program.

For inclusion criteria, patients are referred to the program for any of the following reasons: concerning ED use (as identified by an ED staff member); 10 or more ED visits in 12 months; six or more ED visits in six months; four or more ED visits in one month; or activity by a patient that demonstrates a propensity for future problematic ED encounters – such as violence in the ED or prescription forgery. Patients exhibiting such high-risk activity were believed to be potentially problematic patients, and therefore a plan was developed to preempt frequent, potentially dangerous, recurrent, and problematic visits. There are no exclusion criteria, and patients of any age may be referred. Once a patient has been referred for enrollment in the program, his or her visits are reviewed to determine the underlying medical, psychiatric, and social issues causing the multiple ED visits. A plan of care for the patient is then developed, with the intent to address these issues in the outpatient setting. Care plans may include referring the patient for a case manager, referring the patient to a needed specialist, assisting the patient with unstable housing, or requiring that patients only receive medications from their primary doctor – rather than coming to the ED for refills.

We studied all patients enrolled in the EDRVP between October 2013 and June 2015. For each patient, we reviewed all ED and inpatient visits for the one-year time period before they were enrolled as well as the one-year time period after they were enrolled. Visits were reviewed using the hospital’s electronic medical records system, Sunrise Clinical Manager (Version 14.3; Allscripts Healthcare Solutions, Chicago, IL). We recorded the number of each of the following parameters for the year before and year after enrollment: number of ED visits; number of inpatient admissions; ED LOS; inpatient LOS; ED charges; inpatient charges; number of computed tomography (CT) scans; number of ultrasounds; number of radiographs, and number of ED visits at which blood work was performed.

Additionally, we noted six main reasons why patients were referred to the program: needing pain management; complex psychosocial issues; complex medical conditions; psychiatric illness; substance abuse; and...
need resources or referrals. We recorded the reason for referral for each of our patients. Six chart reviewers reviewed all of the visits and recorded the data using a standardized data collection spreadsheet in Microsoft Excel (Excel 2013; Microsoft Corporation. Redmond, WA). The lead author supervised the chart reviewers to ensure that data collection was standardized and accurate between them.

After data collection was complete, we proceeded with data analysis. As we wanted to determine the effect of ED case management on the study parameters listed above, we compared each of the parameters for each patient from the one-year time period before enrollment in the program to the one-year time period after enrollment in the program. To evaluate for statistical significance, we then used a paired Wilcoxon signed-rank test, comparing the year before enrollment to the year after enrollment. Statistical analysis was performed with Microsoft Excel and Max Stat (Version 3.60; MaxStat. Jever, Germany).

RESULTS

Between October 2013 and June 2015, we enrolled 158 patients into the EDRVP program, which reflects our process of enrolling approximately 10 patients per month over this 19-month period. For administrative reasons, enrollment was significantly less than 10 patients per month on a few occasions. Demographic information of the patients can be found in Table 1. The oldest patient enrolled during this time period was 75 years old at the time of enrollment, with the youngest being nine months old at the time of enrollment.

In the one year prior to enrollment, patients in the program made 1,685 ED visits with 159 inpatient admissions, as compared to 855 ED visits with 97 inpatient admissions after enrollment. The number of CTs, ultrasounds, radiographs, and ED visits during which blood testing was done all decreased as well from the year prior to enrollment to the year after enrollment. All differences were statistically significant with a p-value of <0.05. The complete data on utilization of services is displayed in Table 2.

In the one year prior to enrollment, patients in the program occupied 125 days (a full 24-hour period) of ED bed time, along with 334 days of inpatient bed time, for a total of 459 days of ED and inpatient bed time. After enrollment in the program, this decreased to 83 days of ED bed time, 198 days of inpatient bed time, for a total of 281 days of ED and inpatient bed time. All differences were statistically significant with a p-value of <0.05. The complete data on LOS are displayed in Table 3.

