Oklahoma Health Care Authority

HOUSE BILL 2906 ER UTILIZATION STUDY APPENDICES

Prepared by the Oklahoma Health Care Authority

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APPENDIX A

MACfacts

Key Findings on Medicaid and CHIP

"Revisiting Emergency Department Use in Medicaid"

Source: http://www.macpac.gov/publications

MACfacts
Key Findings on Medicaid and CHIP
July 2014

Revisiting Emergency Department Use in Medicaid

Overview

Medicaid enrollees' emergency department (ED) use accounts for just 4 percent of total Medicaid spending, but because Medicaid enrollees use the ED more frequently than both privately insured and uninsured persons, state Medicaid programs monitor ED use closely (MACPAC 2014).[1] The ED is an expensive place to treat medical problems because it maintains 24-hour staff and resource availability and the hospital settings in which most EDs are based have both high overhead and fixed costs. Thus, payers and health plans have long sought to keep costs down by educating patients about appropriate use of the ED and providing timely access to care in other settings.

Higher ED use among Medicaid enrollees is explained mostly by the higher rates and more severe cases of chronic disease and disability they experience relative to those who are privately insured and uninsured (MACPAC 2012a, 2012b, Mortensen and Song 2008). High ED use also can be a sign of poor access to primary, specialty, dental, and outpatient mental health care in other settings. A recent study of Oregon's 2008 Medicaid expansion to low-income adults reported a rise in ED use among newly insured Medicaid enrollees, fueling concerns that the Medicaid expansion authorized by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) could lead to a surge in ED use, increasing program costs and overcrowding of EDs (Taubman et al. 2014).

This issue brief provides a fact check of commonly held beliefs about ED use in Medicaid. In some cases, common beliefs are supported by the evidence, and in others, they reflect only part of the story. In any case, we seek to provide a more balanced picture of ED use in Medicaid informed by the latest research. To provide further context for policymakers, we review evaluations of recent Medicaid expansions and summarize a MACPAC review of Medicaid program and safety-net providers' efforts to curb ED use.

Revisiting Common Beliefs about ED Visits

Belief: ***Much of the ED use among Medicaid enrollees is unnecessary.***
Fact check: **False.**

The majority of ED visits by non-elderly Medicaid patients are for urgent symptoms and serious medical problems that require prompt medical attention (Sommers et al. 2012). Non-urgent visits account for just 10 percent of all Medicaid-covered ED visits for non-elderly patients, a proportion comparable to that of privately insured patients (Garcia et al. 2010).[2] A review of all studies of non-emergency ED use published between 1990 and 2010 did not find

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a consistent association between Medicaid and disproportionate use of the ED for non-emergency conditions (Uscher-Pines et al. 2013).

The notion that most ED use is inappropriate may be fueled by studies that cite large percentages of ED visits paid for by Medicaid and private insurance as avoidable or preventable (Truven 2013, Weinick et al. 2010). These classifications, however, do not capture the experience of care in real time. Health problems classified in research as avoidable may in fact be urgent in nature and require prompt medical attention from a physician. Some problems, such as chest pain in a 50-year old or an infant's fever and rash, carry high risks for patients and are best evaluated in an ED. This is true even if—after a physician's evaluation and some rapid testing—the vast majority of cases are resolved. A recent study found it nearly impossible to identify prospectively, based on their presenting complaints, those patients who will not need emergency care at the ED (Raven et al. 2013).

Finally, even ED visits that ultimately are determined to be non-urgent can require a physician's assessment, and an ED visit cannot be avoided if the patient has no alternative place to seek care in a timely manner. In 2012, about one in four adult Medicaid enrollees who reported a recent visit to the ED went there because of difficulty accessing another provider, not because of a serious health problem (MACPAC 2014).[3]

Belief: ***Medicaid patients' ED use is increasing.***
Fact check: **Not clear.**

The evidence on this point is conflicting. While patient-reported data show no change in ED use among adult Medicaid enrollees and recent declines for children, a national sample from hospital administrative data shows a sharp increase for visit rates among adults (NCHS 2013, Tang et al. 2010). Reports of an increase in ED use rely primarily on a study of visit-level data from the National Hospital Ambulatory Care Survey (NHAMCS) that found a sharp increase in ED utilization rates between 1997 and 2007 for adults over age 18. The study attributed the increase almost entirely to visits that indicated Medicaid as the expected source of payment (Tang et al. 2010). These data are a problematic source for estimating trends by payer, however, because of changes in the survey's payer coding and other limitations of the payment variable.[4]

According to the National Health Interview Survey (NHIS), the percentage of non-institutionalized individuals in the United States who visited the ED during the past 12 months remained stable over the period 2001 to 2012. There was no significant growth in the percentage of adults age 18 to 64 visiting the ED one or more times or visiting two or more times (NCHS 2013). Of non-elderly adults reporting Medicaid at the time of interview, 42.2 percent in 2000 reported making one or more ED visits within the past 12 months, compared to 39.7 percent in 2012, not a statistically significant change (NCHS 2013).[5,6] The percentage of children with public insurance who made one or more ED visits declined significantly between 2000 and 2012, as did rates for children with private insurance and uninsured children.[7]

Belief: ***Medicaid patients use the ED frequently because they have difficulty getting in to see their regular doctor.***
Fact check: **True.**

Barriers to timely care increase the chances that individuals will use the ED (Cheung et al. 2012). Despite the fact that nearly all Medicaid enrollees report having a usual place of care other than the ED, approximately one-third of adult and 13 percent of child enrollees have reported barriers to finding a doctor or delays in getting needed care

(MACPAC 2014).[8] Delays were more frequently reported by Medicaid enrollees than by people who are privately insured, and enrollees reported that these delays often occurred for several reasons, including: trouble getting through to the practice by phone or reaching a doctor after hours, difficulty getting an appointment soon enough, language barriers, and lack of transportation. For patients with disabilities (who are disproportionately represented in Medicaid), barriers also include facilities that lack appropriate physical access, staff who are not trained to accommodate patients with disabilities, and communication barriers—all of which can lead to delays in care, increased ED use, and preventable hospitalizations (Drainoni et al. 2006, Neri and Kroll 2003).

Medicaid enrollees who report more primary care barriers are more likely to report ED use. Moreover, patients who have better after-hours access to primary care practices report lower ED use and fewer unmet medical needs than patients without after-hours access (O'Malley 2013, Cheung et al. 2012, Cheung et al. 2011, Lowe et al. 2005).[9] This strong association holds regardless of insurance coverage, and also after controlling for differences in patients' illness severity, patient attitudes, characteristics of a patient's primary care practice, and community capacity. It is important to note, however, that studies based on point-in-time surveys can only establish associations, not causality, between barriers to primary care and use of the ED.

Other studies of newly insured individuals coming off a period without insurance find higher ED visits and more barriers to care than individuals insured for the entire year, regardless of the type of insurance—Medicaid included (Ginde et al. 2012; MACPAC 2012a, 2012b; Kenney 2007). Following interruptions in Medicaid coverage (which disrupt access to providers), studies observe more hospitalizations and higher ED use among patients with diabetes (Hall et al. 2008); more psychiatric and other hospital admissions among patients with schizophrenia (Harmon et al. 2003); and higher spending and more ED visits and hospital admissions among patients with depression (Harmon et al. 2007).

Belief: ***Frequent ED use could be avoided if those users had greater access to primary care.***
Fact check: **Partially true.**

Frequent users of the ED also use many other medical care services, including primary care, specialty care, mental health, and inpatient services. In extreme cases, these individuals may be referred to as super-utilizers. A recent study showed that working-age adults who reported four or more ED visits in the past year also reported an average of 3.1 visits to primary care physicians, 8.1 visits to specialist physicians, and 5.9 visits to non-physician providers (Rasch et al. 2013). The general concern about frequent ED users is that their health needs are not well-managed by the current health system (CHCS 2013). Frequent users include a wide array of individuals with diverse and complex needs, but the majority of them are severely disabled or in fair-to-poor health (Rasch et al. 2013, Hunt 2006). Persons with disabilities comprise 65 percent of frequent users (with four or more ED visits in the past year) and have high rates of ED use for injuries, hypertension, heart conditions, pneumonia or bronchitis, and mental disorders (Rasch et al. 2013).

Frequent use of the ED stems from a constellation of psychosocial and medical needs that cannot be addressed simply through primary care. Providers who work with super-utilizers attribute some of the repeat ED use to factors such as fragmented care stemming from serious mental illness and homelessness, high medical comorbidity, untreated substance use, pain diagnoses, physician reliance on EDs for follow-up care, and difficulty getting timely prescription refills (Billings and Raven 2013, Doran et al. 2013, Pines et al. 2011, Linkins et al. 2008). The complexity of super-utilizers' situations makes it difficult to assess how much of their ED use is an indirect consequence of barriers to care, or a direct consequence of complications arising from a disability or chronic condition.

How Medicaid enrollees differ from other frequent users remains largely unknown because most analyses do not stratify results by insurance coverage or examine Medicaid enrollees in detail. One study provides some insight: A large study of Medicaid enrollees in New York City shows that Medicaid-enrolled frequent ED users share certain characteristics with uninsured or otherwise insured frequent ED users, such as a high burden of chronic illness, disability, and dual diagnoses of substance use and mental illness (Billings and Raven 2013). Of enrollees with 15 or more annual ED visits, 62 percent had a history of both serious mental illness and substance use, compared to 10 percent of those with just one annual ED visit.

There is also evidence that some frequent ED users appear to receive inadequate primary or specialty care (while others use these services frequently). Among Medicaid enrollees with 10 or more ED visits in one year (who accounted for 12 percent of all ED visits), about half had weak ties to a regular physician. These individuals used primary care occasionally, used no primary care at all, or saw multiple primary care providers, all likely indicators of inadequate primary care provision, especially given the extreme ED use (Billings and Raven 2013). At least half did not receive outpatient care of any kind in the 30 days after they were discharged from the ED.

Belief: ***Use of the ED will surge as Medicaid expands in 2014.***
Fact check: **Insufficient evidence.**

A recent evaluation of Oregon's expansion of Medicaid to childless adults raised concerns that ED use will surge in states that expand Medicaid (Taubman et al. 2014). A review of existing studies on prior Medicaid expansions suggests that the effects of coverage expansions could vary across states, with some experiencing no increase in ED use and others experiencing short-lived increases. Three evaluations of the 2008 Oregon Medicaid expansion, which opened enrollment to Oregon Health Plan Standard by lottery, found increased use of outpatient services and health care spending overall (Taubman et al. 2014, Baiker et al. 2013, Finkelstein et al. 2012). The most recent analysis found increased ED use after 18 months of enrollment across all ED visits (except those resulting in admission), while the two earlier analyses found no significant change.[10]

Studies of the 2006 Massachusetts reform, which expanded Medicaid as part of a broader state insurance reform, provided conflicting results about the impact on ED use. As in Oregon, the evaluations found either no ED effect (Miller 2012) or increases in ED and office visits (Chen et al. 2011). Analyses of 12 Medicaid expansions, which extended Medicaid to low-income working adults in eight other states between 2000 and 2009—prior to the ACA—found no evidence of increased use of emergency services or erosion of perceived access to care among enrolled adults (Ndumele et al. 2014).[11]

The contrasting behaviors of two groups of enrollees in California's Low Income Health Program (LIHP) show how people, depending on their prior access to health care, use insurance differently once they become covered and that health care coverage can change how people interact with health care systems over time. LIHP was one component of California's pre-expansion initiative that provided comprehensive coverage to legal residents age 19 to 64 prior to December 2013.[12] Some individuals were covered by a legacy program with comparable benefits and seamlessly transferred into LIHP (Lo 2014). Evaluators reported that ED use by this group was low before LIHP and that it remained flat after the transition. By comparison, new LIHP enrollees previously ineligible for coverage showed much higher ED visit rates upon enrolling in LIHP. These rates steadily declined over time and eventually matched the low rate of the continuously covered legacy enrollees.

The effects of Medicaid expansions may differ across states based on the capacity of safety-net providers, the number

of newly eligible enrollees, and delivery system design (McMorrow and Long 2014). Past experience with expansions is limited and has led to conflicting results.

Delivery System Factors Driving ED Use

ED utilization is the result of many different factors, including the patient's and his medical provider's perceived need for prompt care, the perceived severity of the condition, the availability and accessibility of both the ED and alternative sites of care, and physician referrals to the ED. The public conversation on ED use often frames the policy problem as patients' excessive or inappropriate demand for ED services, that is, a presumption that unnecessary visits largely reflect a patient's decision to go to the ED. But other changes in the health system also are likely increasing demand for ED services.

Primary care physicians now frequently send non-emergency patients to the ED for rapid diagnostic work-ups, placing the decision to admit with the ED physician (Morganti et al. 2013, Carrier and Boukus 2013, Carrier et al. 2011). As a result, non-emergency patients seen in the ED have become increasingly medically complex (Pitts 2012). Some of the major reasons that primary care physicians refer non-emergency patients to the ED include the severity or complexity of the patient's illness; the need for more clinical information unavailable to the physician after hours; administrative barriers to direct admissions; and the relative ease of sending patients there (Morganti et al. 2013). There also has been a sharp decline in direct admissions to the hospital by office-based physicians and an even sharper increase in the number of admissions through the ED: now, almost one-half of all non-elective admissions go through the ED (Morganti et al. 2013).

The ED also has evolved to serve an expanded role in health care delivery, providing many services that, historically, took place on an inpatient basis (Morganti et al. 2013, Pitts et al. 2012). Concurrently, investments in technology and information systems have enhanced the emergency physician's opportunities to rapidly diagnose, treat, and manage an expanding range of acute and chronic conditions (Kocher et al. 2011, Korley et al. 2010). Many EDs also have invested resources in better managing patient-flow, resulting in higher patient volume—evidence that hospital systems can both benefit from higher patient volume and address adverse effects of ED crowding over time (Pitts 2012). However, it is important to bear in mind that the overall number of hospital-based EDs in the United States is decreasing, stretching the capacity of remaining EDs to care for a growing population (Hsia et al. 2011).

Programs to Reduce ED Use

Many state Medicaid programs have taken steps to reduce ED use. Common approaches include diverting patients with complaints deemed to be non-urgent to lower-cost settings, charging copayments for so-called non-emergency ED use, and focusing efforts on super-utilizers (Raven 2014). Such efforts involve development of alternative sites for non-emergency care, partnerships between hospitals and existing local clinics that offer extended hours or next-day appointments, IT systems to improve coordination, and programs to educate beneficiaries about appropriate use of settings. In addition, the Centers for Medicare & Medicaid Services (CMS) provided $50 million in federal grant funds to 20 states in 2008 to establish alternate non-emergency service providers or networks of such providers (CMS 2013b).

Analyses of the impact of diversion programs differ in their findings. CMS reported states' success in reducing ED

use varied (CMS 2014).[13] Two independent, comprehensive reviews of these state interventions, and studies of similar efforts nationwide, found mixed results (Raven 2014, Morgan et al. 2013). A MACPAC evaluation of the effectiveness of programs to reduce ED visit use did not find sufficient evidence to conclude that diversion approaches will produce savings to the Medicaid program (as opposed to reducing ED-related costs only), mainly because existing research has not quantified effects on the substitute use of primary care, specialists, laboratory testing and imaging, or the total cost to payers (CAMRI 2013).

Some state Medicaid programs have increased patient copayments (or have considered doing so) as a way to reduce non-emergency use of the ED in Medicaid.[14] Research shows that imposing copayments can reduce ED use, but that it does not promote more efficient use of the ED, and copayments tend to shift use between settings, resulting in cost shifting between providers (Machledt and Perkins 2014). One study found no significant change in non-emergency ED use in nine states that made Medicaid copayment policy changes between 2001 and 2006 (Mortensen 2010), but it did not examine co-occurring changes in office visits and other ambulatory care.[15] Another study found a small decrease in ED use overall (and no decrease for low-acuity conditions) after a $20 surcharge was imposed for non-emergency ED use in Alabama's State Child Health Insurance Program (Becker et al. 2013). Adding a $50 ED copayment and other cost sharing in the Oregon Health Plan resulted in decreased ED use, yet the evaluation also detected increased office visits and no effect on overall expenditures (Wallace et al. 2008). Copayments can be complicated to administer because there currently is no mechanism to safely and accurately identify non-emergency ED use. In addition, identifying ED visits that may be subject to copayments can be administratively burdensome to providers and patients, and copayments may ultimately discourage necessary and unnecessary ED care (Matthews 2012, HMA 2008).

Foundations have funded two major grant initiatives to develop strategies that reduce frequent hospitalizations and use of EDs. These strategies have yielded mixed results (RWJF 2011, Linkins et al. 2008).[16] A MACPAC review of these super-utilizer programs and others found some high-profile programs (e.g., Camden Coalition of New Jersey and Hennepin Health) successfully cut ED use in the targeted population, but program savings came from cutting costs associated with hospital admissions rather than ED visits (Raven 2014, CMS 2013a). Early pilot programs were estimated to be cost-neutral after accounting for new services offered by the intervention (Linkins et al. 2008). Other recent efforts have failed to reduce use or accrue savings to payers, and many have not undergone rigorous evaluation (Raven 2014). It is difficult to extrapolate the impact any particular frequent user program will have if adopted by other communities because the models are customized to local resources and may not be transferrable to different delivery systems or markets (Dunford 2013, Folsom 2013, Brenner 2012).

A major challenge to evaluating frequent user programs is the tendency for a population of high utilizers to regress to lower average use without intervention. Suitable comparison groups are difficult to identify, and the episodic nature of frequent use over time may mask true program effects. Two recent longitudinal studies of frequent ED user populations found that approximately two-thirds of individuals identified as frequent users in the first year of study became low or infrequent users one year later (Colligan et al. 2014, Johnson et al. 2014).

Many ED reduction programs also have faced difficulty sustaining funding and stakeholder buy-in over the long term. Commonly reported obstacles to program sustainability include integrating systems of care, finding a permanent funding source for alternative clinic sites and payment for non-clinical staff and services, state licensing barriers, shared data systems, patient buy-in, and improved access to specialty care (Owens 2012, Kushel 2003). Success will depend on states' capacity to find creative solutions for sustaining programs beyond an initial pilot period.

Conclusions

Medicaid enrollees use the ED more than privately insured or uninsured persons, although there is little evidence of widespread inappropriate use of the ED. Research also points to higher ED use by Medicaid enrollees when they have difficulty accessing their regular doctor and other appropriate settings.

Narrowly targeting ED use through diversion or cost sharing is not guaranteed to reduce ED use or lead to overall program savings for Medicaid. Most evaluations of ED visit reduction programs have not examined the full impact on use and costs to the Medicaid program.

Expanding the availability of primary care could lead to more efficient use of the ED. However, ED use is likely to remain relatively high in Medicaid until new delivery models are in place to address the needs of frequent users. To the extent that ED visit reduction programs focused on frequent users can generate savings, the money will most likely come from their larger impact on inpatient hospital care, which represents a far greater proportion of spending in Medicaid than non-emergency ED care (CAMRI 2013, Smulowitz et al. 2013).

Endnotes

[1] The 4-percent proportion is based on spending for a representative population of non-institutionalized residents in the United States. Thus, total Medicaid spending here does not include spending for persons residing in institutions or their acute care costs. Total Medicaid spending also excludes lump-sum payments made to hospitals and other institutions in the form of supplemental payments and disproportionate share payments. Expenditures for ED services include the hospital facility amount and physician amount (MACPAC calculations based on Medical Expenditure Panel Survey (MEPS) Data Summary Tables, 2011 Full-Year Person File).

[2] Visits are categorized as non-urgent in hospital data when the patient is assessed by a triage nurse upon arrival at the ED as needing to see a physician in a time frame greater than 2 hours but less than 24 hours, presumably giving the patient time to go elsewhere.

[3] Among adults age 19 to 64 covered by Medicaid for the entire year, 35.9 percent reported making at least one ED visit. Of these, about one in four (8.7 percent of all Medicaid enrollees), explained their visit using reasons related solely to provider access. These reasons were "occurred at night or on a weekend" and "doctor's office/clinic was closed." The 8.7 percent excludes individuals who reported that they were taken to the ED by ambulance, whose doctor advised them to go, and whose visit resulted in an admission. These statistics are extracted from Table 26 of MACStats in the March 2014 report to the Congress (MACPAC 2014).

[4] NCHS changed its procedures and instructions to hospitals for classifying events by payer when multiple payer sources are possible. Specifically, until 2005 hospitals were instructed to select only one payment source where two were possible, using a hierarchy to determine the primary expected source (NCHS 2003, page 86). Beginning in 2005, hospitals were instructed to record all payment sources (NCHS 2005, page 103). In addition, the payer variable reflects the hospital's "expected primary source of payment" for the visit rather than the source determined from payment reconciliation. Hospitals can reasonably be expected to change their strategy over time for selecting between Medicaid and other payers to reflect evolving practices for documenting uncompensated care and wider billing practices.

[5] Proportions and standard errors for this calculation were taken from NCHS 2013, Table 87.

[6] MACPAC conducted a multivariate analysis of these trends between 2009 and 2012 and found no significant change in the percentage of full-year insured Medicaid enrollees over age 18 with one or more ED visits in the past year, after controlling for changes in the composition of Medicaid enrollment based on age, sex, and health status. There was a decline in the adjusted percentage with four or more ED visits between 2009 and 2012, but the trend was not statistically significant.

[7] MACPAC conducted a multivariate analysis of these NHIS trends from 2009 to 2012 among full-year insured enrollees and established that the declines observed in unadjusted percentages were not due to changes in the composition (based on age, sex, or health status) of Medicaid enrollees age 18 and younger.

[8] These access measures and reasons for delayed care can be found in MACStats Tables 24–27 in the March 2014 MACPAC report to the Congress (MACPAC 2014).

[9] The three studies cited in the text confirmed this association for Medicaid enrollees, and one of these studies found that Medicaid enrollees experienced higher ED use than privately insured enrollees for the same number of barriers reported (Cheung et al. 2012).

[10] The three studies cited used different data sources, time periods, and populations to examine ED use. Taubman and colleagues (2014) used several methods to compare the ED results across studies, and attributed the earlier results of no change in ED use to incorrect recall of events by enrollees responding to the surveys. Taubman and colleagues relied on administrative data from EDs and were able to accurately identify the site of care and timing of events in relation to enrollment.

[11] The states that expanded Medicaid and the years of implementation were Arizona (2002), Illinois (2002, 2004, 2006), Tennessee (2002), Connecticut (2005), Colorado (2006), Maine (2006), Maryland (2008), and New Jersey (2008).

[12] California's Medicaid Section 1115 waiver, called the Bridge to Reform, established LIHP, which provided comprehensive benefits from July 1, 2011 to December 31, 2013, to low-income individuals age 19 to 64 who were ineligible for other federal and state coverage programs and were legal residents living in the United States for more than five years. LIHP essentially extended coverage provided by the Health Care Coverage Initiative (HCCI), which was established under the same waiver and provided coverage from September 1, 2007 to August 31, 2010. For more details about these programs, see http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/Pages/default.aspx.

[13] Some programs reported no change in ED use per capita or could not determine effects of their program due to numerous confounding factors. See, for example, the ED Grant Summary for Colorado describing the Peak Vista Community Center intervention (CMS 2013b).

[14] Federal statute prohibits states or their contractors from imposing cost sharing on emergency services (as defined by EMTALA) for Medicaid enrollees under 100 percent of poverty level, but authorizes cost sharing on non-emergency use of the ED by non-exempt populations (42 USC §§1396o, 1396o-1). Statute prohibits all cost sharing for certain exempt populations, including children, pregnant women, and most individuals residing in institutions. EMTALA is the Emergency Medical Treatment and Active Labor Act (42 USC §1395dd). EMTALA requires most hospitals to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay, when a patient presents to an emergency room for attention to an emergency medical condition.