In the one year prior to enrollment, charges incurred by ED visits by patients in the program were $5,827,162, with charges incurred during inpatient stays totaling $8,453,761, for a grand total of $14,280,923. In the one year after enrollment in the program, charges incurred by ED visits by patients in the program were $3,041,473, with charges incurred during inpatient stays totaling $5,405,175, for a grand total of $8,446,648. All differences were statistically significant with a p-value of <0.05. The complete data on charges are displayed in Table 4.

| TABLE 1. Population in a study examining the effects of case management on frequent users of the emergency department. n = 158 |
|---|---|---|
| **Total** | **Percent of total group** |
| Homeless | 12 | 7.6 |
| Male | 71 | 44.9 |
| Female | 87 | 55.1 |
| Insurance | | |
| Medicaid | 90 | 57.0 |
| Medicare | 32 | 20.3 |
| Tricare | 3 | 1.9 |
| Commercial | 23 | 14.6 |
| None | 6 | 3.8 |
| Other | 4 | 2.5 |

Age at enrollment (mean) = 42.4 years

| TABLE 2. Utilization of testing and services before and after enrollment of frequent ED users in a case management program. |
|---|---|---|---|---|
| **ED visits (1 year)** | **Post-intervention** | **Absolute change** | **Percent change** | **P-value** |
| | | | | |
| Inpatient admissions (1 year) | 159 | 97 | -62 | -38.99 | 0.002 |
| Computed tomography | 201 | 119 | -82 | -40.80 | 0.0001 |
| Ultrasounds | 71 | 34 | -37 | -52.11 | 0.01 |
| Radiographs | 384 | 239 | -145 | -37.76 | <0.0001 |
| ED visits during which blood testing was done | 724 | 386 | -338 | -46.69 | <0.0001 |

ED, emergency department.
Finally, we reviewed the reasons that patients were referred to the program. The greatest number were referred for issues regarding substance abuse, and the need for improved pain management. Additionally, the majority of patients had more than one issue for which they were identified as needing assistance, with the average number of reasons for referral being two per patient. The complete data are displayed in Table 5.

DISCUSSION

Our study clearly demonstrates that ED case management reduces utilization of services, LOS, and cost in a population of ED frequent users. Clearly in the current U.S. healthcare environment, which is characterized by expensive care and crowded hospitals and EDs, this is critical information and may provide some ideas to develop solutions to the problems of high cost and crowding. In reviewing the data on the reason for referrals to the program, it is apparent that this group of patients has complex needs, with less than a third of the group being referred to the program to address only one issue. This supports the need for a comprehensive case management program like the one we have instituted, as we believe that addressing only a single issue underlying recurrent ED use may not decrease ED utilization. From an ED administration standpoint, the most compelling piece of data appears to be the effect of ED case management on LOS. EDs across the U.S. struggle with crowding, often with critically ill or injured patients being forced to wait in waiting rooms when no beds are available. Our study showed that ED case management for ED frequent users helps this problem in two ways. First, by reducing ED visits and ED LOS, the program directly decreases the amount of ED bed time occupied by these repeat visitors, freeing up beds for patients in the waiting room. Second, by reducing inpatient LOS, ED patients are more likely to have inpatient beds available when needed, reducing the frequency of ED boarding. With less ED boarding, there is more available bed time in the ED for new patients from the waiting room. This increased ability to place new patients from the waiting room allows for new patients to be roomed much more quickly, allowing for critically ill and injured patients to receive time-sensitive treatment more quickly and reducing the door-to-doctor time for all patients in the department.

In looking at the cost implications of our analysis, we must consider the payer mix when considering the implication of reducing ED and inpatient charges in such a drastic fashion, as insurance plans reimburse

### TABLE 3. Length of stay (LOS).

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>Absolute change</th>
<th>Percent change</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay (LOS) in minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED LOS</td>
<td>450,041</td>
<td>299,514</td>
<td>-150,527</td>
<td>-33.45</td>
<td>&lt;0.0001</td>
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<td>Inpatient LOS</td>
<td>1,204,099</td>
<td>711,671</td>
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<td>Total LOS</td>
<td>1,654,140</td>
<td>1,011,185</td>
<td>-642,955</td>
<td>-38.87</td>
<td>&lt;0.0001</td>
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<tr>
<td>Length of stay (LOS) in days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED LOS</td>
<td>125.01</td>
<td>83.20</td>
<td>-41.81</td>
<td>-33.45</td>
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<tr>
<td>Inpatient LOS</td>
<td>334.47</td>
<td>197.69</td>
<td>-136.79</td>
<td>-40.90</td>
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<tr>
<td>Total LOS</td>
<td>459.48</td>
<td>280.88</td>
<td>-178.60</td>
<td>-38.87</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

**ED, emergency department.**

### TABLE 4. The change in charges (in U.S. dollars) before and after frequent users were enrolled in care management program.

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>Absolute change</th>
<th>Percent change</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED charges</td>
<td>5,827,162</td>
<td>3,041,473</td>
<td>-2,785,690</td>
<td>-47.81</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Inpatient charges</td>
<td>8,453,761</td>
<td>5,405,175</td>
<td>-3,048,586</td>
<td>-36.06</td>
<td>0.003</td>
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<tr>
<td>Total charges</td>
<td>14,280,923</td>
<td>8,446,648</td>
<td>-5,834,275</td>
<td>-40.85</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

**ED, emergency department.**
at variable rates. A 2016 Texas study found that for every $1.00 paid by Medicare to reimburse medical services, private insurance paid between $1.15 and $2.35, while Medicaid paid between $0.61 and $0.85. When looking at charges for services on the order of several million dollars, as in our study, the difference between reimbursement by private insurance and public insurance is enormous, also on the order of millions of dollars.

In our study, the majority of patients (57%) had Medicaid insurance, which (as demonstrated by the study above) results in lower reimbursements to the hospital as compared to other insurance programs. While we were unable to perform a formal cost analysis of the charges and reimbursements to the hospital due to limitations in access to the data, the fact that our intervention reduced visits predominately by patients with Medicaid insurance is not likely to be financially harmful to the hospital. Furthermore, in reducing charges by the patients in our program, our intervention was able to save significant monies for all insurance programs in our healthcare system, which could be used for other health improvements and interventions, such as prevention and education.

Finally, it is clear that our intervention — case management for ED frequent users — decreased ED visits, with the results evident from our study, as well as multiple previous studies cited above. In our study, we noted a decrease in inpatient admissions, ED and inpatient LOS, charges, and the use of testing. The question arises as to whether case management reduces these metrics simply by keeping people out of the ED, or whether case management has some additional effect on utilization of services. In looking at Table 2, it becomes clear that ED visits decreased by 49%, with admissions and utilization of testing decreasing by about the same percentage, or slightly less. Continuing with Tables 3 and 4, LOS and charges decreased by less than 49%. This would suggest (although a formal analysis was not performed) that the most effective aspect of ED case management for frequent users is the ability to decrease ED visits, with all other decreased metrics the result of the patient not being in the ED (and therefore subjected to testing, charges, and possible admission).

**LIMITATIONS**

Our study had several limitations. First, because we looked at ED and hospital visits at just one institution our study includes a relatively small number of patients. It is possible that patients in the program simply chose to seek care at other hospitals and EDs. Thus, while we were able to significantly reduce cost, LOS, and utilization at our hospital, similar parameters may have increased at neighboring hospitals due to patients avoiding our institution. A study of the effect of ED case management on multiple hospitals within a geographic region would provide valuable information on this issue.

**TABLE 5. Reasons for referrals to Emergency Department Recurrent Visitor Program. n = 158**

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th># of patients</th>
<th>% of total patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use</td>
<td>101</td>
<td>63.5</td>
</tr>
<tr>
<td>Need pain management</td>
<td>96</td>
<td>60.4</td>
</tr>
<tr>
<td>Psychiatric illness</td>
<td>46</td>
<td>28.9</td>
</tr>
<tr>
<td>Complex psychosocial issues</td>
<td>26</td>
<td>16.4</td>
</tr>
<tr>
<td>Needing resources/referrals</td>
<td>21</td>
<td>13.2</td>
</tr>
<tr>
<td>Complex medical conditions</td>
<td>20</td>
<td>12.6</td>
</tr>
<tr>
<td>Average number of reasons for referrals per patient</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Number of reasons for referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for 1 reason</td>
<td>47</td>
<td>29.7</td>
</tr>
<tr>
<td>Referred for 2 reasons</td>
<td>79</td>
<td>50.0</td>
</tr>
<tr>
<td>Referred for 3 reasons</td>
<td>23</td>
<td>14.6</td>
</tr>
<tr>
<td>Referred for 4 reasons</td>
<td>9</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Second, our study consisted of a retrospective chart review of a program in existence at our hospital, with no control group for comparison. While case management likely accounted for the significant changes in the parameters studied, it is possible that other factors, or simply regression towards the mean, accounted for part or all of our significant decreases.