[15] Another study found reductions in non-urgent ED use over the period 2001–2009 using the NHAMCS data, but this study has not been peer-reviewed (Sabik and Gandhi 2014). Mortenson (2010) conducted a rigorous test of non-emergency ED use by Medicaid beneficiaries on a monthly basis before and after states made changes to copayment policy over the period 2001–2006; the study compared the change in use to the change in ED use in states that made no policy change, a difference-in-difference method.

[16] These initiatives were (1) the Frequent Users of Health Services Initiative, jointly funded by the California Endowment and the California Health Care Foundation, and (2) the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) Super Utilizer Initiative. For a description of the 10 AF4Q super utilizer sites, go to http://www.camdenhealth.org/cross-site-learning/project-locations.

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APPENDIX B

National Emergency Room Utilization Topic Resources

National Emergency Room Utilization Topic Resources

CMCS Information Bulletin July 24, 2013 – Available at

http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf

CMCS Information Bulletin January 16, 2014 – Available at

http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf

Emergency Care: Then, Now, And Next – Available at

http://content.healthaffairs.org/content/32/12/2069.full

Efforts to Divert Non-Urgent ER Use to Alternate Providers, Focusing on Providing Better Care and Lower Costs – Available at

http://www.hhs.gov/asl/testify/2011/05/t20110511a.html

Emergency Department Visits – Available at

http://www.cdc.gov/nchs/fastats/emergency-department.htm

Majority of Dental-Related Emergency Department Visits Lack Urgency and Can Be Diverted to Dental Offices – Available at

http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx

APPENDIX C

EMTALA Statutory Language

Source: www.EMTALA.com

42 U.S. Code § 1395dd - Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

- **(A)** within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
- **(B)** for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

(A)

(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x (r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x (r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition,

observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a (a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a–7a (a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc (a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation
The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions
In this section:
(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)

(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by

(or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who

(A) has been declared dead, or
(B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x (mm)(1) of this title).

(f) Preemption
The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination
A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

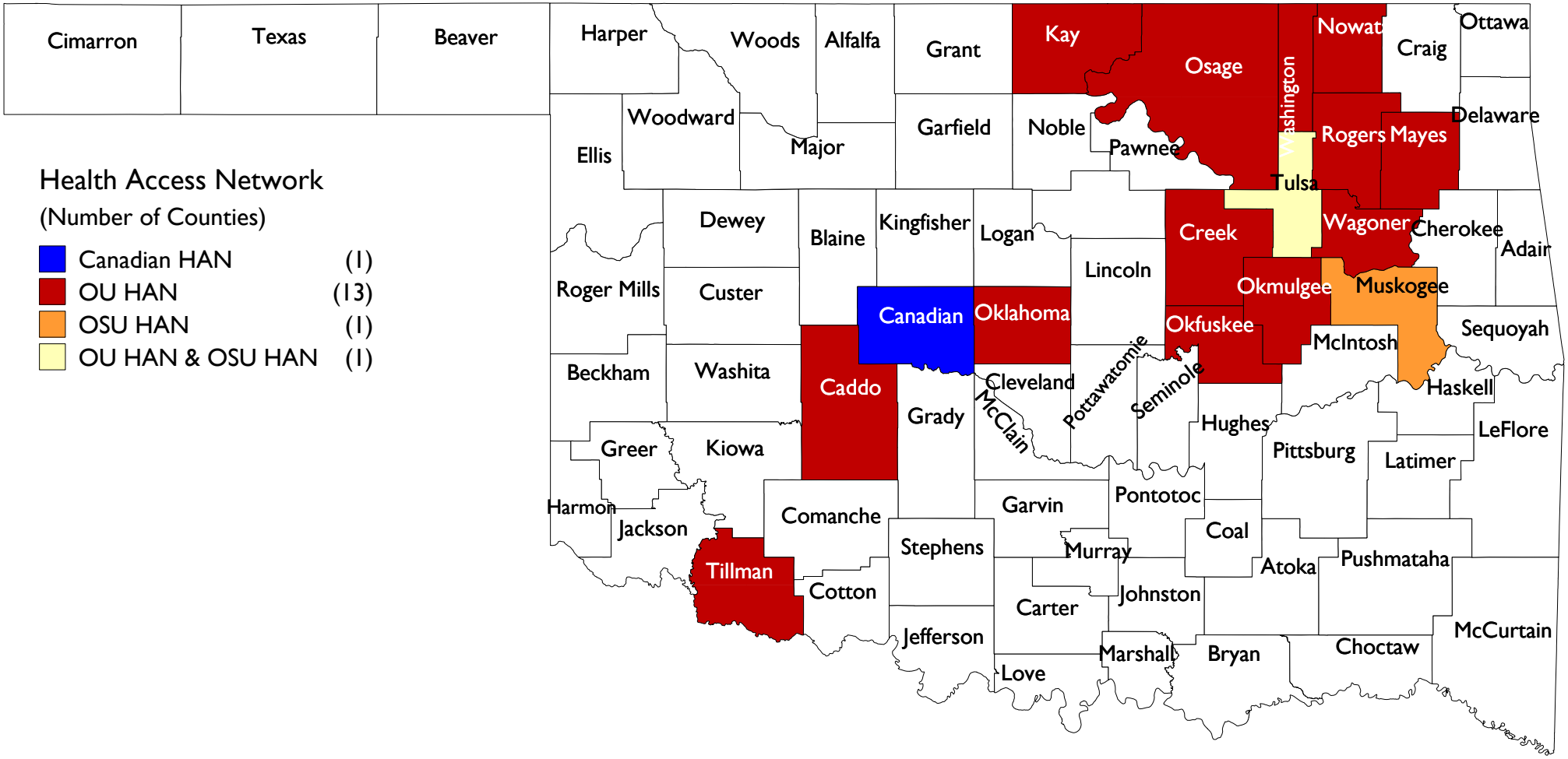
(h) No delay in examination or treatment
A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections
A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

APPENDIX D

Health Access Networks (HANs) Map

Health Access Network



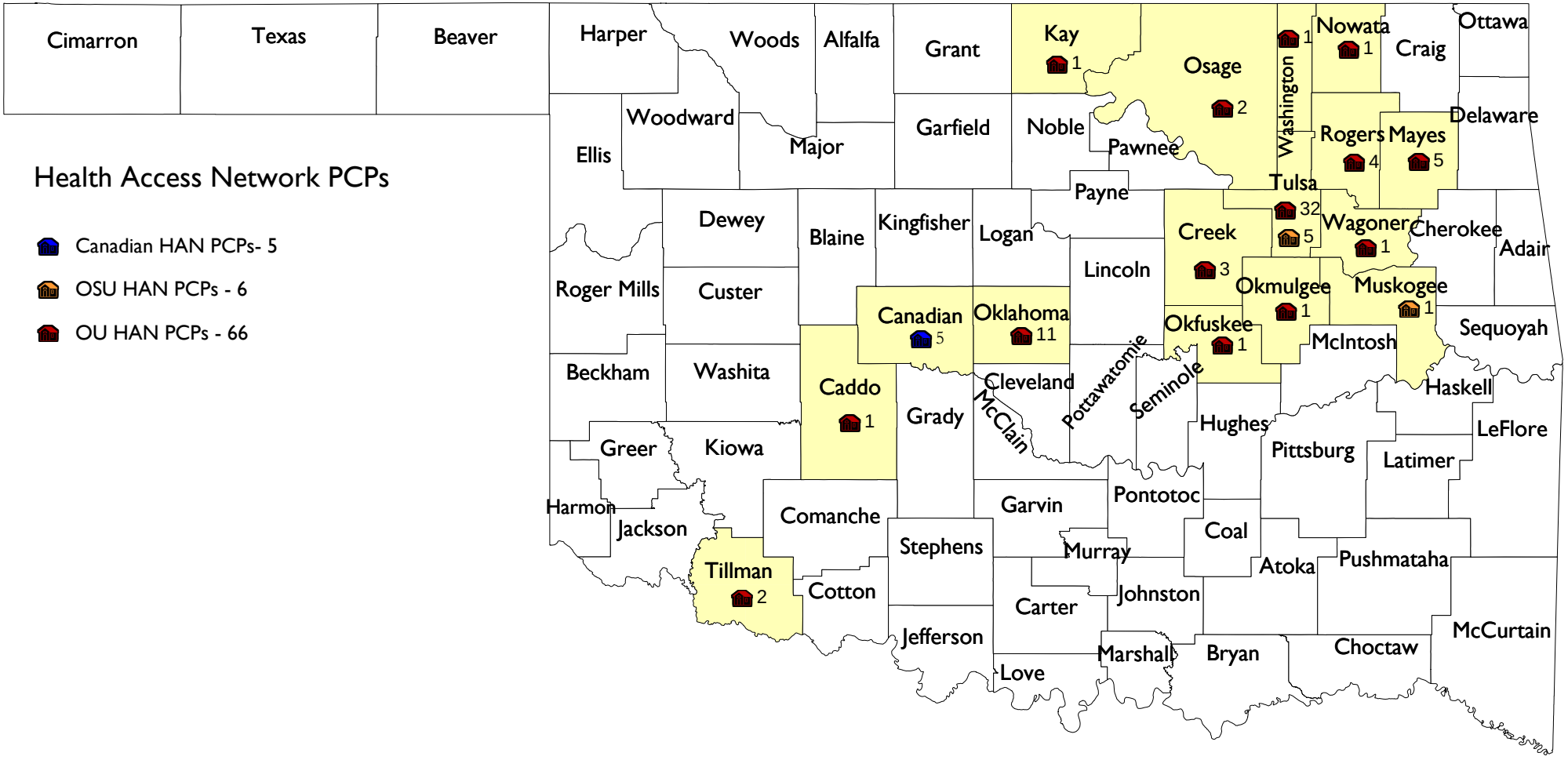
Health Access Network

(Number of Counties)

Canadian HAN	(1)
OU HAN	(13)
OSU HAN	(1)
OU HAN & OSU HAN	(1)

10/23/2013

Health Access Network PCPs



APPENDIX E

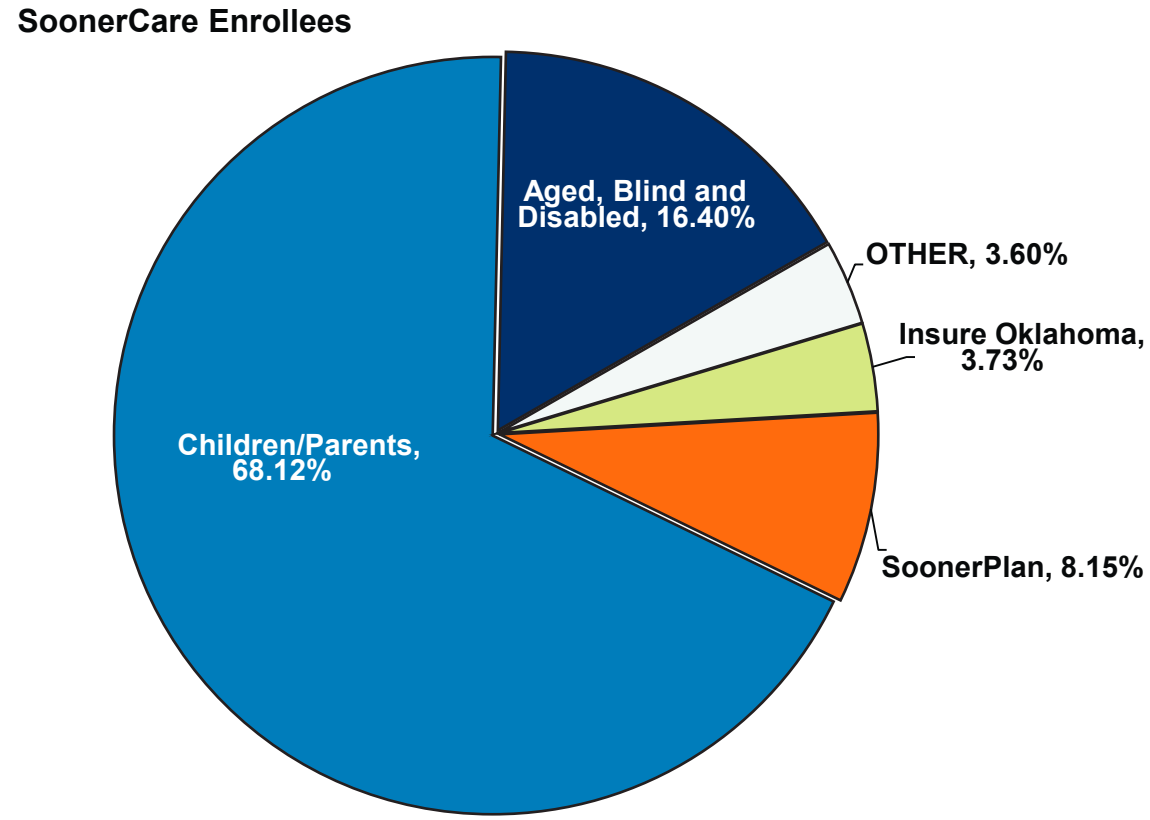
Oklahoma Health Care Authority

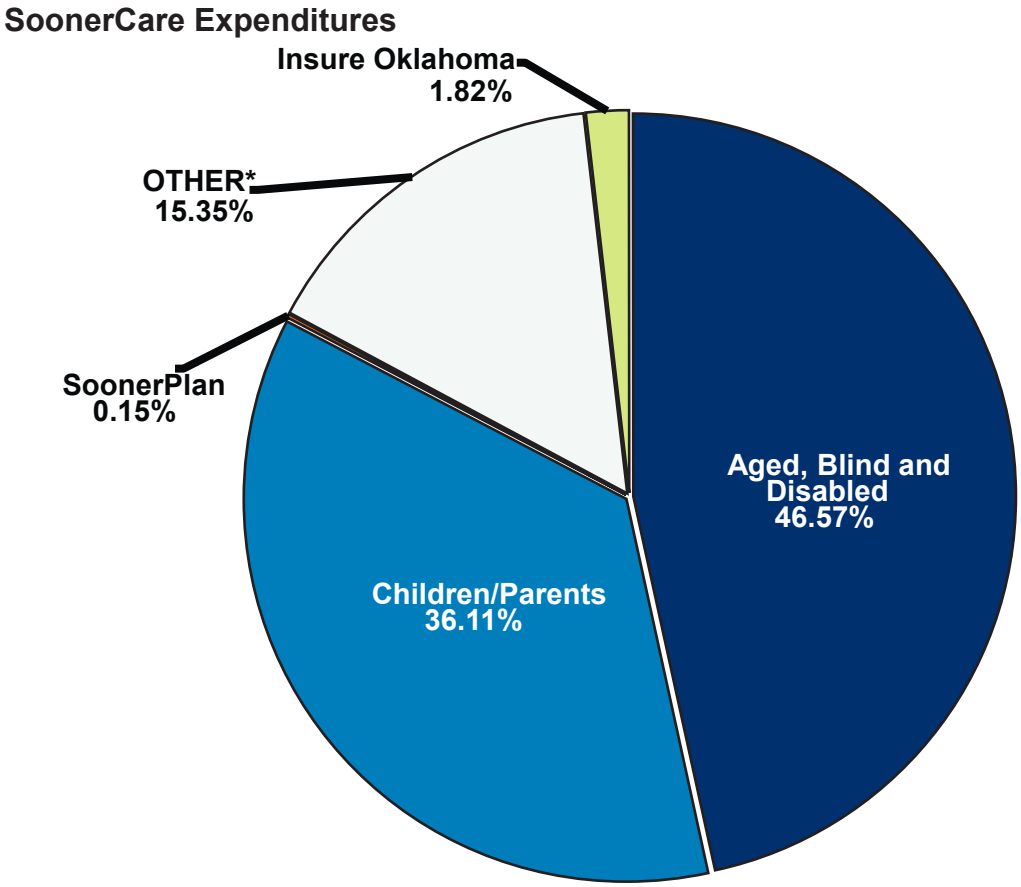
SFY2014 Annual Report

Figure 12 - SoonerCare Enrollees and Expenditures by Aid Category Percentages

Source:
http://www.okhca.org/research.aspx?id=84&parts=7447

Figure 12 SoonerCare Enrollees and Expenditures by Aid Category Percentages





Other enrollees and expenditures include — Refugee, PKU, Qualifying Individual Group One, Service Limited Medicare Beneficiary, Developmental Disabilities Services Division, Supported Living, Soon-to-be Sooners and Tuberculosis members. Children/Parents include child custody. Aged, Blind, Disabled include Tax Equity and Financial Responsibility Act enrollees and expenditures. Other expenditures also include Supplemental Hospital Offset Payment, GME/IME/DSH and Hospital Supplemental payments.

APPENDIX F

Oklahoma Health Care Authority

SFY2014 Emergency Department Fast Facts

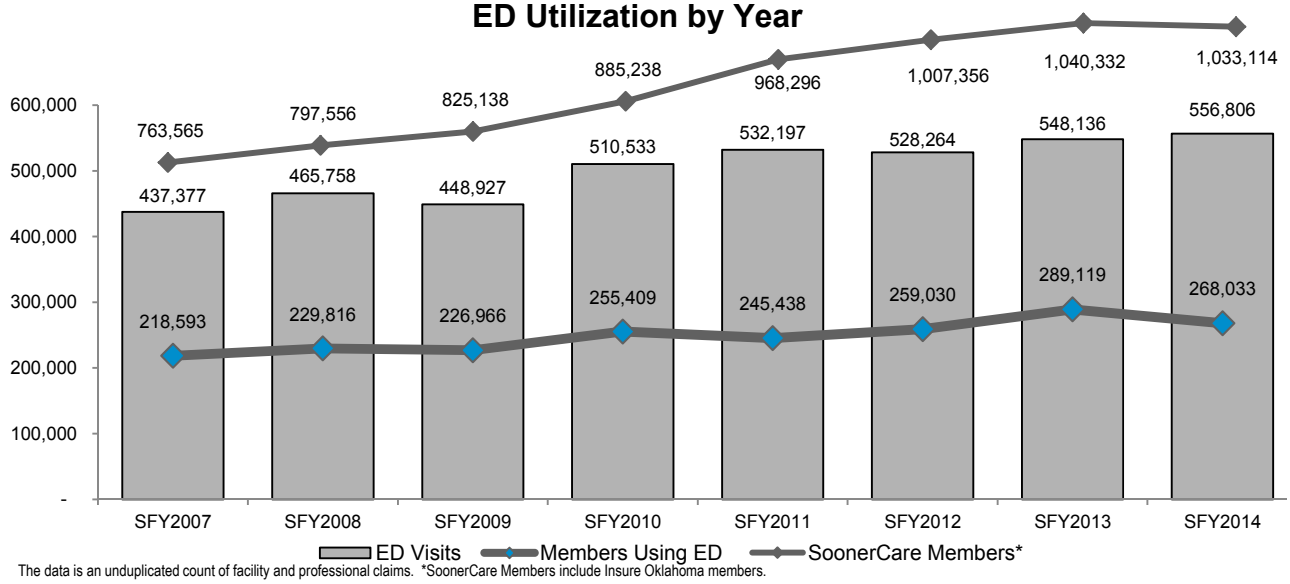
Source:
http://www.okhca.org/research.aspx?id=87&parts=7447

Emergency Department Fast Facts

State Fiscal Year 2014

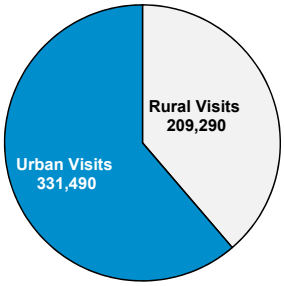
The Emergency Department (ED) Fast Facts provides a summary of SoonerCare ED visits. This summarizes physician, facility ED charges and overall ED utilization by SoonerCare members. No ancillary or SoonerCare Supplemental (Dual Enrollees) costs are included unless otherwise specified.

ED Utilization by Year



The data is an unduplicated count of facility and professional claims. *SoonerCare Members include Insure Oklahoma members.

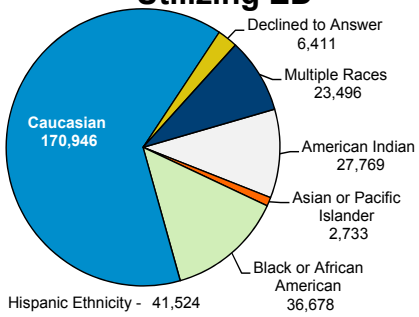
ED Visits by Location



Total Members Utilizing ED	
268,033 (26%)	
Adult	Child
81,425	186,608
Male	Female
113,603	154,430

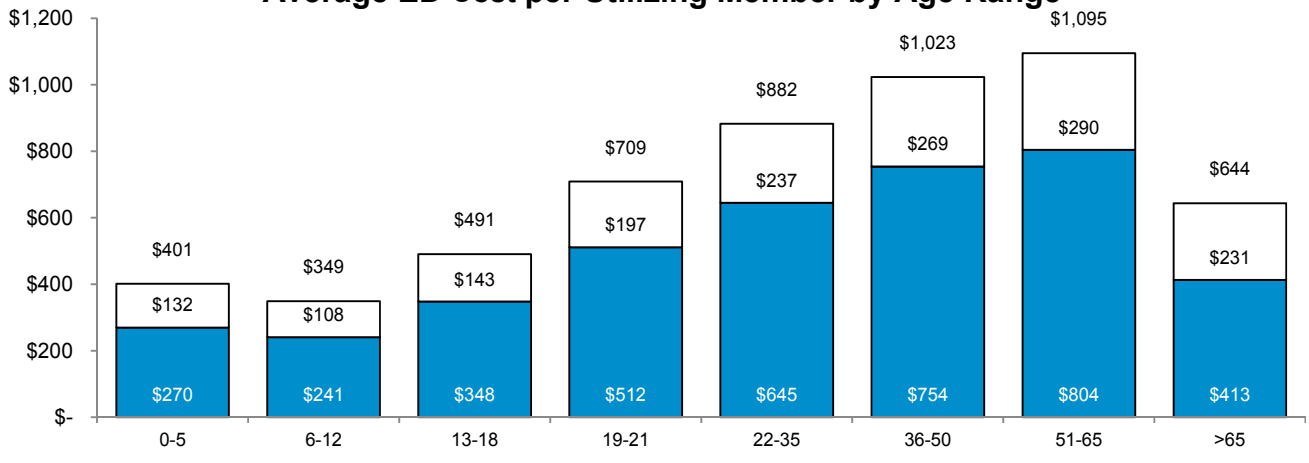
Facility location based on county of billing provider. Urban/rural designation by county is defined by Metropolitan Statistical Area (MSA) data and definitions adopted by the U.S. Health and Human Services Office of Rural Health Policy (ORHP/HHS). Excludes out of state location.

Race Breakdown of Members Utilizing ED



Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Average ED Cost per Utilizing Member by Age Range

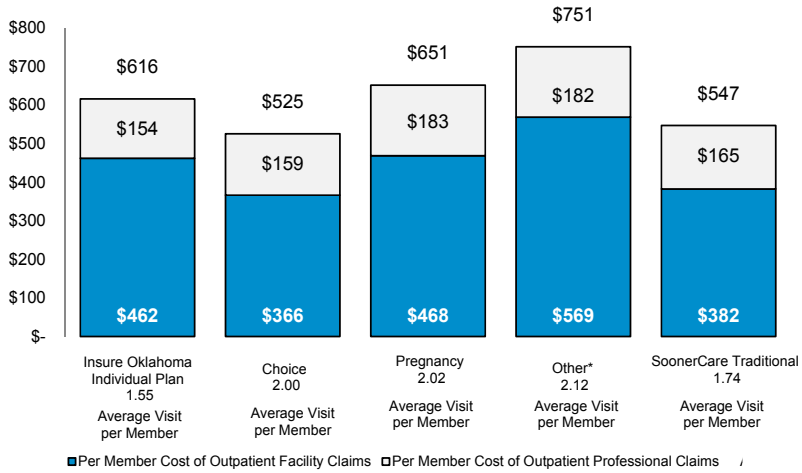


The greater than 65 age range contains a large percentage of members with both Medicaid and Medicare (SoonerCare Supplemental/Dual Enrollees) coverage. OHCA only pays the co-pay and deductible for SoonerCare Supplemental, which accounts for the relative decline in cost for members 65 and older.