Another limitation was that we did not look at testing utilization over the long term, but rather only compared the year prior to the intervention to the year after the intervention. For patients with recurrent complaints, physicians may not choose to perform imaging if imaging has recently been done. So, it is possible that robust imaging done on our patients in the year prior to enrollment decreased physician ordering of imaging studies in the year after enrollment. To be certain that our intervention decreased imaging study utilization, we would have needed to compare imaging in several years prior to enrollment to the year after enrollment.

Finally, as previously mentioned we did not conduct a formal cost analysis of charges and reimbursements to our institution to determine the impact of the significant reduction in ED charges. While again we speculated that with the majority of enrolled patients having Medicaid, the reduced charges represented savings to the hospital, it is possible that the program may have reduced reimbursements to the hospital in an unfavorable way.
CONCLUSION

Case management is an effective means for reducing recurrent ED visits by frequent users. As a result of decreased ED visits, case management also was shown to reduce cost, length of stay, and utilization of testing – both in the ED and the inpatient setting.

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Conflicts of Interest: By the WestJEM article submission agreement, all authors are required to disclose all affiliations, funding sources and financial or management relationships that could be perceived as potential sources of bias. No author has professional or financial relationships with any companies that are relevant to this study. There are no conflicts of interest or sources of funding to declare.

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REFERENCES

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Hemal Kanzaria, MD and Maria Raven, MD, MPH, FACEP published their article “Frequent Emergency Department Users: Focusing Solely On Medical Utilization Misses The Whole Person” in Health Affairs.

Rebecca Gonsalves, MD wrote the article “Intimate Partner Violence and Homicide: A Resident’s Perspective” for The American Foundation for Firearm Injury Reduction in Medicine.

Alicia Kurtz, MD spoke at a California Bridge to Treatment meeting in November about strategizing solutions to address opioid use disorder stigma.

Anna Yap, MD represented the American Medical Association Resident and Fellows Section at the American Medical Association House of Delegates Meeting.

Hunter Pattison, MD represented the residents of California Medical Association and the American Medical Association Residents and Fellows Section at the American Medical Association House of Delegates Meeting.

Amelia Breyre, MD was accepted into the University of California, San Francisco’s EMS/Disaster Medicine fellowship program.

Larissa May, MD, FACEP presented on antibiotics and antibiotic resistance for University of California Davis Health.

Michael Schick, DO, FACEP spoke at the 7th World Congress of Ultrasound in Medical Education on how POCUS is used to help teach biochemistry at the University of California Davis Medical School.

Sangeeta Sakaria, MD got married in November.

Charlotte Wills, MD was awarded 2019 Emergency Medicine Residents’ Association Residency Director of the Year.


Kimberly Schertzer, MD, FACEP published “In Situ Debriefing in Medical Simulation” in StatPearls.

Mike Messina, DO and Hurnan Vongsachang, MD received the Emergency Medicine Residents’ Association 2019 Alexandra Greene Medical Students of the Year.

Maria Sturchler, MD matched for the University of California, San Diego Medical Center Hospice and Palliative Medicine fellowship program.

Stephanie Benjamin, MD was a guest on EMRA*Cast and spoke about how to build resiliency through writing.

Aimee Moulin, MD, FACEP spoke on how California Bridge to Treatment operates and the efforts to implement the program in other communities.

Kareen Tyler, MD, FACEP and Russell F. Jones, MD completed the California International Marathon.