Emergency Department Fast Facts

State Fiscal Year 2014

Average ED Cost Per Utilizing Member by Benefit Program

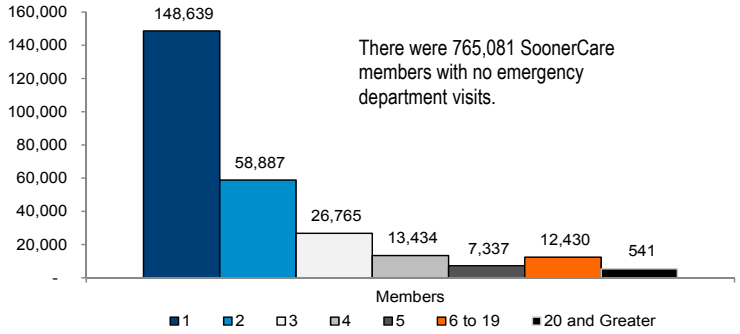


Total ED Cost*
$151,584,802
Average per Visit Cost
$264.98
Average Visit per Utilizing Member
2.08

*The Total ED Cost does not include ancillary services. The total ED cost with ancillary services was $190,540,765.

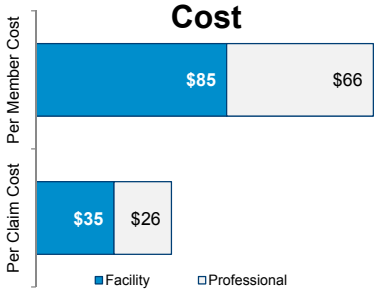
*The Other category includes waiver and custody. It also contains very few members and therefore susceptible to larger variances in per member cost from year to year.

Members by Number of ED Visits



Visits are based on facility claims only.

SoonerCare Supplemental* Cost



*SoonerCare Supplemental is a benefit plan for members enrolled in both Medicare and Medicaid (Dual Enrollees), SoonerCare Supplemental pays the Medicare coinsurance and deductible and provides medical benefits that supplement those services covered by Medicare.

First 10 Listed Diagnosis for Children	Visits
Acute Upper Respiratory Infections Of Unspecified Site	26,820
Unspecified Otitis Media	22,301
Fever, Unspecified	12,321
Acute Pharyngitis	11,183
Unspecified Viral Infection	6,777
Vomiting Alone	6,211
Other And Unspecified Noninfectious Gastroenteritis And Colitis	5,354
Urinary Tract Infection, Site Not Specified	5,088
Asthma, Unspecified Type, With (Acute) Exacerbation	4,791
Head Injury, Unspecified	4,457

First 10 Listed Diagnosis for Adults	Visits
Other Current Conditions Classifiable Elsewhere Of The Mother, Antepartum Condition Or Complication	5,719
Abdominal Pain, Unspecified Site	5,602
Urinary Tract Infection, Site Not Specified	5,454
Headache	4,799
Chest Pain, Unspecified	4,443
Other Chest Pain	3,787
Lumbago	3,446
Abdominal Pain, Other Specified Site	2,838
Acute Pharyngitis	2,787
Acute Bronchitis	2,714

For this report CHILD is defined as an individual age 20 and younger. This publication is authorized by the Oklahoma Health Care Authority in accordance with state and federal regulations. OHCA is in compliance with the Title VI and Title VII of the 1964 Civil Rights Act and the Rehabilitation Act of 1973. For additional copies, you can go online to OHCA's web site www.okhca.org under Research/Statistics and Data (www.okhca.org/research/data). The Oklahoma Health Care Authority does not discriminate on the basis of race, color, national origin, gender, religion, age or disability in employment or the provision of services. Data was compiled by Reporting and Statistics as of the report date and is subject to change.

APPENDIX G

Emergency Room Diversion Grant Program

Participating State Summary Templates

Colorado

Emergency Room Diversion Grant Summary – COLORADO

Project(s): Peak Vista Community Health Centers
Setting(s): Intervention in large, busy urban emergency room in Colorado's second largest city

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with Alternate Care Sites/ Extended Hours of Operation	Hospital & community health center collaborated to recommend non-emergent ER clients use primary care setting for their next visit Extended hours made available at alternate sites.	Clients accepted diversion to medical home site with many reminders and much encouragement. ER visits per capita did not decrease in the study population.	Yes	Medicaid claims data (quantitative). Data collected as part of study (quantitative).
Education/ Outreach/ In-Person Intervention	Alternate sites advertised. Transportation vouchers offered.	Transportation vouchers not accepted by clients.	No	Qualitative data reported by Project staff.
Health Technology	Electronic appointment system used to efficiently manage increase in client visits.	Clients accommodated for visits.	Yes	Qualitative data reported by Project Staff.
Comments				
	Other emergency rooms in urban area not part of study.	Unable to positively link effects of study to increase in ER visits by study population due to multiple confounding variables.	N/A	

Emergency Room Diversion Grant Summary – COLORADO

Project(s): Valley-Wide Health Systems, Inc.
Setting(s): Rural community & migrant health site in southern Colorado

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Collaboration with Alternate Care Sites/ Extended Hours of Operation	A Federally Qualified Health Center (FQHC) was built and staffed near the only emergency room for miles around. Extended hours were also provided.	Yes. High demand and high use.	Yes.	N/A
Education/ Outreach/ In-Person Intervention	Advertising to local communities about availability of extended clinic hours, appointments on short notice and walk-in hours.	"Word-of mouth" and advertising resulted in a large demand by the community to use the FQHC before going to the ER (when appropriate).	Yes.	N/A
Health Technology	Efficient use of the appointment system to find time slots to meet clients' needs	The enormous demand for services was met. We also periodically adjusted the hours of operations to meet clients' needs.	Yes.	N/A
Comments	Given opportunity, clients self-referred to alternative care site without going to ER.	Appears to have played a role in reducing per capita ER use for non-emergent visits.	N/A	N/A

Illinois

Emergency Room Diversion Grant Summary – ILLINOIS

Project(s): Emergency Room Diversion Program
Setting(s): Urban and Rural sites

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with Alternate Care Sites/ Extended Hours of Operation	Hospitals formed collaborations with clinics within or near the hospital as alternate care sites for nonemergency visitors presenting in an ER. Alternate care sites agreed to extend operations past 5:00 p.m., and offer weekend hours with increased staff capacity. Individuals with mental illness (MI) or substance abuse disorders were diverted to the integrated health center for care and triage. Collaboration with local police and hospitals helped re-route patients with MI to the "living room" facility designed specifically for mental health care.	Diversion to clinics in appropriate situations was successful to an extent but remains a challenge because ER care remains free for most patients, while in some cases primary care visits require a co-payment. That difference continues to fuel patient choice about where to receive care. The program did work initially, but due to the increased time required to transport clients to the integrated health center, there was a decline in community involvement. Police and advocates sought treatment for mentally ill clients at the closest location rather than the integrated health center.	Parts of the program are continuing. However, a lack of funding is limiting our ability to reach all our initial goals. The program continues to work with community organizations to develop ways of treating the mentally ill.	Qualitative

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Education/ Outreach/ In-Person Intervention	Outreach by hospitals included pamphlets and referral cards in the ER emphasizing the proper use of the ER. Informed patients of the availability of our 24 hour Nurse Triage lines.	Despite the support from community partners, the short time frame for implementation of the grant made it difficult to change the community culture and to change patterns of behavior.	Yes	Qualitative
Health Technology	Establishing or enhancing Electronic Health Record (EHR) systems that allowed staff to place an alert in the patient's EHR that notified the provider or community health worker of repeat ER visits.	Since the sites are still in the implementation phases of HIT at this time, there is not enough information to analyze. However, it is expected to create a better care system between all collaborations in the health needs of the client.	Yes	Qualitative
		Comments		

Indiana

Emergency Room Diversion Grant Summary – INDIANA

Project(s): Indiana Partnership for Alternatives to Emergency Room Services
Setting(s): Urban - St. Catherine Hospital, East Chicago, Indiana

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with Alternate Care Sites/Extended Hours of Operation	Grant funds were used to provide services in an urgent care clinic located on the hospital campus next to the emergency department. Patients were able to walk in one door for the emergency department and another door for the clinic.	The location did not have the volume necessary to sustain the clinic. While several patients used the clinic instead of the emergency department services, the clinic had to rely on the grant funding to stay open.	No	Qualitative and Quantitative
Education/ Outreach/In-Person Intervention	Pamphlets were provided in the emergency department and patient navigators were used in the clinic to encourage appropriate use of services and to connect members with primary care. An advertising campaign was also used including billboards radio and print advertisements.	Yes, many of the clinic visitors heard about the clinic because of the advertising campaign	No, the clinic closed	Qualitative
Health Technology	N/A	N/A	N/A	N/A

Emergency Room Diversion Grant Summary – INDIANA

Project(s): Indiana Partnership for Alternatives to Emergency Room Services
Setting(s): Wishard Health Services, Indianapolis, Indiana

Primary ER Diversion Categories	Project Strategises	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Collaboration with Alternate Care Sites/Extended Hours of Operation	The grant was used to fund services provided at an urgent visit clinic located in the zip code of Medicaid members who frequently use the emergency department. Advertising, patient education and patient navigators were used to help the Medicaid population who used the clinic to connect with primary care for non-emergency services.	Data did not show a decrease in the overall emergency department utilization; But an exit survey given to clinic patients indicated that if the clinic did not exist they would have gone to the emergency department for care.	Yes, the clinic is still operating today.	Both quantitative and qualitative data
Education/Outreach/ In-Person Intervention	Pamphlets were available in the emergency department and the clinic providing patient education and the location of the clinic for a specific list of non-emergency services. At the clinic, Patient Navigators would connect the members to primary care and instruct members on using their PCP or the clinic instead of the ED. A media campaign was also in place to advertise the clinic location and extended hours.	The evaluation did not include the provider education pamphlets.	N/A	N/A
Health Technology	N/A	N/A	N/A	
Comments				

Maryland

Emergency Room Diversion Grants Summary – MARYLAND

Project(s): Primary Care Coalition (PCC) Primary Care Connect Project
Setting(s): Multiple hospitals and clinics in Montgomery County, Maryland

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with Alternate Care Sites/ Extended Hours of Operation	Hospitals formed collaborations with nearby primary care clinics associated with the hospital, with an agreement to attempt to send nonemergency visitors presenting in an ER to new or existing clinics. Flexible primary care clinic hours	Yes	Yes	Quantitative (logistic regression on likelihood to return to ER)
Education/ Outreach/ In-Person Intervention	Assigned case managers to frequent ER users and/or other targeted ER populations to establish continuity of care (i.e. 'medical home')	Yes	Uncertain	Qualitative
Health Technology	Attempted to standardize systems	No	No	Qualitative
Comments	Challenges in developing standard protocol for referral and connecting various Electronic Health Record systems.			

Missouri

Emergency Room Diversion Grant Summary – MISSOURI

Project(s): Missouri Primary Care Home Initiatives
Setting(s): Urban - Emergency departments throughout St. Louis

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with and Establishment of Alternate Care Sites with Extended Hours of Operation	The MO HealthNet Division collaborated with the St. Louis Integrated Health Network (IHN). IHN partnered with two St. Louis hospitals to participate in the Community Referral Coordinator (CRC) Program. The CRC Program provides a coordinated process for referring emergency department patients to a primary care home.	The CRC program has expanded from the initial pilot sites to seven local hospitals and the program is piloting an expansion into inpatient settings. The percent of CRC encounters resulting in a health center appointment increased. The cost per encounter and the cost per kept appointment dropped.	A number of the hospitals have adjusted their processes to accommodate the CRCs. The CRCs have developed relationships with hospital staff and become part of the general flow of the ED or the hospital inpatient ward. The CRCs have also been allowed access to patient medical records or the ability to general reports on targeted patients.	The IHN engaged the National Opinion Research Center (NORC) to evaluate the Primary Care Home Initiative. NORC analyzed encounter and referral data.
Education/Outreach/ Personal Intervention	The Community Health Education and Empowerment component equips patients with the resources to navigate the network of health care services and assists providers in sustaining high quality services.	The CRC increased awareness for patients of the measures that health centers have taken to become more accessible.	The CRC program is providing a satisfactory experience for the patient and is achieving the goal of connecting patients to primary care services.	NORC conducted focus groups and key informant interviews with stakeholders participating in the CRC program during an in-person site visit.

Emergency Room Diversion Grant Summary – MISSOURI

Health Technology	The Network Master Patient Index (NMPI) component enables exchange of essential patient information across providers.	This initiative strengthened and facilitated communication among safety net providers.	The CRC program has assisted in improving communication between hospitals and health centers, prompted a health information exchange initiative, and brought systemic inconsistencies to the forefront.	NORC conducted focus groups and key informant interviews with stakeholders participating in the CRC program during an in-person site visit.
Comments	N/A			

New Jersey

Emergency Room Diversion Grant Summary – NEW JERSEY

Project(s): ED Community Partnership for Express Care and Case Management (New Jersey)
Setting(s): Newark Beth Israel Medical Center/Newark Community Health Centers; Monmouth Medical Center/Monmouth Family Health Center

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Collaboration with Establishment of Alternate Care Sites/ Extended Hours of Operation	Each pilot hospital formed a collaboration with a nearby federally qualified health center, (FQHC) based on an memorandum of understanding (MOA), to refer nonemergency patients for a follow-up visit-- if they do not have or cannot access their own primary care provider. Pilot hospitals also formed partnerships with Medicaid managed care organizations for assistance in connecting patients to primary care providers in their network and providing additional assistance. Partnering FQHCs increased capacity by adding clinical staff to ensure additional and convenient follow-up appointment times with expanded service hours (e.g., after 5:00 p.m. and Saturday hours). FQHCs also incorporated features needed to serve as patients' medical home. These included: Use of the same providers for a patient's care to the extent possible; access to providers by phone or in person 24/7 and extensive case management, care coordination, etc.	Yes, the collaborations were successful and nearly 9,000 follow-up visits were set at the partner FQHCs. Increased capacity and expanded evening and weekend hours helped provide needed access to primary care services for referred patients. Medical home features and their utilization by patients were successfully increased, including phone access and language services.	Yes, hospitals and FQHCs continue to communicate. Extended hours were justified by increased primary care patient volume.	Quantitative data – patient data tracking Quantitative data – organizational data reports Quantitative data – medical home survey Qualitative data – pilot site narrative reports

Emergency Room Diversion Grant Summary – NEW JERSEY

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Education/ Outreach/ Personal Intervention	During the ER Express Care discharge process and continuing at the FQHC, clinicians and social workers educated patients on the appropriate site of care for various healthcare needs. The importance of using a medical home for primary care services, and contacting their PCP after-hours before going to the ER and limiting ER visits to true emergency situations were also explained. Education messages were targeted to address high volume patient needs, such as medication refills and "doctor's notes"/pregnancy documentation, followed by informing them of the availability of such services at the FQHC. Brochures about "When Should I Go to the Emergency Room?" were distributed in English and Spanish as part of patient education. One FQHC distributed thermometers to new parents, demonstrating how to assess their infants' fevers and discuss it with providers, such as a 24-hr nurse line, before going to the ER. Coupons were distributed at one site to cover the fee for the first FQHC referral to encourage patients to keep their appointments. Education and support was extended to the community at large, with one site allowing walk-ins to get assistance from the project's social worker with scheduling health center appointments, etc. The other site educated new patients to the area, as well as patients of non-project clinicians, about the importance of	Yes, ER utilization for primary care needs, particularly repeat ER utilization, decreased. ER wait times decreased; FQHC volume increased; and FQHC show rates increased significantly among those who showed for their first FQHC visit. Pilots reported that as more and more providers bought into the goals and success of the project, non-project clinicians began to request education of their patients on the concepts of a medical home. Pilots reported that non-project patients requested to see the	Hospitals and FQHCs continue to educate patients. Additional FQHCs are now distributing the ER brochure. Case management is an ongoing feature of the FQHCs' medical home services.	Quantitative data – patient data tracking Quantitative data – organizational data reports Quantitative data – provider satisfaction surveys Qualitative data – pilot site narrative reports

Emergency Room Diversion Grant Summary – NEW JERSEY

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
	a medical home and assisted them with establishing regular care at the FQHC. ER clinicians and FQHC physicians offered patients appropriate care coordination and case management services, including reviewing patient medications, screening for chronic diseases, behavioral health and other co-morbidities. Any special health needs and appropriate referrals to specialty care and disease management programs were done as needed. Case managers at both the ER and FQHC coordinated patient care and arranged transportation and other support services when needed. ER case managers tracked and monitored ER utilization, identifying repeat ER users and determined their reasons for using the ER. At the same time FQHC case managers tracked compliance with follow-up visits and helped patients resolve barriers to using appropriate care sites. ERs, FQHCs and Medicaid HMOs maintained ongoing communication to track patient utilization patterns and coordinate efforts for outreach, educating, addressing barriers and extending additional support services as needed.	Project social workers scheduled health center appointments (in lieu of having an ER visit), because education and information had been shared by word-of-mouth.		

Emergency Room Diversion Grant Summary – NEW JERSEY

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Health Technology	ERs were connected electronically with FQHC appointment systems through a secure Web-based link, allowing ER clinicians to set patients for follow-up appointments at the partner FQHCs. Electronic interface also allowed ER clinicians to share patient information and clinical notes/summary with FQHCs. Project database at each site assisted ER staff in identifying repeat ER visits.	Yes, ERs and FQHCs were successfully connected for appointment setting and patient information sharing	Yes, this connectivity continues to be utilized across all sites.	Qualitative – pilot site narrative reports
Comments	N/A	N/A	N/A	N/A

North Carolina

Emergency Room Diversion Grant Summary – NORTH CAROLINA

Project(s): Improved Access to Non-Emergent Care Initiative in North Carolina
Setting(s): Rural

Primary ER Diversion Categories	Project Strategizes	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Collaboration with Alternate Care Sites/ Extended Hours of Operation	Approaches included creating open access policies that allowed clients calling for an appointment or walking into the clinic to be seen the same day; Enhanced primary care accessing with after-hour services, (past 5:00 pm) and week-end hours.	Mostly on high end users.	Yes.	All phases used pre and post design by comparing nonemergency emergency department (NEED) rates between treatment and control groups.
Education/ Outreach/ In-Person Intervention	Provided informational and educational materials about proper use of medical homes. Some practices gave referrals for follow up so patient could take preventive health measures such as vaccinations and well visits for children. In Phases II & III, Patient Navigators (PNs) gave patients information and materials about the services in their medical homes. Several sites developed care packages that included thermometers and first aid materials as a way of introducing patients into self-management practices. Similar procedures were used in Phases II/III.	Mostly on high end users.	Yes.	Same as above.

Emergency Room Diversion Grant Summary – NORTH CAROLINA

Primary ER Diversion Categories	Project Strategizes	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Health Technology	Both Phase I and Phases II/III sites worked within the already existing structure of Community Care Networks (called CCNC).	Yes. System already in place.	Yes.	N/A.
Comments	The NC ER Diversion initiative involved complex and varied arrangements that took place within the already existing Medicaid managed care structure (CCNC). (in existence for 15yrs.) We used rigorous methodologies (e.g., trend and cohort analyses involving pre-post intervention comparisons between treatment and control groups). Partially because control groups were comprised of CCNC patients, it was hard for the treatment group to show any statistically significant greater benefits than the control groups. All Medicaid managed care patients were already experiencing care aimed to reduce the use of ER and hospitals for non-emergencies. Yet the grant did show some success when intervention targeted patients who had already used the ER for non-emergencies on multiple occasions.			

North Dakota

Emergency Room Diversion Grant Summary – NORTH DAKOTA

Project(s): Emergency Diversion Project
Setting(s): Rural

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Collaboration with Alternate Care Sites/ Extended Hours of Operation	N/A	N/A	N/A	N/A
Education/ Outreach/ Person Intervention	An education campaign was created and used. Posters and flyers were produced to educate individuals on the proper use of the ER. They were distributed through hospital and school mailings.	The results were varied. One facility had a decrease in ER use. The other ER showed an increase at the other facility. We had some outside influences that affected these results.	The brochures are still available for use.	We used quantitative data with using set timeframes and patient data.
Health Technology	N/A	N/A	N/A	N/A
Comments				

Oklahoma

Emergency Room Diversion Grant Summary – OKLAHOMA

Project(s): Community Health Centers, Inc. ER Diversion Project
Setting(s):

Primary ER Diversion Categories	Strategises	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Collaboration with and Establishment of Alternate Care Sites with Extended Hours of Operation	The Oklahoma Care Authority (OHCA) collaborated with the Community Health Centers, Inc. (CHCI), which operates four Federally Qualified Health Centers (FQHCs). One of the FQHCs (Klaasen) added extended hours, and another FQHC (Mary Mahoney) had already implemented extended hours. CHCI also collaborated with St Anthony Hospital's (SAH) and Oklahoma University Medical Center's (OUMC) Emergency Departments. SAH also collaborated with CHCI Homeless Health Care site to reduce homeless individuals' ED use and encourage primary care. OUMC also contracted with CHCI for a Community Health Workers (CHW) in ER diversion for homeless, Medicaid, Medicare, and uninsured individuals.	The extended hours at the Perry Klaassen Clinic were underutilized. That was also the experience with late hours, one day a week, at the CHCI Mary Mahoney site. Patients usually did not schedule appointments any later than 6 pm.	The Mary Mahoney site had long established extended hours of operations which will continue; Klaassen Family Center returned to business hours.	CHCI reviewed patient appointment schedules and their previous experience with longer hours at the Mary Mahoney site. Progress reports included quantitative data on "after-hours" appointments.

Emergency Room Diversion Grant Summary – OKLAHOMA

Primary ER Diversion Categories	Strategises	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Education/Outreach / Personal Intervention	CHCI hired four Community Health Workers (CHW) based at two metropolitan hospitals, a Health Promotion Specialist (HPS), and a Board Certified Internal Medicine Physician. The CHWs were responsible for helping patients navigate through the health care system to ensure access to health services at the appropriate level. This also included connecting to other critical community services, including transportation. CHCI developed targeted educational and informational materials to support this undertaking. The HPS assisted the medical provider in improving patient outcomes, especially for those with chronic conditions.	Mixed. CHW found underlying conditions such as mental illness and substance abuse. Also, a number of ED visits were for dental care. CHCI provided a listing of over 1,000 patients seen with this program to the OUMC to track ER usage. According to these data from 6/1/2009 -- 12/31/2009; 74% of patients did not return to the ER since the CHW intervention. CHCI also provided a list of over 703 patients for the same period to SAH to track ER usage. According to the records, 95% of these patients have returned to the ER at least once since the CHW intervention.	Yes, using patient education materials such as pamphlets and waiting room television programs, along with materials in an exam room provided appropriate use of the ER education. CHCI plans to continue its focus on reducing unnecessary ER use.	Data analysis of the individuals OHCA identified, in the beginning of the grant period, as high ER utilizers.

Emergency Room Diversion Grant Summary – OKLAHOMA

Primary ER Diversion Categories	Strategises	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
Health Technology	Patient registry tracked patient outcomes, including some in-patient access. One CHCI physician had access to electronic medical records (EMR). CHWs used a modification of the High Risk Assessment form for intake at the hospitals for documentation and then entered it into CHCI practice management system. Practice management system collected patient information. An internet program for education materials was used and the CHWs and HPSs were regularly tested on their knowledge.	This had a temporary effect on patient access at some of the sites. EMRs were introduced the last four months of the grant project, CHCI did not have time to collect and evaluate the impact of the electronic health record on ER use in a manner that would yield statistically significant data.	Yes, CHCI is participating in "Meaningful Use for Medicaid" with our EMR system.	N/A
Comments	As evidenced by OHCA's reduction in inappropriate ER utilization in the Medicaid population, this grant underscored that it is easiest to change the habits/behaviors of the insured population, who feel empowered to make rational decisions. In contrast, those without insurance may feel there is no recourse.	The CHCs, and the OHCA CMS Emergency Department Diversion (EDD) had a positive impact on reducing SoonerCare member's ER utilization, as evidenced by OHCA records. This project also had a positive impact in reducing ER utilization for the uninsured.	OHCA Emergency Room Utilization Facts in January of 2010 showed SoonerCare ER visits had a reduction of 64%. In subsequent data, SoonerCare ER utilization had dropped by 84%. More analysis, is needed of more recent time periods, but data is	N/A

Emergency Room Diversion Grant Summary – OKLAHOMA

Primary ER Diversion Categories	Strategises	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (e.g., quantitative, qualitative data, both)
			currently unavailable.	

Pennsylvania

Emergency Room Diversion Grant Summary – PENNSYLVANIA

Project(s): Pennsylvania's Emergency Room Diversion Grant
Setting(s): Urban - ER based Patient Navigator and Primary Care Practice Settings

Primary ER Diversion Categories	Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration(s) with Alternate Care Sites/Extended Hours of Operation	Deployed Mid-level practitioners (Certified Registered Nurse Practitioner and Physician's Assistant) and other support staff to two (2) Primary Care Practices (PCP) settings with historically high non-urgent ER utilization. Expanded hours of operation to 4 days at largest practice location. A third practice had excess capacity and agreed to accept all new patient referrals from an ER based patient navigator. Creation of a part-time primary care practice setting in a community mental health center aimed to improve integration of physical health (PH) and behavioral health (BH) care to patients with serious mental illness.	Yes; backlogs for appointments were reduced or eliminated, and low acuity ER visits were generally reduced. "Sick" and "Well" office visits were increased at participating sites. Low acuity ER visits for the BH population who received integrated care at the community mental health center were reduced, while both sick and well office visits for this subset of the population were increased.	Yes	Quantitative and qualitative data.
Education/Outreach /In-Person Intervention	An Emergency Room based patient navigator provided point-of-service referrals and education aimed at redirecting future care seeking behavior for frequent users of ER services.	Yes; the patient navigator had greater impact with frequent users vs. those who utilized the ER only	Yes	Quantitative and qualitative.

Emergency Room Diversion Grant Summary – PENNSYLVANIA

Primary ER Diversion Categories	Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
	A region wide media campaign including a TV spot, billboards, signs, posters and hand-outs were also utilized, in addition to meetings with key stakeholder groups within the community.	episodically. The effectiveness of the media campaign was difficult to isolate from other interventions. Presentations and focus groups with key community stakeholder groups were well received.		
Health Technology	Three practices all transitioned to a standardized ambulatory electronic medical record (EMR). Telehealth technology is being utilized to help improve transitions in care for inpatient behavioral health (BH) patients discharged to outpatient treatment and recovery as a means of reducing readmissions, future ER visits and to improve compliance with BH appointments post-discharge.	Initial population for the Telehealth discharge process was too small to gather meaningful data. Criterion for utilization has been expanded, providing subjective belief that the process is viewed as positive.	Yes	Qualitative.
	Comments			
	Interventions including an ER based patient navigator, establishment of alternative primary care settings, integration of PH and BH and selective use of technology all contributed to a successful ER Diversion Program which will continue for the near future.			

Tennessee

Emergency Room Diversion Grant Summary – TENNESSEE

Project(s): Tennessee/TC Thompson Children's Site (1 of 3)/ Hospital Volunteer State Health Plan
Setting(s): Urban (Chattanooga, TN)

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes (
Collaboration with Alternate Care Sites/Extended Hours of Operation	Alternate care site "next door" to ER	Yes	Yes	Quantitative data, Patient Satisfaction Surveys
Education/Outreach In-Person Intervention	Assigned Care Coordinators for case management and disease management needs. Established medical homes and arranged PCP visits and transportation. Made patients aware of 24 hr Nurse Triage Line.	Yes	Yes	Quantitative data, Patient Satisfaction Surveys
Health Technology	Used CareAdvance portal system to track patient information, progress, and medical updates for patients.	Yes	Yes	Quantitative data, Patient Satisfaction Surveys
Comments	Used ESI Workflow chart to determine redirection after patient screened in triage.	Yes	Yes	Quantitative data, Patient Satisfaction Surveys

Project(s): Tennessee/ Haywood Site (2 of 3)
Setting(s): Rural

Emergency Room Diversion Grants Summary – TENNESSEE

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with and Establishment of Alternate Care Sites with Extended Hours of Operation	Alternate Care Site with extended hours (evenings, weekends)	Yes	No	Quantitative data, Patient Satisfaction Surveys
Education/ Outreach/ Personal Intervention	Assigned Care Coordinators for case management and disease management needs. Established medical homes and arranged PCP visits and transportation. Made patients aware of 24 hr Nurse Triage Line.	Yes	No	Quantitative data, Patient Satisfaction Surveys
Health Technology	CareAdvance portal system to track patient information, progress, and medical updates for patients	Yes	No	Quantitative data, Patient Satisfaction Surveys
Comments		N/A		

Emergency Room Diversion Grant Summary – TENNESSEE

Project(s): Tennessee/ Nashville Medical Home Connection (3 of 3)
Setting(s): Urban

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with Alternate Care Sites/Extended Hours of Operation	Hospitals would agree to send nonemergency patients to medical homes/ clinics nearby. The medical homes/ clinics had extended hours on evenings and weekends	Yes/ No (Medical homes were established and patients were initially redirected—lost buy-in from hospitals who began to stop redirecting patients to medical homes)	No	Quantitative Data
Education/ Outreach/ In-Person Intervention	Transportation to PCP Assigned patients to medical home Made patients aware of 24hr. Nurse Triage Line	Yes	No	Quantitative Data
Health Technology		N/A	N/A	N/A
Comments		N/A		

Utah

Emergency Room Diversion Grant Summary – UTAH

Project(s): Diversion of Medicaid Non-Emergent Emergency Department Use
Setting(s): Urban

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
Collaboration with Alternate Care Sites/ Extended Hours of Operation	Utah collaborated with Federally Qualified Health Centers (FQHCs). Prior to the ED Diversion project, many of the FQHCs were only accepting new patients under limited criteria. Utah Medicaid was able to elicit an agreement from them to accept new patients who had been identified as using the ED for non-emergent care. In addition, Utah developed a list of after hours and urgent care providers. To do so, we mailed a questionnaire to all group practices in the state that had a primary level provider affiliated to them, i.e., family practice, internal medicine, or pediatrics. We asked four questions, 1) Do you offer urgent care services at your clinic? 2) Are you accepting new patients or existing patients only? 3) Do you allow walk-ins or are appointments necessary? 4) Which Utah Medicaid contracted health plans do you accept? We asked responders to include the days and hours that services are offered. At this point, a list of providers, whose responses showed that they offer extended hours and/or accept walk-ins and new patients, was compiled. This list was then included in an intervention packet that was mailed to participants. We also publish the list on the website developed for the project at www.health.utah.gov/safetowait. (The website	The FQHCs have accepted many new patients because of the outreach and collaboration. We encourage grant participants to find a primary care provider (PCP) and establish care. We provide contact information to them on how to reach an HPR or LHD representative for help in finding a PCP who will accept Medicaid.	We have been successful in fostering and maintaining the relationship with the FQHCs. Our HPRs meet with them quarterly to discuss needs and learn which facilities have openings for new patients. We maintain the list of after-hours urgent care providers. The HPRs and LHD representatives continue to help participants	Clients completed a questionnaire as part of the intervention. Their answers revealed early on in the project that Medicaid clients are not always aware that they are eligible to receive services at an urgent care facility. Only 56 percent of urban clients knew of an urgent care facility near them where they could be treated for non-emergent medical problems.

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
	also contains educational and other resource information.); thereby facilitating a user friendly means by which clients could identify a proximal urgent care for non-emergent care. Furthermore, we collaborated with the department's Health Program Representatives (HPR) and Local Health Department (LHD) representatives to assist participants in finding a primary care provider. Because the representative is in their area, they are familiar with PCPs that are close to client's homes. In some cases, our project staff initiated the contact with the representative and asked them to follow up with clients needing help finding a medical home.		find PCPs when needed.	
Education/ Outreach/ In-Person Intervention	Our basic strategy was to identify clients who were using the ED for non-emergent care and contact them to: 1) provide information about alternative ways to obtain healthcare through a Primary Care Provider (PCP) or urgent care clinic, and 2) understand the clients' reasons for choosing to use the ED by administering a short questionnaire. To understand client's reason for choosing the ED, the staff first contacted participants by telephone; at which time we asked them the same questions outlined on the six-item questionnaire. If the participant was unavailable by telephone, the same questionnaire was then mailed to participants (including a prepaid business reply address printed on the reverse side).	The three sets of measures used to determine outcomes of the program were: 1) additional visits to the ED for non-emergent care after intervention, 2) cost savings determined by use of a PCP rather than an ED, and 3) before and after cost differences when a client who continues to misuse the ED is enrolled in the	The data indicate that it is a worthwhile endeavor to continue the Safe-to-Wait Project beyond the life of the original grant. A client's decision making is influenced by	Utah contracted with the Utah Department of Health, Public Health Informatics, Center for Health Data to analyze the claims data for intervention participants and the control group. They completed a preliminary analysis on claims data from October 2008 through December 2009. The

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
	Furthermore, we developed an educational flyer "Is It Safe to Wait?" which describes three levels of medical acuity based upon answering that question with either "It can wait", "It can wait a little while", or "It can't wait." Clients were instructed to consider alternatives to the ER if it seemed appropriate, using the levels of medical acuity. In addition, clients who were identified for an intervention and were further screened for possible unnecessary use of other covered services. Clients were scored using an algorithm that assigned points for use of multiple physicians, multiple pharmacies and /or multiple prescribers. We generated alerts to workers to fully review claims of high scoring clients for possible enrollment in the Restriction Program. When clients are enrolled in the Restriction Program they are assigned a PCP, pharmacy and educated regarding the nearest urgent care provider to their home. As was, and still is, the standard practice, claims were not paid unless the client followed the program requirements for referrals to other physicians. Prescriptions were, and are today, only paid when either written by or approved by the PCP. This channels clients to the PCP first when they have a medical need.	Restriction Program. Participants who received interventions yet continued to use the ED for non-emergent care were shown to be 11 percent, as compared to 24 percent of clients who were diverted to the control group. This computes to a 55 percent reduction in repeat non-emergent ED visits for participants after intervention. Three percent of the participants used the ED for non-emergent care; as compared to the 11 percent of the control group. As expected, dollars were saved when participants choose use alternatives to the ED for non-emergent care. This was demonstrated by using the following	the intervention demonstrated by a 55 percent reduction in repeat non-emergent ED visits for participants. Utah has fully automated claims analysis and the intervention process. It has been incorporated into the Restriction Program where employees continue to complete all aspects of the project.	final analysis included data through December 2010. Analysis was conducted on participants who met the following qualifications: were between the ages of 15-65, had claims prior to and following the month of ED misuse (so that pre and post measures were not influenced by lack of claims), had Medicaid eligibility at least two months prior to and following the month of ED misuse, and were fee-for-service participants who did not subsequently enroll with a managed health plan.

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
		assumptions: Participants were considered to have exhibited the behavior of going to the ED for a non-emergent reason. Therefore, the assumption was made that the influence of the educational intervention caused the participant to seek medical care from sources other than the emergency room (cost avoidance). Therefore, under the cost avoidance assumption we were able to determine facility costs saved by Utah Medicaid. To do this we multiplied the number of people who chose an office visit as opposed to the ER (post intervention), by the average hospital charge for one ED visit ($702/ non-emergent visit).		

Primary ER Diversion Categories	Project Strategies	Did it Work?	Sustained?	Evidence Used to Evaluate Outcomes
		The amount saved was shown to be $2,018,952 (post intervention), during the course of the study.		
Health Technology	Health technology was not utilized in Utah's ERDG project.			
Comments				

APPENDIX H

Kaiser Family Foundation (KFF) State Health Facts

Medicaid Benefits Data Collection –

Institutional and Clinic Services

Medicaid Benefits: Outpatient Hospital Services

Source: http://kff.org/data-collection/medicaid-benefits/

Copayment Requirements

Location	Copayment Required	State-Specific Information
Alabama	**$3/non-emergency visit in ER**	Any identified copayment requirements are applicable to beneficiaries age 18 and older.
Alaska	**5% of payment for non-emergency services**	Any identified copayment requirements are applicable to beneficiaries age 18 and older.
Arizona	**$2.30/visit for any outpatient therapy service**	Any identified copayment requirements are applicable to beneficiaries age 19 and older unless otherwise exempt. The copayment requirements shown on the tables apply to the traditional Medicaid population as permitted in federal law. Copayment requirements for the Transitional Medical Assistance (TMA) and AHCCCS waiver populations are higher, for a few additional services and not reflected on the tables; these groups may be denied non-emergency services for failure to pay the required copayments.
California	**$5/non-emergency visit in ER, $1/visit for other services**	Irrespective of the amounts shown on the tables, copayments are not required for any service for beneficiaries younger than age 19 or for which the program's payment is $10.00 or less.
Colorado	**$3/visit**	Any identified copayment requirements are applicable to beneficiaries age 19 and older. Providers may collect multiple copayments, if applicable, on the same date of service, e.g., a hospital could collect a copayment for both an outpatient visit and a laboratory service.
Florida	**5% of payment for non-emergency visit to ER, $3/visit for other outpatient services**	
Georgia	**$3/non-emergency visit**	
Idaho	**$3.65/visit up to 5% of income/year across all services, $3/non-emergency visit in ER**	
Iowa	**$3/non-emergency visit in ER**	
Kansas	**$3/non-emergency visit**	
Kentucky	**$3/ambulatory visit; 5% of payment for non-emergency visit in ER up to $6**	Any identified copayment requirements are applicable to beneficiaries age 18 and older and do not apply to preventive services; beneficiaries eligible for both Medicare and Medicaid are exempt from cost sharing.

Location	Copayment Required	State-Specific Information
Maine	**$.50-$3/day, depending on payment, up to $30/month**	
Michigan	**$3/non-emergency visit in ER, $1/hospital clinic visit**	
Minnesota	**$3.50/non-emergency visit in ER**	
Mississippi	**$3/non-emergency visit with some exceptions**	
Missouri	**$3/day except emergency and therapy services**	
Montana	**$5/visit**	
Nebraska	**$3/vist**	Any identified copayment requirements are applicable to beneficiaries age 19 and older. The State requires a $1 per visit copayment for occupational therapy and physical therapy and a $2 per visit copayment for speech pathology services rendered in an independent clinic setting but requires a $3 per visit copayment if the services are rendered in an outpatient hospital setting.
New Mexico	**A - $0-$7/non-emergency visit to ER, B - $20/non-emergency visit to ER and $7/visit for other services, A - ER copays waived for admissions - see state-specific FN**	**Group A:** The State Coverage Initiative, an 1115 waiver program, covers parents of Medicaid and CHIP-eligible children as well as childless adults between the ages of 19 and 64. These adults receive a benefit package similar to basic commercial coverage, which is more limited than the Traditional Medicaid package, and are required to pay copayments for some services. Copayments with a range are applied based on the individual's income. Services are generally delivered through contracted managed care organizations and there is an annual benefit limit of $100,000. **Group B:** The State has also added the optional Medicaid buy-in group of disabled adults permissible through the Balanced Budget Act of 1997. These beneficiaries receive full Medicaid benefits but are required to pay copayments for some services. Unique copayment information for these disabled adults is identified on the tables as "B."
New York	**$3/non-emergency visit**	

Location	Copayment Required	State-Specific Information
North Carolina	**$6/non-emergency visit to ER, $3/visit for other services**	
North Dakota	**$3/non-emergency visit in ER**	Any identified copayment requirements are also applicable to beneficiaries dually eligible for Medicare and Medicaid unless they are institutionalized.
Ohio	**$3/non-emergency visit in ER**	All identified copayments apply to the Traditional Medicaid population within federal limitations and to the buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA).
Oklahoma	**$3/visit**	
Oregon	**A - $3/visit**	**Group A:** This group includes the Traditional Medicaid population, covered under OHP Plus. This includes families with income below 100 percent of the federal poverty level (FPL), the elderly, blind and disabled, and pregnant women and children living in families with income at or below 185 percent of the FPL. Also covered under OHP Plus is the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA.) OHP Plus program participants age 19 and older are required to make copayments for specified services if the program makes any payment, even if Medicare or their private insurance covered part of the cost of the service.
Pennsylvania	**$.65-$3.80/service, depending on payment rate, $.50/unit of psychotherapy service**	Any identified copayment requirements are applicable to beneficiaries age 18 and older in accordance with federal regulations. The copayment amount for x-ray services is also applicable to such services rendered in a clinic, physician office or outpatient hospital setting and may be collected in addition to a copayment required for other services provided.
Rhode Island	**$3/non-emergency visit in ER**	
South Carolina	**$3.40/non-emergency visit**	Except as specified in federal law, any identified copayment requirements are applicable to beneficiaries age 19 and older.
South Dakota	**5% of payment up to $50/visit, non-emergency only**	

Location	Copayment Required	State-Specific Information
Tennessee	**B1 - $10/ER visit if not admitted** **B2 - $50/ER visit if not admitted**	**Group B:** This group includes TennCare Standard, provides a similar package of services for certain adults and children who do not meet eligibility criteria for TennCare Medicaid but who meet other eligibility criteria established by the State. Cost sharing requirements in TennCare Standard vary according to income level. TennCare Standard enrollees who are children with income at or above 100 percent of the federal poverty level (FPL) have cost sharing obligations; those with income at or above 100 percent but below 200 percent of the FPL (identified as B1) have lower copayment obligations than enrollees with income at or above 200 percent of the FPL (identified asB2). Within federal constraints, TennCare Standard adults have the same copayment requirements for prescription drugs as TennCare Medicaid adults.
Utah	**A & B - $6/non-emergency visit in ER and $3/non-preventive care visit, C - $30/non-emergency visit in ER and $5/visit for other care**	**Group A:** This group includes Traditional Medicaid, which provides a comprehensive package of covered services for primarily children, pregnant women, and the aged, blind and disabled, with some limitations and nominal copayments where permitted under federal law. Included in this category is the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA). **Group B:** This group includes non-traditional Medicaid, which provides a smaller package of covered services for certain adults receiving or previously receiving cash assistance through the State's Temporary Assistance for Needy Families (TANF) program, with some limitations and nominal copayments up to an annual maximum of $500. **Group C:** This group includes the Primary Care Network, which provides a very limited package of covered services for parents of Medicaid-eligible children and other adults with income below 150 percent of the FPL and has higher copayments with an annual maximum of $1,000. The State does not require copayments for any preventive services.

Location	Copayment Required	State-Specific Information
Vermont	**A - $3/visit, B - $25/visit in ER**	**Group A:** This group includes the State's Traditional Medicaid population, including low-income families and caretaker relatives and the aged, blind and disabled, as well as optional and expansion populations of pregnant women with income at or below 200 percent of the federal poverty level (FPL) and the working disabled, permitted through the Balanced Budget Act of 1997, with income at or below 250 percent of the FPL. **Group B:** This group includes the VHAP population includes uninsured adults age 18 and older with income at or below 185 percent of the FPL.
Virginia	**$3/non-emergency service**	
Washington	**$3/non-emergency visit in ER**	
Wisconsin	**$3/visit**	Any identified copayments are applicable to pregnant women if the service is unrelated to pregnancy.
Wyoming	**$3.65/non-emergency visit in ER**	

Prior Authorization Requirements

Location	Prior Approval Required
Alaska	**Specified surgical procedures**
Arizona	**Specified surgical procedures, rehab services**
Arkansas	**Specified surgical procedures**
Georgia	**Specified procedures**
Idaho	**Specified services**
Indiana	**Specified services**
Louisiana	**Rehab and specified surgeries**
Missouri	**Specified services**
Nevada	**Specified services**
North Carolina	**More than 8 outpatient psych visits and any therapy services**
Oklahoma	**Specified surgical procedures and other services**
Oregon	**Specified surgical and therapy procedures**
Rhode Island	**PT, OT and SP**
Texas	**Specified services**
Virginia	**Specified services**
Washington	**Specified services**
West Virginia	**Specified surgical procedures and other services**
Wisconsin	**Specified surgical procedures and other services**

Limits on Service Days

Location	Limit on services days
Alabama	**3 non-emergency visits/year unless outpatient surgery, lab, dialysis, radiation or chemotherapy, non-emergency visit to ER counts toward both outpatient and physician visit limits**
Alaska	**Outpatient psych and substance abuse not covered**
Arizona	**Coverage of outpatient OT and SP services limited to ALTCS members**
Arkansas	**12 non-emergency visits/year**
Connecticut	**1 visit/day**
District of Columbia	**Cosmetic and oral surgery limited to emergency repair due to injury or trauma**
Florida	**6 ER visits/year for non-pregnant adults, $1,500/year limit for non-emergency services (excluding labor/delivery, chemotherapy, dialysis and surgery) in combination with OT and PT**
Georgia	**Observation limited to less than 24 hours**
Idaho	**6 ER visits/year if no admission, varying visit limits for therapies including psych which may be included in limits with other providers**
Iowa	**Varying visit limits for cardiac rehab, behavioral health and substance abuse, eating disorder and pain management therapies defined as non-inpatient programs**
Kansas	**Non-emergency visits count toward physician visit limit, rehab must be restorative**
Louisiana	**3 ER visits/year and count against physician visit limit, no limit for managed care enrollees**
Nebraska	**No visit payable within 3 days of inpatient admission, substance abuse treatment not covered**
New Hampshire	**4 ER visits/year, visits for OT, PT and SP count toward the eighty 15-minute time units/year for therapy providers**
New Mexico	**A - outpatient detox limited to 10 days/year**
New York	**Beneficiary Specific Utilization Thresholds apply - see state-specific FN**
North Carolina	**22 ambulatory visits/year included in limits with other specified practitioners - limits set annually by the legislature**
North Dakota	**30 therapy visits/year included in limits for other providers of therapy services**
Oklahoma	**Outpatient behavioral health services not covered for nursing facility residents**
Oregon	**Services limited to funded conditions on the priority list**
Pennsylvania	**Frequency limits vary by service**
South Dakota	**Substance abuse treatment not covered, cosmetic surgery limited to emergency repair due to injury or trauma**
Utah	**A & B - outpatient psych and substance abuse services limited to 30 days/year and included in inpatient limit, C - services limited to emergency treatment in ER**
Virginia	**Limits vary by service**

Location	Limit on services days
Wisconsin	**Outpatient psych services limited to 5 hours/day up to 120 hours/month and 40 hours/year for nursing facility residents; OT, PT and SP services must be billed as if rendered by the therapist and are reimbursed accordingly**
Wyoming	**12 visits/year in combination with physician, nurse practitioner and clinic visits, therapy services must be restorative and are limited to 20 visits/year across all therapy providers**

Reimbursement Methodologies

Location	Reimbursement Methodology
Alabama	**Fee for service**
Alaska	**Prospective cost based rate using percentage of charge**
Arizona	**All-inclusive rate per episode of care using Medicare groupings for most surgical procedures or fee for service**
Arkansas	**Cost based payment for pediatric, teaching and critical access hospitals; fee for service for other hospitals**
California	**Fee for service, state may negotiate all-inclusive per visit rates with certain hospitals and all-inclusive rates for adult day health care centers**
Colorado	**Cost based payment**
Connecticut	**Fee for service or percentage of charge**
Delaware	**Fee for service**
District of Columbia	**Cost based payment**
Florida	**Prospective cost based per diem or rate per service, lab and x-ray services paid fee for service**
Georgia	**Cost based payment using percentage of charge**
Hawaii	**All-inclusive rate per episode of care using Medicare groupings for most surgical procedures or fee for service with limits**
Idaho	**Fee for service using hospital cost as upper limit**
Illinois	**Fee for service or prospective rate/visit**
Indiana	**Fee for service, with surgical procedures grouped using Medicare methodology**
Iowa	**Fee for service, with surgical procedures grouped using Medicare methodology, ancillaries paid at Medicare rates**
Kansas	**Fee for service**
Kentucky	**Fee for service with surgical procedures grouped using Medicare methodology or cost based payment**
Louisiana	**Cost based payment or fee for service**
Maine	**Fee for service, with surgical procedures grouped using Medicare APC methodology and payment at 93% of Medicare rate**
Maryland	**Fee for service using rates approved by cost review commission**
Massachusetts	**Hospital-specific episode-based payment/day, excludes physician and lab services**
Michigan	**Prospective payment system using Medicare OPPS/APC methodology and a state-determined rate reduction factor**
Minnesota	**Payments based on Medicare methodology, cost based payment for critical access hospitals**
Mississippi	**Prospective payment system using Medicare OPPS/APC methodology**
Missouri	**Percentage of charge, fee for service for certain lab and radiology services**
Montana	**Fee for service using Medicare APC methodology**
Nebraska	**Percentage of charge with limits, lab services paid fee for service, cost based payment for critical access hospitals**

Location	Reimbursement Methodology
Nevada	**Fee for service with surgical procedures grouped using Medicare methodology**
New Hampshire	**Percentage of charge**
New Jersey	**Cost based payment**
New Mexico	**Prospective payment system based on Medicare methodology**
New York	**Prospective payment using APGs**
North Carolina	**Prospective cost based rate or fee for service settled annually to 80% allowable cost**
North Dakota	**Fixed percentage of charge**
Ohio	**Prospective payment with surgical procedure groupings paid by level, clinic and ER visit procedures paid by level, fee for service or percentage of charge for selected services**
Oklahoma	**Fee for service using surgical group rates, ancillaries paid separately**
Oregon	**Cost based payment with limits**
Pennsylvania	**Fee for service**
Rhode Island	**Medicare reimbursement rates with adjustors and utilizing Ambulatory Payment Classification codes**
South Carolina	**Fee for service**
South Dakota	**Cost based payment**
Tennessee	**See state-specific FN**
Texas	**Cost based payment, prospective payment with surgical procedures grouped using Medicare methodology**
Utah	**Prospective payment system**
Vermont	**Fee for service, with surgical procedures grouped using Medicare methodology; lab procedures paid fee for service, using Medicare Relative Value Units and a state conversion factor; psych services paid on per diem basis**
Virginia	**Cost based payment with limits**
Washington	**Most urban hospitals paid prospective cost based rates, rural hospitals paid prospective percentage of charge**
West Virginia	**Fee for service**
Wisconsin	**Cost based payment with limits**
Wyoming	**Payment based on Medicare Outpatient Prospective Payment System methodology**

APPENDIX I

Provider Profiling Objectives, Methods and Examples

OKLAHOMA HEALTH CARE AUTHORITY

***SoonerCare* Provider Profiling of ER Utilization**
Overview and Methodology

This quality improvement project was designed to review annual office visit and emergency room visit utilization rates of ***SoonerCare*** beneficiaries assigned to each ***SoonerCare*** practice.