Angela Lumba-Brown, MD and Michael Collins, MD published their article “Concussion Guidelines Step 2: Evidence for Subtype Classification” in Neurosurgery.

George Sternbach, MD, FACEP retired from Stanford University School of Emergency Medicine after 42 years of service.

Katherine Staats, MD presented research on the importance of gender diversity in the workplace at the National Association of EMS Physicians 2020 Annual Meeting.

Benjamin Linquist, MD; Jennifer A. Newberry, MD, JD, FACEP; and Matthew Strehlow MD, FACEP published an article in BMJ Journals called “Workplace violence among prehospital care providers in India: a cross-sectional study”.

Bryn Eisfelder, MD and Jeffrey Sakamoto, MD were named 2020-2021 Chief Residents at Stanford Emergency Medicine.

David A. Kim, MD, PhD; Benjamin Lindquist, MD; Sam Shen, MD, MBA, FACEP; Alexei Wagner, MD, MBA; and Grant Lipman, MD, FACEP published their article “A body bag can save your life: a novel method of cold water immersion for heat stroke treatment” in JACEP Open.

Laleh Gharahbaghian, MD, FACEP received the Stanford Department of Emergency Medicine Outstanding Educator of the Month Award in January.

Eric Snyder, MD, FACEP was named Chief Risk Officer of Emergent Medical Associates.

Did you get a new job? Get promoted? Get published? Achieve a goal?

Let California ACEP know and we will include it in this new section of Lifeline. Tweet your accomplishment and tag @californiaacep or submit your accomplishments at: https://californiaacep.site-ym.comsurveys/?id=Accomplishments.
The California Emergency Medicine Advocacy Fund (CEMAF) has transformed California ACEP’s advocacy efforts from primarily legislative to robust efforts in the legislative, regulatory, legal, and through the Emergency Medical Political Action Committee, political arenas. Few, if any, organization of our size can boast of an advocacy program like California ACEP’s; a program that has helped block Medi-Cal provider rate cuts, lock in $500 million for the Maddy EMS Fund over the next 10 years, and fight for ED overcrowding solutions! The efforts could not be sustained without the generous support from the groups listed below, some of whom have donated as much as $0.25 per chart to ensure that California ACEP can fight on your behalf. Thank you to our 2019-20 contributors (in alphabetical order):

- Alvarado Emergency Medical Associates
- Antelope Valley Emergency Medical Associates
- Beach Emergency Medical Associates
- Berkeley Emergency Medical Group, Inc.
- Chino Emergency Medical Associates
- Coastline Emergency Physicians Medical Group
- Culver Emergency Medical Group
- Hollywood Presbyterian Emergency Medical Associates
- Mills Peninsula Emergency Medical Group
- Napa Valley Emergency Medical
- Orange County Emergency Medical Associates
- Pacific Coast Emergency Medical Associates
- Pacific Emergency Providers APC
- Pacifica Emergency Medical Associates
- Riverside Emergency Physicians
- San Dimas Emergency Medical Associates
- Sherman Oaks Emergency Medical Associates
- South Coast Emergency Medical Group, Inc.
- Tarzana Emergency Medical Associates
- TeamHealth
- Temecula Valley Emergency Physicians, Inc.
- US Acute Care Solutions
- Valley Emergency Medical Associates
- Valley Presbyterian Emergency Medical Associates
- VEP Healthcare
- Vituity
- West Hills Emergency Medical Associates

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**CALIFORNIA ACEP SPONSORED & CO-SPONSORED COURSES**

**2020 Legislative Leadership Conference**
April 14, 2020 | Sacramento, California
Register Here: [https://californiaacep.org/event/LLC2020](https://californiaacep.org/event/LLC2020)

**Save the Date! 2020 AdvancED Annual Conference**
September 25, 2020 | San Diego, CA

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**SUBMIT A LIFELINE ARTICLE**

Looking for a way to share your emergency medicine experience? Want to share a story from your last shift? Or maybe career or life advice? We’re looking for member and guest articles, including letters-to-the-editor. Please note that all articles and letters are reviewed and may be edited for grammar and content.