Objectives:

- Insure that each ***SoonerCare*** beneficiary receives continuing care under the direction of his/her assigned provider.
- Increase communication with clinics and providers.
- Submit provider/clinic-specific data to ***SoonerCare*** PCP/CMs for educational and/or possible quality improvement activities.
- Analyze beneficiary use of ER services for ***SoonerCare*** quality improvement activities.
- Support the intervention efforts of ***SoonerCare*** providers.

Brief Overview of Methodology:

- Using **paid claims and encounter data***, the number of office visits and emergency room visits for each beneficiary was calculated and compared with an expected number of office visits and emergency room visits based on the average number from ***SoonerCare*** PCP/CMs.
- A ratio of observed to expected visits (O/E) was computed for each provider and compared with the mean O/E ratio for ***SoonerCare*** PCP/CMs.
- These ratios were risk-adjusted to control for differences in health status that would be expected to impact emergency room utilization using the Adjusted Clinical Group (ACG) Case-Mix System.

*The ratio of observed to expected visits for a provider is dependent on paid claims and encounter data. Claims/encounters that are not submitted will result in an inaccurate number of observed office visits.

A Direct Standardization Method to Risk-Adjust ER Visit Rates:

To make a fair inference that a provider's observed ER Visit Rate truly reflects the provider's propensity to refer beneficiaries to the ER (or the beneficiary's preference for ER visits) it is first necessary to rule out other explanations. An important source of variation in ER Visit Rates is the health status, or case-mix of the provider's panel. Risk-Adjustment using the ACG system[1] accounts for this source of variation so that fair

[1] The Adjusted Clinical Group (ACG) is a patient case-mix adjustment system developed by researches at Johns Hopkins School of Hygiene and Public Health. The ACG grouper assigns each patient a single, mutually exclusive ACG value, which is a relative measure of the patient's expected, or actual consumption of, health services. For additional information, please refer to http://www.acg.jhsph.edu/.

inferences may be drawn from comparison of providers' risk-adjusted visit rates. These steps describe the ACG risk-adjustment method.

1) Link beneficiary ER and Office Visit (OV) claims to providers by date. For each provider, include all claims where claim dates of service fall within the beginning and ending dates of provider assignment for the provider/beneficiary pair.
2) Group claims by provider/beneficiary pair and count ER visits made by the beneficiary while assigned to the provider, and count OV made by the beneficiary while assigned to the provider. This results in a "base-file" with one row for each unique provider/beneficiary assignment pair, and a count of ER and OV made by the beneficiary while assigned to the provider.
3) Link the beneficiary ACG to the base-file by beneficiary ID number. Group the beneficiary/provider pairs by beneficiary ACG, sum the number of ER visits made by beneficiaries in the ACG, and sum the number of OV made by beneficiaries in the ACG. Compute the ACG-Specific ER Visit Rate as: sum(ER) / (sum(ER)+sum(OV)) for each ACG.
4) Group the beneficiary/provider pairs by provider ID and sum the number of ER visits made by beneficiaries while assigned to the provider, and sum the number of OV made by beneficiaries while assigned to the provider. Compute the Provider-Specific Observed ER Visit Rate as: sum(ER) / (sum(ER)+sum(OV)) for each provider.
5) Link the ACG-Specific ER Visit Rate to the base-file by beneficiary ACG. Group the base-file by provider ID and compute the Provider-Specific Expected ER Visit Rate as: sum(ACG-Specific ER-Visit Rate) / number of beneficiaries assigned to the provider. This expected rate is the average case-mix adjusted ER visit rate for each provider.
6) For each provider, compute the ratio of Observed to Expected Provider-Specific ER Visit Rate (O/E Ratio). If any providers have an expected number of office visits or an expected number of ER visits less than 5, they are deemed to have insufficient data to produce a reliable O/E Ratio; so no ratio will be computed for these providers.
7) Providers with significantly higher-than-average O/E Ratios may be overly-reliant on ER *versus* Office Visits (or their clients may make excessive use of ER *versus* Office Visits). The next section discusses the statistical tests used to determine which providers have higher-than-average risk-adjusted ER visit rates.

Statistical Tests Used to Compare Providers' Risk-Adjusted ER Visit Rates:

Risk-adjustment removes the effect of differences in beneficiary health status, which is an important source of variability in the observed ER Visit Rates. When we compare risk-adjusted ER Visit Rates between providers, the only remaining source of variation should be the provider's true propensity to direct beneficiaries to the ER rather than office visits (or the preference of the provider's beneficiaries for ER visits). However, there are two additional sources of variation to be accounted for: (1) the total number of visits to each provider, and (2) variation due to random chance in the selection of observations.

1) Since the provider's ER Visit Rate is the number of ER visits divided by the total number of ER and office visits to the provider, providers with very few total visits have an intrinsically higher degree of variability (i.e. one ER visit counts for 20% if a provider has only 5 total visits, but counts for just 2% if a provider has 50 total visits).
2) All available data for each provider during a year is used to compute the provider's ER Visit Rate, so the rate is not estimated from a sample of the available data. However, if the ER Visit Rate is subject to random variability over time (i.e. random "peaks and valleys") then there is an element of randomness introduced by the selection of a particular time period to collect observations, and this random "sampling error" must be accounted for to make fair inferences about the stability of providers' ER Visit Rates over time.

Statistical significance tests are used to take these sources of variation into account when comparing estimated visit rates between providers. We use two tests to account for random variance both *within* providers and *between* providers. A provider must pass both tests to be considered to have an abnormally high risk-adjusted ER Visit Rate. First the provider's O/E Ratio must be greater than the upper limit of the 95% confidence interval for the mean O/E Ratio of all providers. Second, the provider's Expected ER Visit Rate (E) must be less than the lower 95% confidence limit for their Observed ER Visit Rate (O). Providers who pass both tests have O significantly higher than E, and O/E significantly higher than average. To identify providers with significantly higher-than-average O/E ratios we use the Standard Normal Confidence Interval:

a. Compute the mean O/E Ratio for all providers (M).
b. Compute the standard deviation of the O/E Ratio for all providers (S).
c. Count the number of providers (N).
d. Compute the 95% Confidence Interval for the mean = 1.96 x S/sq.root(N)
e. Compute the Upper Limit = M + 1.96 x S/sq.root(N)
f. Providers who have O/E Ratios greater than the Upper Limit have significantly higher-than-average risk-adjusted ER visit rates.

To identify providers with O significantly higher than E, we use a Bayesian Confidence Interval:

a. Compute the Bayesian estimate of mean O for each provider: m = (ER visits +1) / (Total visits +1).
b. Compute the lower limit of the Bayesian 95% CI from the Beta distribution: lower limit = betainv(.025,ER visits +1, Office visits +1)
c. Providers who have expected ER visit rates less than the lower limit of the confidence interval for the observed ER visit rate have observed rates significantly higher than the expected (risk-adjusted) rate.

References:

Shryock, Henry, Siegel, Jacob and Associates, 1976. *Methods and Materials of Demography*, Academic Press, NY. p 241-2.
“ACG Risk-Adjustment and Provider Profiling.” Chapter 12 in: Weiner, Jonathan P. et al. 2001. *ACG Software Documentation/Users Manual: Version 5.0 (December, 2001)*, Johns Hopkins University, Baltimore.

FAQs about Provider Profiles on Emergency Room Utilization

Q: Who receives a profile?

A: Not all PCPs receive a profile. We analyze data from members who have been assigned to your panel for at least 11 months during a one-year review period and had at least one visit in the office or ER. That's because PCPs may not have had a chance to develop a relationship with members who had less eligibility. If a PCP had members who were on the panel for at least 11 months and if there were enough office or ER visits for valid statistical profiling, then the PCP will receive a profile.

Q: How many visits are required for a valid profile?

A: Providers receive a profile if at least 5 office visits and 5 ER visits are expected. (The meaning of "expected" is explained below.) This is a total for all of the members who had enough eligibility, as defined above. If the expected number of office visits or ER visits is less than 5, then a valid statistical profile cannot be created, and the provider will receive a letter saying s/he had insufficient data for profiling.

Q: I am a provider with more than one service location. How does this impact my profile for ER utilization?

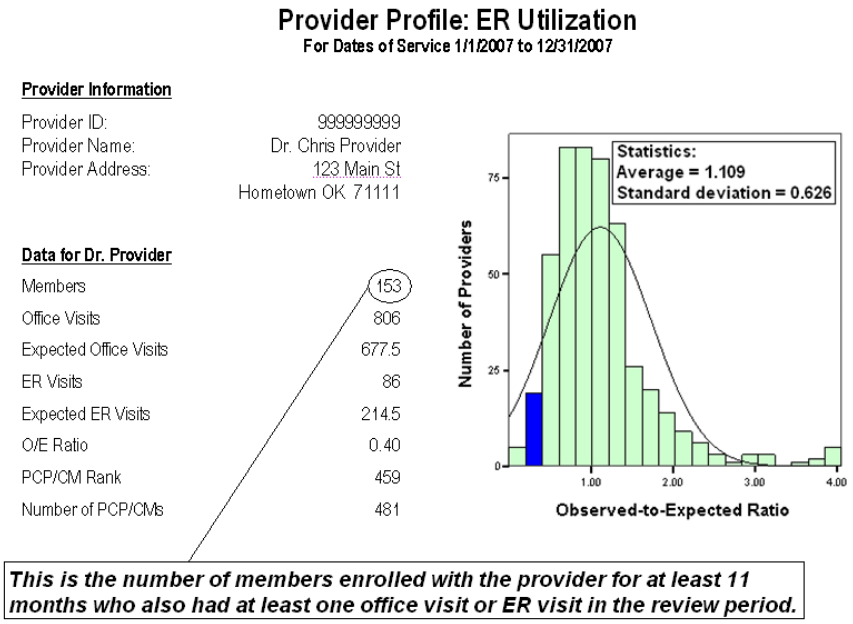
A: We combine data from all of your service locations so that we will have the best chance of being able to provide you with a profile. We mail the profile to the service location serving the largest number of SoonerCare Choice members.

Q: How often are the ER utilization profiles created?

A: We send out profiles twice a year. The review period for one profile covers the calendar year, and the review period for the other profile is the state fiscal year (July 1-June 30). We wait at least 90 days after the review period to allow time for all claims to be paid.

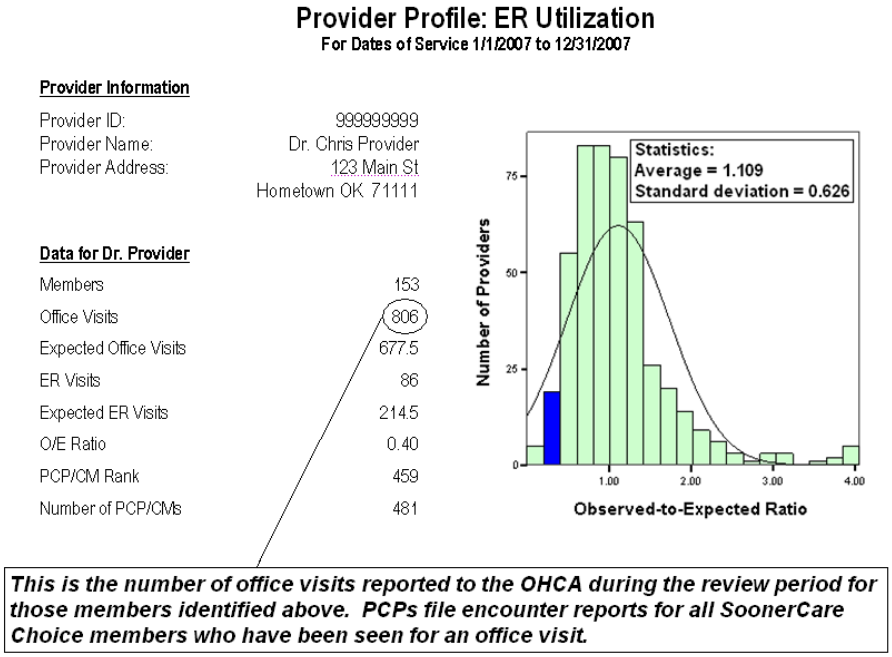
Q: My records show more members on my panel than you're showing on the profile. Why?

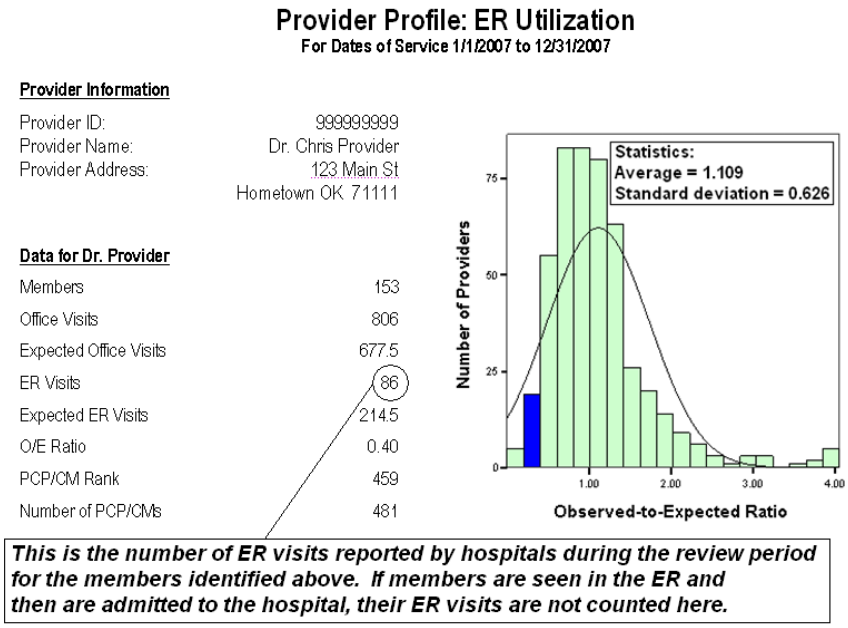
A: We count only those members who had 11 or 12 months of enrollment with the PCP. It wouldn't be fair to hold PCPs even partly responsible for the ER utilization of members who have only recently been assigned to a panel.



Q: How do you count the number of office visits and ER visits that have been made by these members? Where is this information shown on the profile?

A: The number of office visits that were provided to these members and the number of ER visits that these members made are counted based on claims and encounter data submitted by PCPs and hospitals. ER visits are not counted if the members then were admitted for a hospital stay.





Q: My records show that I provided more office visits than the number shown on my profile. Why?

A: The profile counts the office visits only for those members with 11 or 12 months of enrollment with the PCP.

Q: My profile shows an expected number of ER visits equal to 214.5. How can you calculate the number of ER visits that you would expect for a group of patients?

A: This is where we use the Adjusted Clinical Group (ACG) Case-Mix System developed by Johns Hopkins University. The ACG software assigns an ACG number for each member based on the person's illness burden. Then we examine our data, comparing all the members with the same ACG scores. Based on the data for all members included in the review period, we determine the rate of ER utilization statewide for people with the same ACG score. For example, members with a certain ACG score might have 20% of their total visits occurring in the ER. This expected rate is then associated with all the members with that ACG score.

Once we have an expected ER rate for all the members on your panel, we average these numbers. Out of all your members' visits (office + ER), the expected number of ER visits is based on this average rate. The rest of the total visits (office + ER) would be expected as office visits.

Provider Profile: ER Utilization

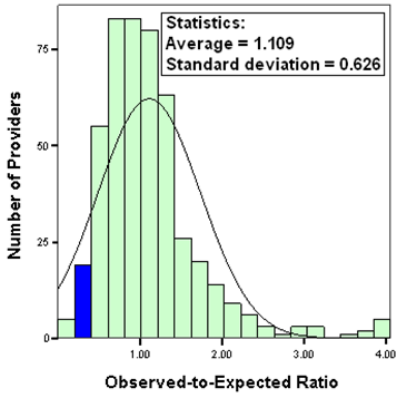
For Dates of Service 1/1/2007 to 12/31/2007

Provider Information

Provider ID:	999999999
Provider Name:	Dr. Chris Provider
Provider Address:	123 Main St
	Hometown OK 71111

Data for Dr. Provider

Members	153
Office Visits	806
Expected Office Visits	677.5
ER Visits	86
Expected ER Visits	214.5
O/E Ratio	0.40
PCP/CM Rank	459
Number of PCP/CMs	481



The expected number of ER visits is calculated using the ACG score. Each member is assigned an ACG score. We combine members from all the providers in the analysis; and within each ACG group, we calculate the proportion of total visits (office + ER) that occurred in the ER. A greater proportion of total visits would be expected in the ER if a PCP's panel consists of sicker members.

Provider Profile: ER Utilization

For Dates of Service 1/1/2007 to 12/31/2007

Provider Information

Provider ID:	999999999
Provider Name:	Dr. Chris Provider
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	Hometown OK 71111

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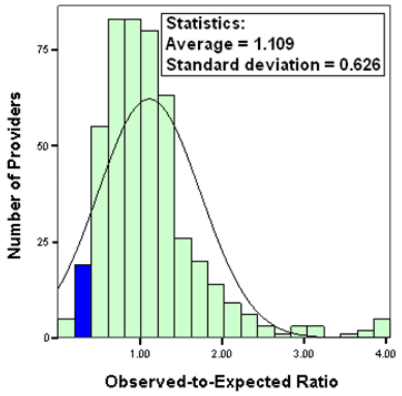


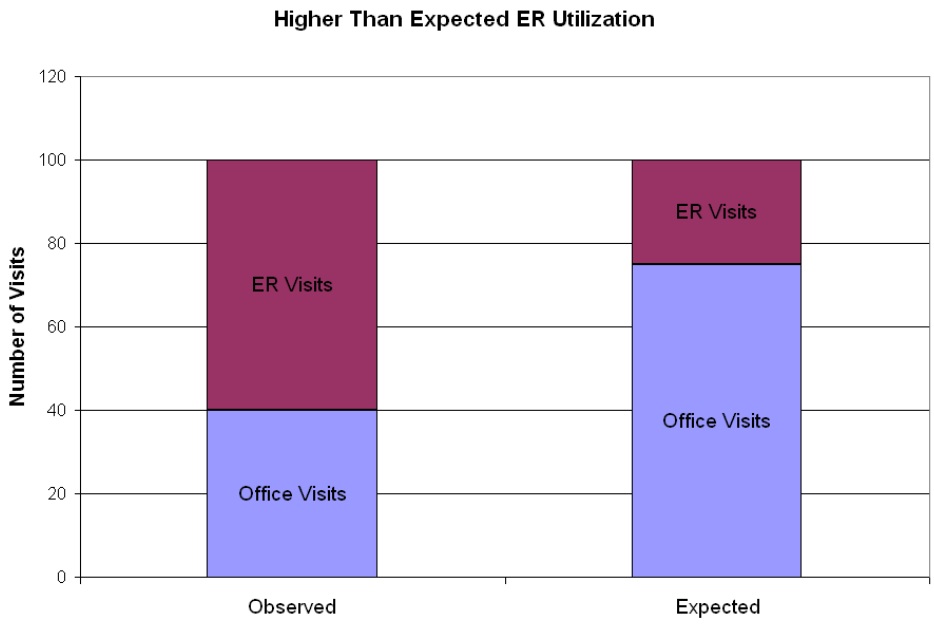
Once the expected number of ER visits has been calculated, we would expect the rest of the total visits to occur in the PCP's office. So the Expected Office Visits is computed by subtracting the Expected ER visits from the total number of office visits and ER visits. Here, the total number is 892 (= 806 office visits + 86 ER visits). By subtracting the Expected ER (214.5) from 892, we obtain Expected Office Visits = 677.5.

Q: Could you give me some easier examples?

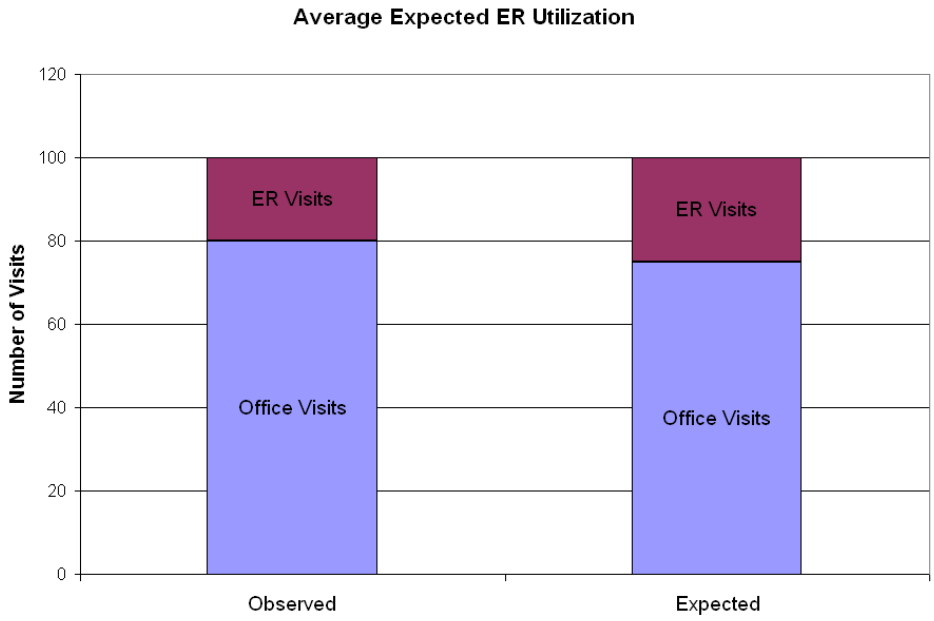
-- Let's say that a provider has 20 members with 11 or 12 months of enrollment who also had office or ER visits during the review period.

-- Further, let's assume these members have an average ER rate of 0.25, based on their ACGs and the ER utilization of all members in the analysis statewide with the same ACGs. In other words, we would expect members with the same illness burden as your members to end up in the ER for 25% of their total visits (office + ER).
-- If these members had 40 office visits and 60 ER visits, then the total visits = 100, and they were seen in the ER 60% of the time – not the 25% that we expected based on their illness burden and the pattern of ER utilization statewide.

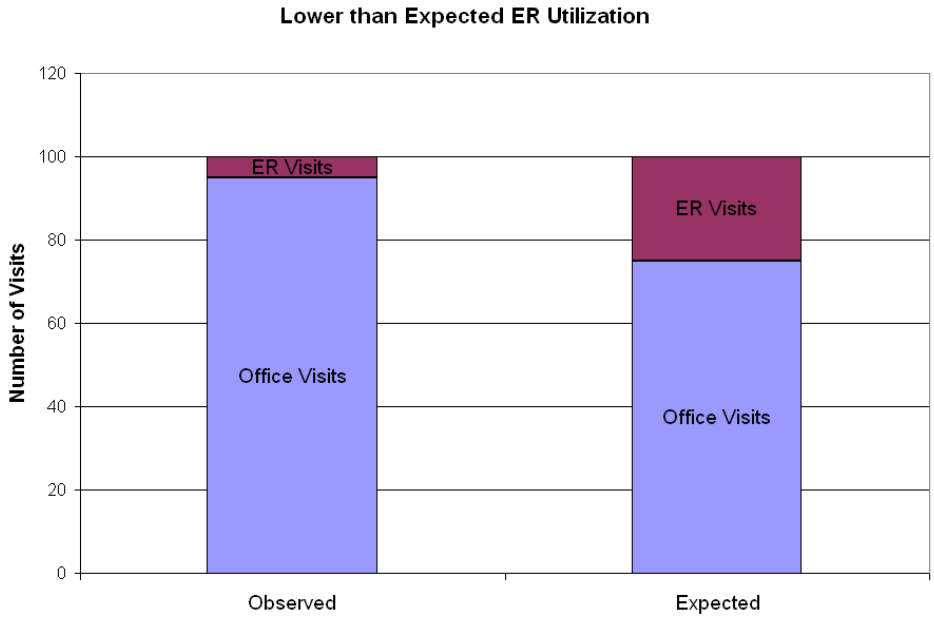
This is an example of higher than expected ER utilization. To illustrate this example, please examine the graph below. It compares the observed (actual) office and ER visits with the expected office and ER visits.



As another example, let's say that a second provider had the same number of members with the same expected ER utilization rate (25%), and the members had a total of 100 visits (office + ER). But the second provider saw the members 80 times, and the members had a total of 20 ER visits. This would be an example of average ER utilization, as illustrated in the next graph.

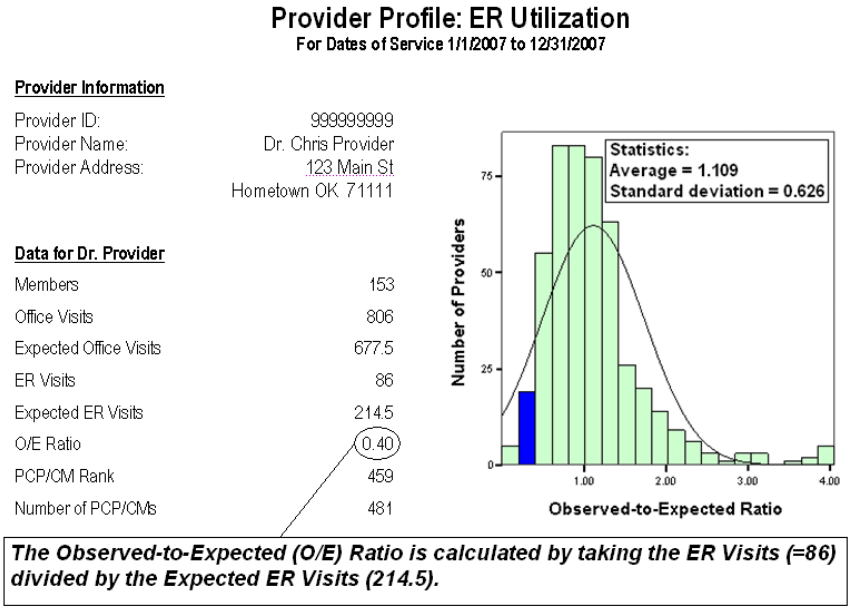


Finally, let's consider a third provider, with the same number of members with the same illness burden and the same expected rate of ER use (25%) of the total 100 visits (office + ER). But these members went to the ER only 5 times, with 95 office visits during the review period. This example of low ER utilization is shown in the next graph.



Q: What is the "O/E Ratio" reported on the profile?

A: This statistic is the first step toward determining whether the ER utilization rate is average, lower than average or higher than average. The observed-to-expected (O/E) ratio is found by taking the number of observed (actual) ER visits and dividing it by the expected number of ER visits. In the illustration below, the O/E ratio = 0.40. This number is found by taking the observed number of ER visits (86) and dividing it by the expected number of ER visits (214.5). This is an example of a provider whose members had lower than expected ER utilization.



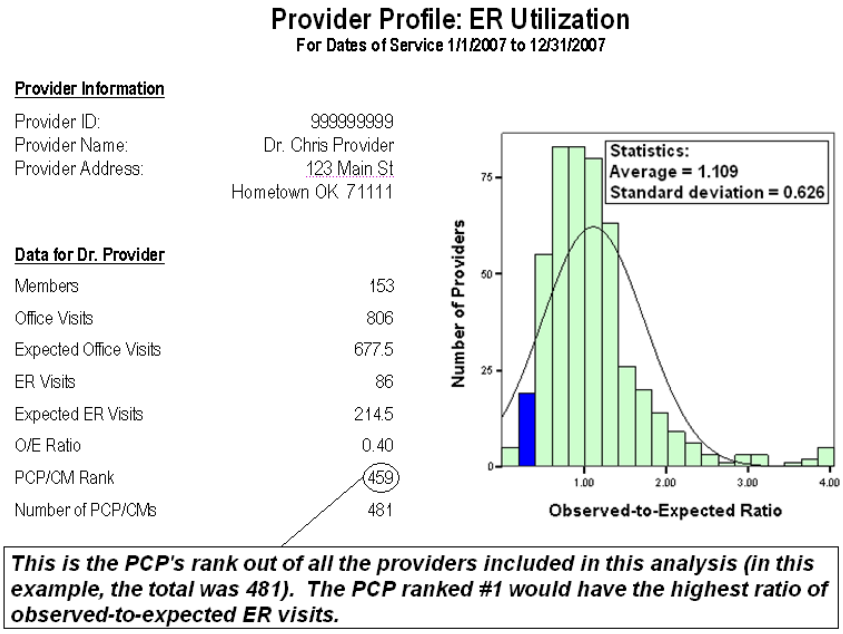
Q: How is the O/E ratio used?

A: We use the O/E ratio to compare your members' ER utilization rate to the statewide average. A confidence interval is computed to help us determine whether your O/E ratio is statistically the same as the average of all providers' O/E ratios – or if the difference is statistically "big." A confidence interval is similar to a *margin of error*, which is used in opinion polls. A margin of error may be used to determine whether one candidate is significantly more popular than another, or if the difference in the popularity of the two candidates is so close that they are statistically equal.

If the O/E ratio perfectly equals 1, then we know that expectations have been met – that is, the Observed and Expected are the same. The confidence interval (not reported on the Provider Profile) provides a range of values around the O/E ratio. If the confidence interval brackets the number 1, then the Observed and Expected ER visits are statistically the same. We use a second confidence interval (based on Bayesian statistics) to take into account the illness burden of the members. Your O/E ratio must be significantly different from the statewide average O/E ratio on both of these confidence intervals before we conclude that the members' ER utilization rate is higher than average. We can provide more information on the calculation of the confidence intervals upon request; please contact the Quality Assurance and Improvement Department of the OHCA at (405) 522-7672.

Q: What is the "Rank" on the profile?

A: We assign rank by placing all providers' data in order according to the O/E ratio. The provider with the largest O/E ratio (that is, with the highest number of observed ER visits, relative to the expected ER visits) is ranked first.



Q: The profile has a graph, and one bar is shown in a different color. Why?

A: This bar indicates where your O/E ratio is located, relative to other providers who had enough data for a valid profile to be created for this review period.

Q: I received a letter saying there was not enough data for a profile to be created. How much data do you need?

A: The expected office visits and expected ER visits both need to be greater than or equal to 5 in order to create a valid statistical profile.

Q: What if I have other questions that you haven't covered here?

A: Please contact our Quality Assurance and Improvement Department at (405) 522-7672.

APPENDIX J

Frequent and Persistent Utilizer Letters

High Utilizer Letter

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

_____

RE: EMERGENCY ROOM USE

Dear Member:

You have been identified as a SoonerCare member who has gone to the Emergency Room (ER) ten (10) times or more between ____ and ____. Our records show you went to the ER __ times from _____ through ____.

The Emergency Room is for emergencies. You should see your SoonerCare Primary Care Provider (PCP) for routine health care. Your current PCP is _____ and your PCP's office number is_____.

Because we want you to get the best health care possible, we will continue to look at the Medicaid services you are receiving.

We will try to contact you to discuss your use of the ER and your health care needs. Please contact Member Services at 1-800-987-7767 for help.

Sincerely,

The Member Services Department

If you would like help in understanding this letter, please call 1-800-987-7767.
Si a usted le gustaría ayuda en entender esta carta, favor de llamar a 1-800-987-7767.
Yog koj xav tau kev pab kom to taub daim ntawv no, thov hu rau 1-800-987-7767.
Если у Вас есть вопросы, связанные с этим письмом, звоните по телефону 1-800-987-7767.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

_____

RE: USO DE LA SALA DE URGENCIAS

Estimado Miembro:

Se reportó que usted como un miembro de SoonerCare ha acudido a la Sala de Urgencias (ER) diez (10) veces o más entre _____ y _____. Nuestros registros muestran que acudió a la ER _____ veces desde _____ a _____.

La Sala de Urgencias es para urgencias. Debe acudir a su Proveedor de cuidado primario (PCP) de ***SoonerCare*** para recibir atención de rutina. Su PCP actual es _____ y el número de su consultorio es_____.

Porque queremos que reciba la mejor atención médica posible, seguiremos observando los servicios Medicaid que usted recibe.

Trataremos de contactarlo para hablar con usted sobre el uso de la ER y sobre sus necesidades de atención médica. Por favor, contacte los Servicios para Miembros en el 1-800-987-7767 para recibir ayuda.

Cordialmente,

Departamento de Servicios para Miembros

Persistent Utilizer Letter

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

August 28, 2009

«First_Name» «Last_Name»
«Full_Street_Address»
«City», «State» «Zip_Code»

RE: EMERGENCY ROOM USE

Dear Member:

You have been identified as a SoonerCare member who has gone to the Emergency Room (ER) thirty or more times during October 2008 through June 2009. Our records show you went to the ER «Total_ER_Claims» times during October 2008 through June 2009. Our records also show you had «Total_PCP_Claims» visits to your Primary Care Provider (PCP) during this time.

The Emergency Room is for emergencies. You should see your SoonerCare Primary Care Provider (PCP) for routine health care. Your current PCP is «PCP_Name» and your PCP's office number is «PCP_Phone_Number».

We will try to contact you to discuss your usage of the ER and your health care needs. Please contact Member Services at 405-522-7488 for help or questions.

Sincerely,

The Member Services Department

If you would like help in understanding this letter, please call 1-800-987-7767.
Si a usted le gustaría ayuda en entender esta carta, favor de llamar a 1-800-987-7767.
Yog koj xav tau kev pab kom to taub daim ntawv no, thov hu rau 1-800-987-7767.
Если у Вас есть вопросы, связанные с этим письмом, звоните по телефону 1-800-987-7767.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

August 28, 2009

«First_Name» «Last_Name»
«Full_Street_Address»
«City», «State» «Zip_Code»

RE: USO DE LA SALA DE URGENCIAS

Estimado Miembro:

Se reportó que usted como un miembro de SoonerCare ha acudido a la Sala de Urgencias (ER) treinta veces o más durante October 2008 through June 2009. Nuestros registros muestran que acudió a la ER «Total_ER_Claims» veces durante October 2008 through June 2009. Nuestros registros también muestran que asistió «Total_PCP_Claims» veces a citas con su Proveedor de cuidado primario (PCP) durante este tiempo.

La Sala de Urgencias es para urgencias. Debe acudir a su Proveedor de cuidado primario de SoonerCare (PCP) para recibir atención de rutina. Su PCP actual es «PCP_Name» y el número de su consultorio es «PCP_Phone_Number».

Trataremos de contactarlo para hablar con usted sobre el uso de la ER y sobre sus necesidades de atención médica. Por favor, contacte los Servicios para Miembros en el 405-522-7488 para recibir ayuda o responder inquietudes.

Cordialmente,

Departamento de Servicios para Miembros

APPENDIX K

House Bill 2842

Oklahoma Medicaid Reform Act of 2006

Source:
https://www.sos.ok.gov/documents/legislation/50th/2006/2R/HB/2842.pdf

An Act

ENROLLED HOUSE
BILL NO. 2842

By: Steele, Balkman, Cox, Denney, DeWitt, Terrill, Worthen, Armes, Bingman, Cooksey, Dank, DePue, Duncan, Kern, Martin and Perry of the House

and

Adelson of the Senate

An Act relating to public health and safety; creating the Oklahoma Medicaid Reform Act of 2006; authorizing implementation of phase one by certain date; requiring evaluation and report; stating purpose of act; authorizing the Health Care Authority to submit any waivers to the Legislature for approval before implementation; providing powers, duties, and responsibilities of the Oklahoma Health Care Authority under the program; providing for a grievance resolution process; establishing cost-sharing methods; providing for electronic records for Medicaid providers; establishing an electronic prescribing pilot program; authorizing the Oklahoma Health Care Authority to establish an incentivizing reimbursement program for nursing homes; authorizing the Oklahoma Health Care Authority to provide programs for disease management and alternatives for long-term care; authorizing a program to encourage the proper use of emergency rooms; establishing a physician hotline; setting payment error rate; extending benefits to certain persons; requiring hospitals to establish discount programs for certain persons; establishing the Task Force on Nursing Home Insurance Access; specifying membership and duties; requiring certain information to be provided to certain persons regarding coverage; amending Section 7, Chapter 374, O.S.L. 2002, as amended by Section 3, Chapter 412, O.S.L. 2003 (63 O.S. Supp. 2005, Section 3240.5), which relates to the Community Hospitals Authority; increasing membership of authority; amending 56 O.S. 2001, Section 1010.1, as last amended by Section 1, Chapter 136, O.S.L. 2004 (56 O.S. Supp. 2005, Section 1010.1), which relates to health care coverage; expanding scope of program under certain circumstances; extending assistance to certain employers; amending 63 O.S. 2001, Section 1-707, which relates to rules and standards; expanding duties of the Oklahoma Hospital Advisory Council; amending 63 O.S. 2001, Section 5009.2, which relates to membership of the Advisory Committee on Medical Care for Public Assistance Recipients; adding pediatric member; repealing 63 O.S. 2001, Section 1-

702b, as last amended by Section 1 of Enrolled Housed Bill No. 2465 of the 2nd Session of the 50th Oklahoma Legislature, which relates to new health care facilities; repealing Section 2, Chapter 431, O.S.L. 2004 (63 O.S. Supp. 2005, Section 1-702d), as last amended by Section 2 of Enrolled Housed Bill No. 2465 of the 2nd Session of the 50th Oklahoma Legislature, which relates to the Uncompensated Care Equalization Committee; providing for codification; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.1 of Title 56, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 10 of this act shall be known and cited as the "Oklahoma Medicaid Reform Act of 2006".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.2 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority is authorized to seek waivers and/or other federal authorizations to create a statewide program to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Oklahoma Medicaid Program.

B. The Oklahoma Health Care Authority shall develop and submit for approval, applications for waivers of applicable federal laws and regulations as necessary to implement the provisions of the Oklahoma Medicaid Reform Act of 2006. Copies of all waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section shall be provided to the Legislature within ten (10) days of their approval. The Oklahoma Health Care Authority shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the Oklahoma Medicaid Reform Act of 2006. This implementation plan shall be submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate.

C. By July 1, 2008, phase one of this act shall be implemented within a contiguous area of the state with rural and urban characteristics. The Oklahoma Health Care Authority shall contract for an independent evaluation and report findings of this phase of the act to the Governor and the Legislature. After an independent evaluation and report to the Governor and Legislature, if it is determined that the evaluation establishes improved access to health care, improved health care outcomes, and improved cost efficiencies, it is the intent of the Legislature that components of the act be phased in statewide by the year 2013.

D. Upon this evaluation and determination of improvement by the Governor and Legislature, the Oklahoma Health Care Authority shall

negotiate a plan for statewide expansion of the act from the Centers for Medicare and Medicaid Services.

E. The purpose of the Oklahoma Medicaid Reform Act of 2006 is to:

1. Provide Medicaid consumers who are younger than sixty-five (65) years of age and considered insurable more options in the selection of a health care plan that meets the needs of consumers and allows consumers to exercise greater control over the medical care that consumers receive. For purposes of this section "insurable" means that the cost of enrolling an individual in a private plan is equal to or less than the cost to the state of the individual remaining in the current Medicaid program;

2. Stabilize Medicaid expenditures in the act areas compared to Medicaid expenditures in the test areas for the three (3) years preceding implementation of the act, while ensuring:

a. consumer education and choice,

b. access to medically necessary services,

c. coordination of preventative, acute, and long-term care services, and

d. reductions in unnecessary service utilization;

3. Provide an opportunity to evaluate the progress of statewide implementation of the Oklahoma Medicaid Reform Act of 2006 as a replacement for the current Medicaid system; and

4. Introduce competition as a factor that lowers the cost of the act.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.3 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall have the following powers, duties, and responsibilities with respect to the development of the program established in Section 2 of this act:

1. The consumer education component shall include the following:

a. to develop a choice counseling system to ensure that the choice counseling process and related material are designed to provide consumers an understanding of both public and private health insurance options provided by this act including incentives through face-to-face interaction, by telephone, and in writing, and through other forms of relevant media,

b. to develop a system to ensure that there is record of recipient acknowledgment that choice counseling has been provided, and

c. to develop a choice counseling system that promotes health literacy and includes an educational component

that is intended to promote proper utilization of the health care system;

2. The consumer choice component shall include the following:

a. to develop a system to enable insurable Medicaid consumers to access commercial health insurance policies,

b. to develop an actuarially sound cost per Medicaid consumer within different age groups and other relevant categories including health status to provide medically necessary services which may be separated to cover comprehensive care, enhanced services, and catastrophic care. This cost would be converted into a credit or instrument of value for the Medicaid consumer to purchase qualified health insurance policies,

c. in conjunction with the Oklahoma Insurance Department, to determine benefits and standards for commercial insurers accessed by Medicaid consumers,

d. to allow consumers to purchase health care coverage through an employer-sponsored health insurance plan instead of through a qualified health insurance plan. This provision shall be known as the employee choice option. A recipient who chooses the Medicaid employee choice option shall have an opportunity for a specified period of time, as authorized by the Centers for Medicare and Medicaid Services, to select and enroll in a qualified health insurance plan,

e. to develop a process for Medicaid consumers to select commercial health insurance options, the Oklahoma Health Care Authority shall develop a plan to implement a personal health account system as an enhanced benefit. Monies deposited into a personal health account shall only be used by the recipient to defray health-care-related costs including, but not limited to, copayments, noncovered benefits, and wellness initiatives. The Health Care Authority shall promulgate rules guiding personal health account transactions; and

3. To provide a grievance-resolution process for Medicaid consumers enrolled in a health plan. This process shall include a mechanism for an expedited review of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

4. To provide a grievance-resolution process for health care providers employed by or contracted with a health plan to settle disputes among the provider and the health plan or the provider and the Oklahoma Health Care Authority.

5. By July 1, 2008, the Oklahoma Health Care Authority shall institute cost-sharing methods and/or benefit modifications within federal limitations to eligible persons whose family income is between one hundred thirty-three percent (133%) and one hundred eighty-five percent (185%) of the federal poverty level. The

benefits shall be no less than the state-sponsored health care coverage through the state premium assistance program authorized in subsection D of Section 1010.1 of Title 56 of the Oklahoma Statutes.

6. Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

7. The Oklahoma Health Care Authority shall develop a system to ensure that the implementation of the provisions of this act do not negatively affect the ability of American Indian or Alaska Native beneficiaries to access services at Indian Health Service facilities, tribally operated health facilities and Urban Indian Health Programs.

8. The Oklahoma Health Care Authority shall develop a system to ensure that the implementation of the provisions of this act do not negatively affect the reimbursement structure between the Oklahoma Health Care Authority and the Indian Health Service facilities, tribally operated health facilities and urban health programs.

9. The Oklahoma Health Care Authority shall develop mechanisms through intergovernmental transfers which will allow tribally operated facilities that elect to provide services to beneficiaries other than American Indian or Alaska Native beneficiaries to receive reimbursement for such services.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.4 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall conduct a needs analysis to design a database of clinical utilization information or electronic medical records for Medicaid providers. This system shall be web-based and allow providers to review on a real-time basis the utilization of Medicaid services including, but not limited to, office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse. The Oklahoma Health Care Authority shall evaluate and report findings to the Governor and the Legislature by January 1, 2008.

B. The Oklahoma Health Care Authority shall design and implement an electronic prescribing pilot program. The pilot program may include, but is not limited to, providing hardware, software, and connectivity for a limited number of prescribers. The prescribers who participate may be given vouchers for hardware, software, and connectivity, or the Oklahoma Health Care Authority may use direct vendor contracts. The Oklahoma Health Care Authority shall:

1. Within the messaging capabilities of the electronic prescribing system alert prescribers when patients are prescribed multiple drugs that may be duplicative, contraindicated, or have other potential problems related either to other medications or health status of the patient;

2. Track spending trends for prescription drugs and deviation from best-practice guidelines and notify prescribers who consistently fall outside those guidelines, comparing those prescribers who are using the electronic prescribing system to those who are not in order to determine whether the pilot program should be expanded; and

3. In conjunction with disease management programs or other targeted interventions, alert prescribers to patients who fail to refill ongoing or maintenance medication prescriptions in a timely fashion.