The Summer Issue of Lifeline will be about social emergency medicine. We welcome your thoughts on the topic.

If you would like more information or would like to submit a guest article, email info@californiaacep.org.

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**NOMINATE A CAL/EMRA ALL-STAR**

Do you have an EM all-star hiding in your program and want to get their name out there? We’re looking for residents or medical students that deserve recognition!

Nominations can be submitted at [bit.ly/nominate4calemra](bit.ly/nominate4calemra).

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**WE MOVED!**

The Chapter moved suites on October 1st. Please update your records with our new address:

California ACEP
1121 L Street, Suite 401
Sacramento, CA 95814
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

### MARCH 2020

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>5th at 11am</td>
<td>Government Affairs Subcommittee #1 Conference Call</td>
</tr>
<tr>
<td>5th at 1pm</td>
<td>Government Affairs Subcommittee #2 Conference Call</td>
</tr>
<tr>
<td>5th at 3pm</td>
<td>Government Affairs Subcommittee #3 Conference Call</td>
</tr>
<tr>
<td>12th at 10am</td>
<td>Government Affairs Committee (GAC) Conference Call</td>
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<tr>
<td>15th</td>
<td>Board Nominations Close Online</td>
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### APRIL 2020

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<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>14th</td>
<td>Legislative Leadership Conference (LLC) Sacramento, CA</td>
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<tr>
<td>15th</td>
<td>Board of Directors Meeting Sacramento, CA</td>
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<tr>
<td>26th–29th</td>
<td>ACEP Leadership and Advocacy Conference Washington DC</td>
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### MAY 2020

<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>1st</td>
<td>Chapter Award Nominations Open Online</td>
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<tr>
<td>5th at 9am</td>
<td>Reimbursement Committee Conference Call</td>
</tr>
<tr>
<td>14th at 10am</td>
<td>Government Affairs Committee (GAC) Conference Call</td>
</tr>
<tr>
<td>15th–31st</td>
<td>Board of Directors Elections Online</td>
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</tbody>
</table>
SOUTHERN CALIFORNIA – ORANGE COUNTY: Positions available for full and part time BC/BE EM and Peds EM physicians. Partnership track is available for full time physicians. We are a stable, democratic group established in 1976 serving two best in class hospitals. St. Joseph Hospital is a STEMI center and Stroke Center with 80,000 visits per year. CHOC Children’s Hospital is a Level II trauma center, tertiary referral center and teaching hospital (several residency and fellowship rotations) with 80,000 visits per year. Excellent call panel coverage, excellent compensation, malpractice and tail coverage, and scribe coverage. Sign on bonus for full time hires.

Email CV and references to EMSOC@emsoc.net, fax to 714-543-8914

VENTURA CALIFORNIA: We have moved into our brand new Hospital and Emergency Department as of December 2018! Central coast of California and 70 miles from LAX. Positions available in two facilities for BC/BE emergency physician. STEMI Center, Stroke Center with on-call coverage of all specialties. Teaching facility with residents in Family Practice, Surgery, Orthopedics and Internal Medicine. Admitting hospital teams for Medicine and Pediatrics. Twenty-four hour OB coverage in house and a well established NICU. Physician’s shifts are 9 hrs and two 12 hour shifts of PA/NP coverage. All shifts and providers have scribe services 24/7. Affiliated hospital is a smaller rural facility 20 minutes from Ventura in Ojai. Malpractice and tail coverage is provided. New hires will work days, nights, weekends and weekdays.

Send resume to Alex Kowblansky MD FACEP at kowblansky@cox.net

To advertise with Lifeline and to take advantage of our circulation of over 3,000 readers, including Emergency Physicians, Groups, and Administrators throughout California who are eager to learn about what your business has to offer them, please contact us at info@californiaacep.org or give us a call at (916) 325-5455.
Looking for an ITLS course?