C. A report of this pilot program shall be submitted to the Governor and the Legislature no later than eighteen (18) months after the start of the program.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.5 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority in cooperation with the State Department of Health, a statewide organization of the elderly, representatives of the Health and Human Services Interagency Task Force on long-term care, and representatives of both statewide associations of nursing facility operators shall develop an incentive reimbursement rate plan for nursing facilities that shall include, but may not be limited to, the following:

1. Quality of life indicators that relate to total management initiatives;

2. Quality of care indicators;

3. Family and resident satisfaction survey results;

4. State Department of Health survey results;

5. Employee satisfaction survey results;

6. CNA training and education requirements;

7. Patient acuity level;

8. Direct care expenditures pursuant to subparagraph e of paragraph 2 of subsection I of Section 1-1925.2 of Title 63 of the Oklahoma Statutes; and

9. Other incentives which include, without limitation, participation in quality initiative activities performed and/or recommended by the Oklahoma Foundation for Medical Quality in capital improvements, in-service education of direct staff, and procurement of reasonable amounts of liability insurance.

B. The Oklahoma Health Care Authority shall negotiate with the Centers for Medicare and Medicaid Services to include the authority to base provider reimbursement rates for nursing facilities on the criteria specified in subsection A of this section.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.6 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall develop a formal program for disease management to improve the quality of care and reduce the cost of care. The Authority is authorized to contract for the development of the program if contracting is more cost effective to the state than developing the program internally. The disease management program may utilize pharmacy services including, but not limited to, Medication Management Therapy. The program may include, but not be limited to, asthma, diabetes, chronic obstructive pulmonary disease, renal disease and/or congestive heart failure.

The disease management program shall consist of:

1. Claims data analysis;

2. Population selection and targeting;

3. Intervention through educational tools for patients and providers and treatment guidelines for physicians;

4. Quality measurements of program structure, performance indicators, and outcome measures; and

5. Reporting of outcome measure data.

B. The Oklahoma Health Care Authority shall evaluate and report findings to the Governor and the Legislature no later than eighteen (18) months after the start of the program.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.7 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall develop and administer a plan for the implementation of alternatives for long-term care. The plan shall include, but not be limited to:

1. The continued development and funding of community-based options throughout the State of Oklahoma;

2. The establishment of a cash and counseling program that focuses on increasing personal responsibility, efficiency in utilization, and consumer satisfaction;

3. The establishment of a program providing for state incentives to Oklahoma citizens for long-term care planning; and

4. Stronger private/public partnerships at the community level in order to address unmet patient needs.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.8 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall continue to develop and administer a program that will encourage the timely and

appropriate use of primary care services in lieu of emergency room utilization. The program shall include, but not be limited to, the implementation of:

1. Educational strategies;

2. Technology-based monitoring; and

3. Co-payment structures as provided for in Section 3 of this act.

B. The Oklahoma Health Care Authority may develop a pilot program utilizing state-licensed health care professionals to perform educational interventions with consumers who highly utilize emergency room services or to perform other services to reduce unnecessary emergency room visits.

C. The Oklahoma Health Care Authority shall develop and implement a telephone information health line pilot program under which physicians are available by telephone twenty-four (24) hours a day to answer medical questions and provide health information for the Medicaid population. If the Health Care Authority determines that the pilot program reduces unnecessary emergency room visits and the pilot program demonstrates a net cost-savings, the Health Care Authority shall expand the program into a statewide initiative.

D. The Oklahoma Health Care Authority shall evaluate and report findings to the Governor and the Legislature by January 1, 2008.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.9 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall establish a method to deter abuse and reduce errors in Medicaid billing, payment and eligibility through the use of technology and accountability measures for the Authority, providers and consumers. The Authority shall achieve a payment error rate measurement of no greater than five percent (5%) by fiscal year 2009. The Oklahoma Health Care Authority shall evaluate and report findings to the Governor and the Legislature.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall apply for any necessary waiver to extend health care benefits to persons up to the age of twenty-three (23) years if the person is enrolled as a full-time student in an accredited university or college in the State of Oklahoma.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-723.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each hospital in this state shall establish a discount program for hospital charges for qualified self-pay patients who have household incomes of up to three hundred percent (300%) of the federal poverty guidelines. This discount program shall not be

required for patients who are eligible for or enrolled in private or public insurance plans providing hospital coverage, including indemnity plans.

B. While a hospital may set uniform prices for its services, products, and fees, qualified self-pay patients shall be eligible for minimum discounts from the hospital so that the hospital charge after the discount shall not exceed the greater of the amount Medicare would pay for the same services, or the cost of services as determined by multiplying the hospital's whole cost-to-charge ratio by the billed charges.

C. It shall be the responsibility of the patient to establish their eligibility for the discount.

D. The provisions of this section do not apply to procedures that are not medically necessary as determined by the treating physician.

E. In a collection action brought by the hospital, a patient may assert the provisions of this section as a defense to the action. To be available as a defense, the patient must establish eligibility for the discount by proving:

1. The household income of the patient is below three hundred percent (300%) of the federal poverty guidelines; and

2. The patient is not eligible or enrolled in private or public insurance plans providing hospital coverage.

If the elements are established, the hospital is limited in its collection efforts to the greater of the amount Medicare would pay for the same services, or the cost of services as determined by multiplying the hospital's whole cost-to-charge ratio by the billed charges.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-821.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created, to continue until February 1, 2007, the "Task Force on Nursing Home Insurance Access".

B. The Task Force shall consist of sixteen (16) members:

1. Three members shall be appointed by the Speaker of the Oklahoma House of Representatives as follows:

a. one member who represents an intermediate care facility for the mentally retarded (ICF/MR),

b. one member who represents a nursing home facility, and

c. one member of the Oklahoma House of Representatives appointed by the Speaker of the House of Representatives;

2. Three members shall be appointed by the President Pro Tempore of the State Senate as follows:

a. one member who is a practicing attorney in the area of elder or health care law,

b. one member who represents a statewide elder justice organization, and

c. one member of the State Senate appointed by the President Pro Tempore of the State Senate;

3. Four members shall be appointed by the Governor as follows:

a. one member who is a practicing attorney in insurance and medical malpractice law,

b. one member who has experience in health economics,

c. one member who represents the insurance industry, and

d. one member who represents a nursing home facility;

4. The Director of the Department of Human Services, or a designee;

5. The Director of the State Department of Health, or a designee;

6. The President of the Oklahoma Association of Health Care Providers, or a designee;

7. The Commissioner of the Oklahoma Insurance Department, or a designee;

8. The President of the Oklahoma Association of Home Care, or a designee; and

9. The Director of the Oklahoma Health Care Authority, or a designee.

C. The appointed member from the Oklahoma House of Representatives and the appointed member from the State Senate shall serve as cochairs of the Task Force. The cochairs shall convene the first meeting of the Task Force. The members of the Task Force shall elect any other officers during the first meeting and upon a vacancy in any office. The Task Force shall meet as often as necessary.

D. Appointments to the Task Force shall be made by July 1, 2006.

E. A majority of the members of the Task Force shall constitute a quorum. A majority of the members present at a meeting may act for the Task Force.

F. Nonlegislative members of the Task Force shall be reimbursed by their respective agencies for necessary travel expenses incurred in the performance of duties pursuant to the provisions of the State Travel Reimbursement Act. Legislative members of the Task Force shall be reimbursed for necessary travel expenses incurred in the performance of duties in accordance with the provisions of Section 456 of Title 74 of the Oklahoma Statutes.

G. Administrative support for the Task Force including, but not limited to, personnel necessary to ensure the proper performance of the duties and responsibilities of the Task Force, shall be provided by the Oklahoma Health Care Authority to be supplemented, if necessary, by the state agencies involved in the Task Force, and the staff of the House of Representatives and the State Senate. All participating state agencies shall provide for any administrative support requested by the Task Force.

H. The Task Force shall develop recommendations for providing greater access to liability insurance coverage for nursing home facilities including, but not limited to, improved enforcement of nursing home quality standards, affordable premiums, risk management, alternative forms of insurance, and strengthened regulation of the insurance industry.

I. The Task Force shall examine the feasibility of transferring the administration of community-based services from the Department of Human Services to the Oklahoma Health Care Authority.

J. The Task Force shall publish a report of findings and recommendations by February 1, 2007, including recommendations for any resulting legislation.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4513 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All entities providing health insurance or health care coverage to individuals residing within the state shall provide such information on coverage and benefits as may be required by any health care provider, health plan, health plan sponsor or their agent regarding the coverage provided by the entity to any patient or beneficiary of the medical service provider, health plan, or health plan sponsor.

B. Any health care provider, health plan, health plan sponsor or their agent is authorized to transmit the simple human identifiers in ANSI X.12 270 inquiries including the name, gender, date of birth, and member number or policyholder identification number if required by the health plan of a patient to any and all entities licensed or registered to provide health insurance or health care coverage to individuals residing within the state to establish the coverage in force for a patient presenting or about to present a claim.

C. Any party named in subsection A of this section shall have a cause of action for injunctive relief and costs including, but not limited to, attorney fees for the enforcement of this section against any noncompliant health plan.

SECTION 14. AMENDATORY Section 7, Chapter 374, O.S.L. 2002, as amended by Section 3, Chapter 412, O.S.L. 2003 (63 O.S. Supp. 2005, Section 3240.5), is amended to read as follows:

Section 3240.5 A. There is hereby created the Community Hospitals Authority, an agency of the State of Oklahoma, a body corporate and politic, with powers of government and with the

authority to exercise the rights, privileges and functions as specified in the Community Hospitals Authority Act.

B. The Authority shall be composed as follows:

1. The presidents of Oklahoma State University and the University of Oklahoma or their designees;

2. One member appointed by the Governor who shall be a citizen and resident of a metropolitan area meeting the criteria provided in paragraph 4 of Section 3240.2 of this title who has no direct affiliation with a participating health care system or a university listed in paragraph 1 of this subsection;

3. One member appointed by the Speaker of the House of Representatives;

4. One member appointed by the President Pro Tempore of the State Senate;

5. The Director of the Oklahoma Health Care Authority; and

6. One representative from each of the three participating health care systems, as defined in Section 3240.2 of this title, who shall each serve terms of three (3) years and may be reappointed;

7. One representative from the Oklahoma Department of Commerce designated as the Community Action Agency for the largest county in terms of population included within the geographic boundaries of the Community Hospitals Authority;

8. One representative from the chamber of commerce, or any other organization of business entities, from the largest metropolitan area in terms of population included within the geographic boundaries of the Community Hospitals Authority;

9. One representative appointed by the existing members of the Authority from a city-county health department; and

10. One representative appointed by the existing members of the Authority from a charitable or philanthropic foundation with assets in excess of Five Hundred Million Dollars ($500,000,000.00) that has demonstrated a commitment to supporting the missions of the Community Hospitals Authority.

C. The members appointed by the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the State Senate shall serve terms of three (3) years and may be reappointed. Successors shall be appointed for terms of three (3) years.

D. Each member of the Authority, prior to appointment, shall be a resident of the state and a registered voter.

E. The members of the Authority shall serve without compensation but may be reimbursed for all actual and necessary travel expenses incurred in the performance of their duties in accordance with the provisions of the State Travel Reimbursement Act.

F. A quorum of the Authority shall be a majority of the voting members. The members of the Authority shall annually elect a chair from among its membership.

SECTION 15. AMENDATORY 56 O.S. 2001, Section 1010.1, as last amended by Section 1, Chapter 136, O.S.L. 2004 (56 O.S. Supp. 2005, Section 1010.1), is amended to read as follows:

Section 1010.1 A. Sections 1010.1 through 1010.7 of this title shall be known and may be cited as the "Oklahoma Medicaid Program Reform Act of 2003".

B. Recognizing that many Oklahomans do not have health care benefits or health care coverage, that many small businesses cannot afford to provide health care benefits to their employees, and that, under federal law, barriers exist to providing Medicaid benefits to the uninsured, the Oklahoma Legislature hereby establishes provisions to lower the number of uninsured, assist businesses in their ability to afford health care benefits and coverage for their employees, and eliminate barriers to providing health coverage to eligible enrollees under federal law.

C. The Oklahoma Health Care Authority shall provide coverage under the state Medicaid program to children under the age of eighteen (18) years whose family incomes do not exceed one hundred eighty-five percent (185%) of the federal poverty level.

D. 1. The Authority is hereby directed to apply for a waiver or waivers to the Centers for Medicaid and Medicare Services (CMS) that will accomplish the purposes outlined in subsection B of this section. The Authority is further directed to negotiate with CMS to include in such waiver authority provisions to:

a. increase access to health care for Oklahomans,

b. reform the Oklahoma Medicaid Program to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing,

c. enable small employers, and/or employed, uninsured adults with or without children to purchase employer-sponsored, state-approved private, or state-sponsored health care coverage through a state premium assistance payment plan. If by January 1, 2008, the Employer/Employee Partnership for Insurance Coverage Premium Assistance Program is not consuming more than seventy-five percent (75%) of its dedicated source of funding, then the program will be expanded to include parents of children eligible for Medicaid, and

d. develop flexible health care benefit packages based upon patient need and cost.

2. The Authority may phase in any waiver or waivers it receives based upon available funding.

3. The Authority is hereby authorized to develop and implement a ~~pilot~~ premium assistance plan to assist small businesses and/or

their eligible employees to purchase employer-sponsored insurance or "buy-in" to a state-sponsored benefit plan.

4. During the implementation of the premium assistance program, the Authority is hereby authorized to seek from the Centers for Medicare and Medicaid Services any waivers necessary to accomplish an expansion of the premium assistance program to include employers with fifty employees or less up to any level supported by existing funding resources.

E. 1. There is hereby created in the State Treasury a revolving fund to be designated the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund".

2. The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of:

a. all monies received by the Authority pursuant to this section and otherwise specified or authorized by law,

b. monies received by the Authority due to federal financial participation pursuant to Title XIX of the Social Security Act, and

c. interest attributable to investment of money in the fund.

3. All monies accruing to the credit of the fund are hereby appropriated and shall be budgeted and expended by the Authority to implement a premium assistance plan.

SECTION 16. AMENDATORY 63 O.S. 2001, Section 1-707, is amended to read as follows:

Section 1-707. A. The State Board of Health, upon the recommendation of the State Commissioner of Health and with the advice of the Oklahoma Hospital Advisory Council, shall promulgate rules and standards as it deems to be in the public interest for hospitals, on the following:

1. Construction plans and location, including fees not to exceed Two Thousand Dollars ($2,000.00) for submission or resubmission of architectural and building plans, and procedures to ensure the timely review of such plans by the State Department of Health. Said assessed fee shall be used solely for the purposes of processing approval of construction plans and location by the State Department of Health;

2. Physical plant and facilities;

3. Fire protection and safety;

4. Food service;

5. Reports and records;

6. Staffing and personal service;

7. Surgical facilities and equipment;

8. Maternity facilities and equipment;

9. Control of communicable disease;

10. Sanitation;

11. Laboratory services;

12. Nursing facilities and equipment; and

13. Other items as may be deemed necessary to carry out the purposes of this article.

B. 1. The State Board of Health, upon the recommendation of the State Commissioner of Health and with the advice of the Oklahoma Hospital Advisory Council and the State Board of Pharmacy, shall promulgate rules and standards as it deems to be in the public interest with respect to the storage and dispensing of drugs and medications for hospital patients.

2. The State Board of Pharmacy shall be empowered to inspect drug facilities in licensed hospitals and shall report violations of applicable statutes and rules to the State Department of Health for action and reply.

C. 1. The Commissioner shall appoint an Oklahoma Hospital Advisory Council to advise the Board, the Commissioner and the Department regarding hospital operations and to recommend actions to improve patient care.

2. The Advisory Council shall have the duty and authority to:

a. review and approve in its advisory capacity rules and standards for hospital licensure,

b. evaluate, review and make recommendations regarding Department licensure activities, provided however, the Advisory Council shall not make recommendations regarding scope of practice for any health care providers or practitioners regulated pursuant to Title 59 of the Oklahoma Statutes, and

c. recommend and approve:

(1) quality indicators and data submission requirements for hospitals, <u>to include:</u>

<u>(a) Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators Available as part of the standard inpatient discharge data set, and</u>

<u>(b) for acute care intensive care unit patients, ventilator-associated pneumonia and device-related blood stream infections,</u> and

(2) the indicators and data to be used by the Department to monitor compliance with licensure requirements, and

d. to publish an annual report of hospital performance to include the facility specific quality indicators required by this section.

D. 1. The Advisory Council shall be composed of nine (9) members appointed by the Commissioner with the advice and consent of the Board. The membership of the Advisory Council shall be as follows:

a. two members shall be hospital administrators of licensed hospitals,

b. two members shall be licensed physicians or practitioners who have current privileges to provide services in hospitals,

c. two members shall be hospital employees, and

d. three members shall be citizens representing the public who:

(1) are not hospital employees,

(2) do not hold hospital staff appointments, and

(3) are not members of hospital governing boards.

2. a. Advisory Council members shall be appointed for three-year terms except the initial terms after November 1, 1999, of one hospital administrator, one licensed physician or practitioner, one hospital employee, and one public member shall be one (1) year. The initial terms after the effective date of this act of one hospital administrator, one licensed physician or practitioner, one hospital employee, and one public member shall be two (2) years. The initial terms of all other members shall be three (3) years. After initial appointments to the Council, members shall be appointed to three-year terms.

b. Members of the Advisory Council may be removed by the Commissioner for cause.

E. The Advisory Council shall meet on a quarterly basis and shall annually elect from among its members a chairperson. Members of the Council shall serve without compensation but shall be reimbursed by the Department for travel expenses related to their service as authorized by the State Travel Reimbursement Act.

SECTION 17. AMENDATORY 63 O.S. 2001, Section 5009.2, is amended to read as follows:

Section 5009.2 A. The Advisory Committee on Medical Care for Public Assistance Recipients, created by the Oklahoma Health Care Authority, pursuant to 42 Code of Federal Regulations, Section 431.12, for the purpose of advising the Authority about health and medical care services, shall include among its membership the following:

1. Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care. The Advisory Committee shall, at all times, include at least one physician from each of the six classes of physicians listed in Section 725.2 of Title 59 of the Oklahoma Statutes; provided, however, such physicians shall be participating providers in the State Medicaid Plan;

2. Members of consumers' groups, including, but not limited to:

a. Medicaid recipients, and

b. representatives from each of the following consumer organizations which represent the interests of:

(1) people who are economically disadvantaged,

(2) children,

(3) the elderly,

(4) people with mental illness,

(5) people who are developmentally disabled, and

(6) people with alcohol or substance abuse problems; ~~and~~

3. The Director of the Department of Human Services; and

4. A member approved and appointed by the Oklahoma Academy of Pediatrics who shall:

a. monitor provider relations with the Oklahoma Health Care Authority, and

b. create a forum to address grievances.

B. The Advisory Committee shall meet bimonthly to review and make recommendations related to:

1. Policy development and program administration;

2. Policy changes proposed by the Authority prior to consideration of such changes by the Authority;

3. Financial concerns related to the Authority and the administration of the programs under the Authority; and

4. Other pertinent information related to the management and operation of the Authority and the delivery of health and medical care services.

C. 1. The Administrator of the Authority shall provide such staff support and independent technical assistance as needed by the Advisory Committee to enable the Advisory Committee to make effective recommendations.

2. The Advisory Committee shall elect from among its members a chair and a vice-chair. A majority of the members of the Advisory Committee shall constitute a quorum to transact business, but no vacancy shall impair the right of the remaining members to exercise all of the powers of the Advisory Committee.

3. Members shall not receive any compensation for their services, but shall be reimbursed pursuant to the provisions of the State Travel Reimbursement Act, Section 500.1 et seq. of Title 74 of the Oklahoma Statutes.

D. The Authority shall give due consideration to the comments and recommendations of the Advisory Committee in the Authority's deliberations on policies, administration, management and operation of the Authority.

SECTION 18. REPEALER 63 O.S. 2001, Section 1-702b, as last amended by Section 1 of Enrolled Housed Bill No. 2465 of the 2nd Session of the 50th Oklahoma Legislature, is hereby repealed.

SECTION 19. REPEALER Section 2, Chapter 431, O.S.L. 2004 (63 O.S. Supp. 2005, Section 1-702d), as last amended by Section 2 of Enrolled Housed Bill No. 2465 of the 2nd Session of the 50th Oklahoma Legislature, is hereby repealed.

SECTION 20. Section 11 of this act shall become effective July 1, 2007.

SECTION 21. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 25th day of May, 2006.

Presiding Officer of the House of Representatives

Passed the Senate the 25th day of May, 2006.

Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Governor this 26
day of May, **20** 06,
at 1:30, **o'clock** P **M.**

By: Blair Gaddis

Approved by the Governor of the State of Oklahoma the 9 **day of** June **20** 06, **at** 10:02, **o'clock** A **M.**

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Secretary of State this 9th
day of June, **20** 06,
at 10:47, **o'clock** A **M.**

By: M. Susan Savage

APPENDIX L

"Reducing Costs and Driving Behavior Change: A Review of OHCA Interventions for Reducing Non-Emergent Visits"

Reducing Costs and Driving Behavior Change: A Review of OHCA Interventions for Reducing Non-Emergent ER Visits

Oklahoma Health Care Authority

March 2014

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Introduction

Appropriate utilization of emergency room (ER) care is critical to ensuring an effective and efficient health care system. Costs associated with non-emergent visits to the ER can be avoided by interventions and incentives targeting both patient and provider behavior, as well as access to appropriate care that meets consumer demand (e.g., after-hours access, geographic proximity). Effective strategies include a structure that provides an alternative to non-emergent ER utilization, interventions that change behavior of those who continue to visit the ER for non-emergent care despite viable alternatives and repercussions for patients who do not respond to interventions and incur avoidable costs. This review provides a brief description of OHCA interventions to reduce non-emergent ER visits.

Primary Care Delivery System

OHCA intentionally designed the primary health care delivery system for SoonerCare to promote use of the appropriate level of care for members and to reduce non-emergent visits to the ER. Influencing member behavior and ensuring efficient delivery of care begins well before members visit the ER.

Patient-Centered Medical Home

OHCA administers SoonerCare Choice (Choice), a patient-centered medical home (PCMH) system launched in January 2009 and built on the foundational values of accessibility, continuity, comprehensiveness, family-centeredness, coordination, compassion and culturally-sensitive care. The Choice program is based on joint principles adopted by the American Academy of Pediatrics, the American Academy of Family Physicians, the American Osteopathic Association and the American College of Physicians. These principles address the medical home partnership, in which access is facilitated to specialty care, educational services, out-of-home care, family support and other public and private community services important to the overall health of the patient.

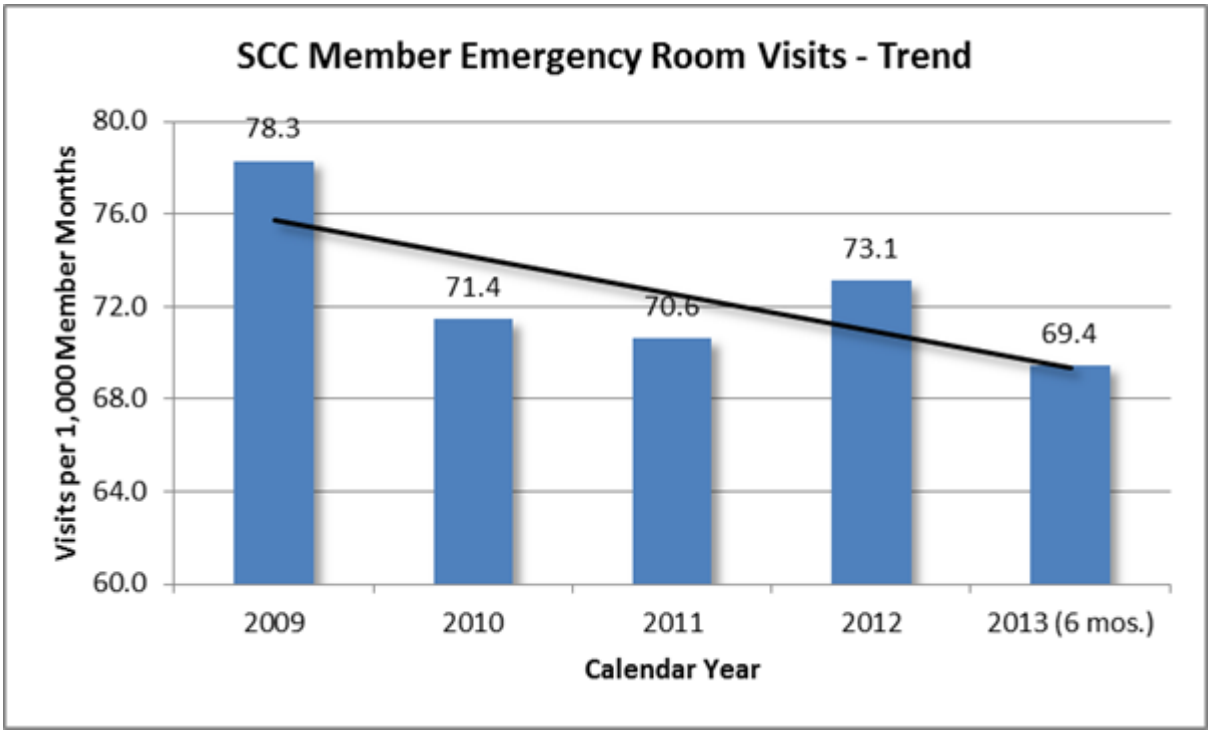
The Choice program obtains regular feedback from an advisory group comprised of Oklahoma physicians. More than 2/3 (69%) of all members enrolled in SoonerCare receive care through this system. Choice medical home providers are categorized in one of three tiers based on the services they provide, with access being a critical component for each tier.