EMREF offers the following California providers list:

American Health Education, Inc
Perry Hookey, EMT-P
7300B Amador Plaza Road, Dublin, CA 94568
Phone: (800) 483-3615
Email: info@americanhealtheducation.com
Web: www.americanhealtheducation.com

American Medical Response (AMR)
Ken Bradford, Operations
841 Latour Court, Ste D, Napa, CA 94558-6259
Phone: (707) 953-5795
Email: ken.bradford2@gmail.com

Compliance Training
Jason Manning, EMS Course Coordinator
3188 Verde Robles Drive, Camino, CA 95709
Phone: (916) 429-5895
Fax: (916) 256-4301
Email: Kurgan911@comcast.net
Web: www.compliance-training.com

CSUS Prehospital Education Program
Thomas Oaks, Program Director
3000 State University Drive East, Napa Hall, Sacramento, CA 95819-6103
Office: (916) 278-4846
Mobile: (916) 316-7388
Email: thomasfly@stbglobal.net
Web: www.ccs.csus.edu

EMS Academy
Nancy Black, RN, Course Coordinator
1170 Foster City Blvd #107, Foster City, CA 94404
Phone: (866) 577-9197
Fax: (650) 701-1968
Email: nancy@caems-academy.com
Web: www.caems-academy.com

ETS – Emergency Training Services
Mike Thomas, Course Coordinator
3050 Paul Sweet Road, Santa Cruz, CA 95065
Phone: (831) 476-8813
Toll-Free: (800) 700-8444
Fax: (831) 477-4914
Email: mthomas@emergencytraining.com
Web: www.emergencytraining.com

Loma Linda University Medical Center
Lyne Jones, Administrative Assistant
Department of Emergency Medicine
11234 Anderson St., A108, Loma Linda, CA 92354
Phone: (909) 558-4344 x 0
Fax: (909) 558-0102
Email: LJones@llhs.llumc.edu
Web: www.llu.edu

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Phone: (909) 558-4344 x 0
Fax: (909) 558-0102
Email: LJones@llhs.llumc.edu
Web: www.llu.edu

Medic Ambulance
James Pierson, EMT-P
506 Couch Street, Vallejo, CA 94590-2408
Phone: (707) 644-1761
Fax: (707) 644-1784
Email: jpierson@medicambulance.net
Web: www.medicambulance.net

Napa Valley College
Gregory Rose, EMS Co-Director
2277 Napa Highway, Napa CA 94558
Phone: (707) 256-4596
Email: gross@napavalley.edu
Web: www.winecountrycpr.com

NCTI – National College of Technical Instruction
Lena Rohrabaugh, Course Manager
333 Sunrise Ave Suite 500, Roseville, CA 95661
Phone: (916) 960-6284 x 105
Fax: (916) 960-6296
Email: lrohsa@calnet.com
Web: www.ncti-online.com

PHI Air Medical, California
Eric Lewis, Course Coordinator
801 D Airport Way, Modesto, CA 95354
Phone: (209) 550-0884
Fax: (209) 550-0885
Email: elewis@philhelico.com
Web: http://www.phiairmedical.com

Riggs Ambulance Service
Greg Petersen, EMT-P, Clinical Care Coordinator
100 Riggs Ave, Merced, CA 95340
Phone: (209) 725-7010
Fax: (209) 725-7044
Email: Gregg@riggsambulance.com
Web: www.riggsambulance.com

Rocklin Fire Department
Chris Wade, Firefighter/Paramedic
3401 Crest Drive, Rocklin, CA 95765
Phone: (916) 625-5311
Fax: (209) 725-7044
Email: Chris.Wade@rocklin.ca.us
Web: www.rocklin.ca.us

Rural Metro Ambulance
Brian Green, EMT-P
1345 Vander Way, San Jose, CA 95112
Phone: (408) 645-7345
Fax: (408) 275-6744
Email: brian.green@rmetro.com
Web: www.rmetro.com

Defib This (ERT)
Brian Green, EMT-P
1543 Pacific Avenue, Suite 104, Capitol CA 95060
Phone: (916) 426-9111
Web: www.defibthis.com

Verihealth/Falck Northern California
Ken Bradford, Training Coordinator
2190 South McDowell Blvd, Petaluma, CA 94954
Phone: (707) 766-2400
Email: ken.bradford@falck.com
Web: www.verihealth.com

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.
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www.californiaacep.org