Choice **program goals** include:

- Reduce inappropriate emergency room visits and hospitalizations;
- Guarantee the availability of a medical home with a primary care provider;
- Enhance patient choice and participation in health decisions;
- Ensure members receive necessary preventive and primary care, including immunizations and health screenings;
- Realign payment incentives to improve cost effectiveness & quality; and,
- Promote the use of health information systems.

Choice **program results** include (Source: Pacific Health Policy Group):

- Increase in satisfaction with "getting needed care" for both children and adults;
- Decrease in ER utilization;
    - *In a typical month* in CY 2009, for every 1,000 SoonerCare members, there were 78 ER visits.
    - *In a typical month* in the first half of 2013, for every 1,000 SoonerCare members, there were 69 ER visits.
    - Members enrolled in Choice for at least 6 months have lower ER utilization.
    - On a per member basis, ER visits declined by 11.3 percent from CY 2009 to CY 2013. This equates to 42,900 avoided ER visits totally an estimated $15 million in cost avoidance.
- Decrease in avoidable hospitalizations;
    - The 30-day readmission rate declined from 13.9 percent in CY 2009 to 10.2 percent in the first half of CY 2013.
- Additional Choice evaluation results available at http://www.okhca.org/research.aspx?id=88&parts=7447.



Source: Pacific Health Policy Group.

Health Access Networks

OHCA has worked with the provider community to develop three health access networks (HANs) serving more than 120,000 SoonerCare members in the state. HANs enhance the Choice program by creating community-based, integrated health networks to support patient-centered medical home, resulting in increased access to appropriate levels of care, enhanced quality and coordination of care and reduction in costs. HANs receive $5 per member per month for care management duties, and focus on use of electronic medical records, access to specialty care and community resources, telemedicine, quality improvement and care coordination for complex health needs. A reduction in non-emergent ER utilization and improved health outcomes are among the expected results for members served by a HAN. An independent evaluation is currently underway.

OHCA Provider Services provides a monthly report to HAN providers that includes all ER utilization for their members. From July 2013 to September 2013 (most recent data), HAN providers mailed 2,346 letters to their members visiting the ER two or more times in a quarter,

664 letters to those with three or more visits, 423 letters to those with four to fourteen visits and 15 letters to persistent users with 15 or more visits in a quarter.

Comprehensive Primary Care Initiative

OHCA partners with Medicare, Blue Cross Blue Shield and Community Care to implement and evaluate an innovative, multi-payer Comprehensive Primary Care Initiative (CPCI) aimed at improving health outcomes, improving the delivery of care and reducing costs. CPCI includes 68 participating practices and currently serves approximately 28,000 Choice members. Participating providers must develop an annual budget or forecast, provide care management for high risk patients, provide 24/7 patient access guided by medical record, assess and improve patient care experience, use data to guide improvement in care at the provider level, demonstrate active engagement and care coordination across the medical neighborhood, improve patient shared decision-making, participate in a market-based learning collaborative and meet requirements for Stage 1 meaningful use. CPCI efforts are expected to reduce non-emergent ER utilization. An independent evaluation is currently underway.

Interventions for Frequent ER Utilizers

Though the vast majority of SoonerCare members utilize the appropriate level of care, OHCA works diligently across operational units to identify frequent ER utilizers and takes action to change member behavior and, as necessary, terminate enrollment. Member interventions are conducted by Member Services, Population Care Management, Pharmacy Services and Legal Services. Provider-focused interventions are conducted by Provider Services.

Member Behavior

The quarterly average for the number of frequent ER utilizers, defined as two or more visits per quarter, is 20,101. This number is then grouped in to three categories based on frequency. On average, there are approximately 17,732 members per quarter with two or three ER visits, 2,320 members per quarter with four to fourteen ER visits and 49 members per quarter with 15 or more ER visits. OHCA employs a multifaceted approach to changing member behavior, including implementation of the frequent ER utilization program, interventions by population care management staff and a pharmacy lock-in program.

Frequent ER Utilization Program

The following steps are taken to intervene and change member behavior related to frequent ER utilization. In many cases, OHCA Member Services conducts the intervention. However, complex cases may be handled by OHCA Population Care Management.

1. OHCA identifies members served by the Choice program or an Indian Health Service/Tribal facility/Urban Indian Clinic (ITU) who have two or more paid ER visits per quarter within a calendar year.
2. A letter is sent to each Choice & ITU member identified. The letter is stratified based on age (adults age 21 and older and children age 20 and younger) and by frequency of ER utilization. Letters for those with two or three ER visits per quarter are informational and require no response. The letter for those visiting the ER four to fourteen times in a quarter requests that the member contact OHCA Member Services for education. Complex cases may be referred to Population Care Management. If a member participates in the OHCA Health Management Program (HMP) or receives services from the OHCA Chronic Care Unit (CCU), intervention is provided by staff in these units.
3. A second letter is generated to members with four to fourteen ER visits two weeks after the initial letter.
4. Members with 15 or more ER visits in a quarter are identified as persistent members. For this group, an OHCA Member Services Coordinator (Coordinator) attempts contact by phone at three different times on three different days. If the Coordinator does not reach a persistent member after three attempts, a letter is mailed that includes total ER visits for the quarter and directs member to contact the Coordinator.
5. Persistent members are forwarded to the OHCA pharmacy director to be considered for pharmacy lock-in.
6. Persistent members are assigned to the ER Intervention Team consisting of a member services coordinator, member services supervisor and a provider services specialist for care evaluation. The ER Intervention Team has three months from the date of identification to verify eligibility and intervene through phone contact.
7. If a persistent member is reported twice after an intervention is completed, s/he is referred to the OHCA Legal Services Division (Legal) and no further action will be taken by ER Intervention Team. Supporting documents will be sent to Legal with this referral

and the assigned investigator will mail the member a warning letter. If a member continues to be reported on the persistent member list, Legal will be notified with supporting documents.

Population Care Management

In addition to the intervention provided by Member Services, complex cases may be handled by staff in the OHCA Population Care Management (PCM) Division. PCM services include case management, a Health Management Program (HMP) and a Chronic Care Unit (CCU). For some complex cases, case management staff may conduct interventions with frequent ER utilizers in addition to those provided by Member Services. However, members receiving services from HMP or CCU who are identified as frequent ER utilizers are contacted by and receive intervention from staff in those units rather than from Member Services as they have established relationships with the members.

Case management teams work with members to ensure access to appropriate care and resources, and to change behavior through one-on-one education and support. Frequent ER utilizers may be referred to case managers by Member Services, providers or other sources. On average, case managers provide intervention to approximately 36 members per quarter for frequent ER utilization.

HMP works with Choice members who have, or are at risk, for developing a chronic disease with the goal of improving their health. OHCA contracts with Telligen to provide these services. As part of the service delivery model for the 33 practices serving 4,040 members who participate in HMP, health coaches are embedded in practices to assist with member education and behavior change, including frequent ER utilization when applicable. On average, approximately 256 members per quarter are referred to HMP for frequent ER utilization.

For high-risk or at-risk members with chronic conditions who are served by practices without a health coach, the CCU works with 410 members to provide care coordination, teach self-management principles and apply behavior modification principles to improve health status. Approximately 37 members per quarter are referred to the CCU from member services for frequent ER utilization.

Evaluation of PCM initiatives with an impact on frequent ER utilization has focused thus far on HMP. An external evaluation by the Pacific Health Policy Group indicates a 5 percent reduction in emergency room use for those receiving face-to-face intervention and an 18 percent

reduction among those receiving telephonic intervention. An independent evaluation of PCM and CCU efforts is currently underway.

Pharmacy Lock-In

OHCA also monitors inappropriate utilization of prescription medication which is sometimes correlated with frequent ER utilization. To address this issue, OHCA administers a Pharmacy Lock-In Program to assist health care providers in monitoring potential abuse or inappropriate utilization of controlled prescription medications by SoonerCare members. When warranted, a member may be "locked-in", and therefore required to fill all prescriptions at a single designated pharmacy. Referrals to the Pharmacy Lock-In Program come from several sources, including physicians, pharmacies, case workers and OHCA staff.

In order to qualify for lock-in review, an individual must be currently enrolled in SoonerCare or the Insure Oklahoma Individual Plan. Dual-eligible individuals who are enrolled in both SoonerCare and Medicare do not qualify for the Pharmacy Lock-In Program, as their pharmacy benefits are administered by a Medicare Part D drug plan.

After a member is referred to this program, the following information is reviewed:

- Pharmacy claims;
- Hospital/ER claims;
- Physician claims;
- History of diagnoses; and
- Number of prescribers and their specialties.

If the member's utilization is determined to be potentially inappropriate, the lock-in process is started and the member is required to fill all prescriptions at a single pharmacy. The member is given the opportunity to choose a designated pharmacy. This pharmacy is contacted for consent prior to the member being locked-in.

Provider Education and Support

To supplement member-focused initiatives, OHCA works closely with providers to ensure they are well-equipped with the necessary data and resources to ensure that members access the appropriate level of care. Provider Services works one-on-one with practices serving

members identified as persistent utilizers. Incentive payments are also available for practices meeting established thresholds for member ER utilization.

Frequent ER Utilization Program

1. OHCA identifies members served by the Choice program or an Indian Health Service, tribal or urban Indian facility (ITU) who have two or more paid ER visits per quarter (calendar year).
2. A letter is generated to the primary care provider (PCP) for the identified Choice and ITU members. The letter includes the ER date of service, facility and first three diagnoses billed on the claim.
3. A dedicated Provider Services Education Specialist responds to and documents all resulting PCP inquiries. Appropriate members are referred to Population Care Management. In addition, hospital outreach is done as needed.
4. For persistent members utilizing the ER 15 or more times in a quarter, a dedicated Provider Services Education Specialist immediately conducts outreach calls to the PCP.

In addition, OHCA Provider Services provides a monthly report to Graduation Medical Education providers (i.e., University of Oklahoma and Oklahoma State University) that includes all ER utilization by enrolled members during a given month. The report includes data related to the member's eligibility, ER facility used and the diagnoses filed on the related claim.

SoonerExcel Incentive Payments

OHCA provides incentive payments to PCPs who meet or exceed the ER utilization compliance rate and educate patients on proper ER utilization. A compliance ratio for the PCP is calculated based on the observed-to-expected (O/E) ER visits. The complete methodology can be found at http://www.okhca.org/providers.aspx?id=9426&menu=74&parts=8482_10165.

Legal Sanctions and Member Removal

If a persistent member is reported twice after an intervention is completed or if the ER Intervention team is unable to contact the member after being identified for two consecutive quarters, s/he is referred to Legal and no further action will be taken by ER Intervention Team. Supporting documents will be sent to Legal with this referral and the assigned investigator will

mail the member a warning letter. If a member continues to be reported on the ER persistent utilization list, Legal will be notified with supporting documents.

The following steps are taken by Legal upon receipt of a referral:

1. Within 20 days, a certified letter is sent by the assigned investigator to the member informing them of their referral to Legal for persistent ER utilization.
2. Thirty days after the certified letter is sent, OHCA Member Services will provide an updated report of the member's usage spanning the time from the letter date to present. The report includes:
    - Total paid by OHCA for ER visits, total PCP visits, and prescriptions provided to member
    - Top five (if possible) billing codes for each ER visit and office visits
    - Total number of admittance claims resulting from an ER visit
    - Date/ Hospital Name/Location/ Provider Name (if applicable) where the visit took place
    - Any referrals/notes provided by medical professionals regarding suspected fraud/abuse
    - Any other information deemed pertinent by referring Member Services staff
3. Upon receipt of updated report, investigators have 45 days to determine if additional inquiry is necessary to reach a conclusion on the case. This time frame accounts for work load, case complexity and other issues that may arise to prevent a shorter completion period.

Once Legal has completed their research, they will send a letter via certified mail informing the member of possible sanctions. The letter allows for a 20 day response time, and includes instructions for filing for an appeal hearing. If the hearing is in OHCA's favor, the member's benefits will be sanctioned for six months after which time s/he can reapply for benefits.

If the member appears on the frequent ER utilization list again, the case will be forwarded to Legal with no further action by the ER Intervention Team. Legal will again contact the member regarding the sanctions process. If the member is sanctioned again, it will be for a

period of 12 months after which time s/he will be allowed to reapply for benefits. If the member shows up after being reinstated again, s/he will be referred back to Legal for the sanctioning process. If the member is sanctioned again, s/he will lose benefits and not be allowed to reapply. The ER Intervention Team will continue to notify Legal of the member's ER utilization during the course of an investigation.

Since this intervention was launched in December 2011, 30 members have been referred to Legal. Of these referrals, 10 members have been suspended for a six month period, while two members have been suspended for a 12 months period. No members have remained persistent utilizers after the 12 month suspension which would result in permanent loss of benefits.

Conclusion

OHCA initiatives aimed at ensuring access and utilization of the appropriate level of care for SoonerCare members is multifaceted and includes a patient-centered system for health care delivery that promotes primary and preventive care through a medical home provider charged with care coordination, as well as interventions to change behavior of members identified as frequent ER utilizers. An independent evaluation of the patient-centered medical home and the Health Management Program show a reduction in inappropriate ER utilization as a result of these efforts, and evaluation of other OHCA initiatives is currently underway. Combined, these efforts result in reduced costs for patient care while ensuring responsive and responsible service delivery to Oklahoma children and families.

APPENDIX M

SoonerExcel Incentive Payment System

Source:
http://okhca.org/providers.aspx?id=9426&menu=74&parts=8482_10165

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STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

ED Utilization

Summary

The Emergency Department (ED) utilization incentive's purpose is to supply further payment to PCP's that meet or exceed the ED utilization compliance rate and to incentivize PCP's to educate panel members about proper ED usage. The first payment will be made in April 2009 based on dates of services between October 1, 2008 and December 31, 2008 with paid dates through March 31, 2009.

Criteria

Providers will be paid a per member month rate for the relative member months in his or her panel. The relative member months are determined as follows:

- Providers with observed-to-expected (O\E) ratios of member ED visits and office visits below the lower end of the historical 95% confidence interval will have their actual panel member months count twice. (Highest level of compliance)

- Providers with O\E ratios above the upper end of the historical 95% confidence interval will have their actual panel member months count once. (Lowest level of compliance)

- All other providers will have their actual panel member months count one and a half times. (Moderate level of compliance)

Payment will be determined by the percentage of relative member months in a provider's panel out of all relative member months multiplied by the funds available for the quarter.

Each service location is considered a unique provider.

Panel Eligibility

For ED utilization, the base payment is determined by the consistent SoonerCare Choice memberships from the provider's panel. These are the members that are most likely to be affected with proper education about emergency room practices. Members must be enrolled with that provider in the quarter of interest and the previous quarter a combined total of at least 4 months.

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OKLAHOMA HEALTH CARE AUTHORITY

Claims

ED claims are SoonerCare Choice physician fee-for-service claims with procedure codes between 99281 and 99285.

OV claims are SoonerCare Choice encounters on PCP claims only.

Claim status is different from denied.

Only claims with a first date of service in the period of interest are included in the calculations.

Risk Adjustment

Provider panels are risk adjusted using the John Hopkins University Adjusted Clinical Group (ACG) Case-Mix System. SoonerCare Choice members are designated a categorical ACG score by the John Hopkins University ACG Case-Mix System based on the claim history and characteristics of the members. Although there are over 100 categories available, members will only fall into one category. Hence, qualifying members on the PCP panel are categorized by the ACG score. ACG values are updated semi-annually. An ED ratio is then calculated for each ACG value. This ratio is the ratio of ED visits by all members in that ACG category to all visits (ED and OV) from members in that category.

ACG Rates for Selected ACG Scores			
ACG Score	***Office Visit Count***	***ED Visit Count***	***ACG Specific ED Rate***
0100	*3962*	*637*	*0.1385*
0200	*8766*	*2638*	*0.2313*
0300	*9737*	*3606*	*0.2702*
…	*…*	*…*	*…*

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OKLAHOMA HEALTH CARE AUTHORITY

A provider's expected ED rate is the sum of the expected ACG specific ED rates of each member in his or her panel that had either an ED visit or an OV visit in the period of interest divided by the same count of members. In the below example, the provider will have an expected ED rate of .1853 = (0.9268/5).

Provider ABC's Expected ED Rate				
Provider	***Client ID***	***ACG Score***	***ACG Specific ED Rate***	***Provider ED Rate***
ABC	*Member 1*	*4910*	*0.2039*	*---*
ABC	*Member 2*	*2900*	*0.2321*	*---*
ABC	*Member 3*	*0100*	*0.1385*	*---*
ABC	*Member 4*	*1900*	*0.1773*	*---*
ABC	*Member 5*	*4220*	*0.1750*	*---*
TOTALS	***5***		***0.9268***	***.1853***

A provider's observed ED rate is the sum of the actual observed ED visits by members in his or her panel that had any type of visit in the period divided by the total visits (ED and OV). In this example, the observed ED rate is .1739 = (4/23).

Actual Visits by Provider ABC's Clients			
Client ID	***Office Visit Count***	***ED Visit Count***	***All Visits***
Member 1	4	2	6
Member 2	5	0	5
Member 3	0	1	1
Member 4	9	1	10
Member 5	1	0	1
TOTALS	***19***	***4***	***23***

The O/E ratio is the observed ED rate divided by the expected ED rate.

Provider ABC's O/E Ratio		
Expected ED rate	***Observed ED rate***	***O/E Ratio***
.1853	*.1739*	*.9385*

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ED Utilization Quarterly Payment Example

The allotment for this measure is $500,000 annually. The amount available per quarter is $125,000.

The example shows providers with comparative volumes, but different performance measures. The 95% confidence interval around the historical O/E ratio has a range of 1.05 (O/E ratios less then this number receive a rate of 2) and 1.17 (O/E ratios greater than this number receive a rate of 1). O/E ratios between 1.05 and 1.17 will receive a rate of 1.5.

Observed ED Visit Rate	Expected ED Visit Rate	O/E Ratio	Actual Member Months	Rate	Relative Member Month Count	% of Payment	Quarterly Payment	Payment per Member Month
0.20747906	0.2261484	0.9174465	23,150	2	46,300.00	0.0369656	$4,620.67	$0.20
0.33538251	0.2724188	1.2311284	18,178	1	18,178.00	0.0145132	$1,814.14	$0.10
0.29776446	0.2687024	1.108157	13,653	1.5	20,479.50	0.0163507	$2,043.82	$0.15
0.24612403	0.269446	0.9134448	1,419	2	2,838.00	0.0022658	$283.23	$0.20
0.38378378	0.2367489	1.6210586	1,401	1	1,401.00	0.0011185	$139.82	$0.10
0.34080717	0.3084303	1.1049732	1,371	1.5	2,056.50	0.0016419	$205.24	$0.15

Source: APS Healthcare

APPENDIX N

Stakeholder Meeting Information

Oklahoma Hospital Association

August 28th, 2014

Major Challenges

Access to Care - From the perspective of the SoonerCare member the issues of PCPs being booked for up to two weeks, the lack of PCPs and PCPs not being open after hours (most patients do not have ability to take off work during day to see PCP) create major challenges in regards to access to care

Behavioral Health - From the perspective of ER docotors the issues of an overabundance of psych patients in the ER, the difficulty in finding them beds (inordinate amount of time spent trying to find bed), the bulk of case management being devoted to psych issues, rural hospitals lacking behavioral health staff (requires police to stay with patient until treatment is found), heightenend variability of community resources in rural areas versus metropolitan areas and the lack of behavioral health providers available in rural areas couple with the fact they are not paid for by Medicaid creates major challenges in regards to addressing behavioral health issues that cause increased inappropriate use of the ER

Regulatory Barriers - From the perspective of hospital adminstration the liability/risk associated with EMTALA (don't want to divert or educate public because of liability under EMTALA) and the threat of tort/malpractice suits create major challenges in addressing inappropriate ER use. In addition from the member perspective members will utilize the ER to avoid copays as hospitals cannot deny care based on the inability/unwillingness of members to pay their copays

Minor Challenges

Patient Satisfaction - deeming patients non-emergent decreases satisfaction (executive bonuses based on patient satisfaction), one (1) unhappy patient speaks louder than ten (10) happy patients

Recommendations

Staffing - Look at hiring community health/social workers to decrease burden on facilities (coordinate with patients to obtain community resources/provide education on appropriate use of ER), increase use of mid-level providers (NPs, PAs)

Payment Reform - Increase visit cost to encourage PCP visit (trigger/pay care management fee only after patients has been seen by their PCP), global payment for EMTALA mandated medical screening, possible increased Medicaid reimbursement for to privately held mental health facilities for statewide resource allocation

Facilities - onsite urgent care facilities to divert non-emergent patients to (reimburse as clinic visit instead of ER visit), utilize telemedicine equipment to do psychological evaluations

Education - develop member/parental education at front-side of the ER, put education at point of care

Variety Care

September 2nd, 2014

Major Challenges

Organizational - From the perspective of the ER doctor they are at odds with the hospital administration in regards to the issue of diverting non-emergent patients. Administration views ER visits as a revenue source while ER doctors believe that non-emergent patients should be diverted from the ER to their PCP or other community resources (i.e. urgent care).

Minor Challenges

No minor challenges were identified by this group.

Recommendations

Staffing - Allow lower level practicioner to do EMTALA screening/treatment, place triage nurse in call centerChronic disease management program (put sickest from ER into program developed by Variety Care), change behavior through education, co-location inside hospital, increase use of mid-level provider

Disease Management - manage chronic disease patients (put sickest ER patients from ER into program developed by Variety Care), put 20 congesitve heart failure patients into FQHC and use half of the savings from them not being in the ER to buy back specialty care for other FQHC patients

Facilities - Lease space from hospital (run/staffed/administered by FQHC), get to hospital through FQHC (incentivize hospital)

Education - explain difference in consumer cost at point of service, provide patient with education about FQHC services and provide them with a $25 voucher to receive services from the FQHC, onboard new patients and provide them strong public education on how to utilize the system (one on one communication), develop simple book to increase health literacy, develop an application for smartphones, call together FQHC and hospital to discuss agreement and how to handle insurance/appointments

Oklahoma Department of Mental Health and Substance Abuse Services

September 3rd, 2014

Major Challenges

Access to Care - From the perspective of mental health crisis center managers the number of uninsured adults is the larger problem in the grand scheme of things is a major challenge. In addition, the need for behavioral health services is very large and unforutnately there are not enough resources to serve everybody according to mental health crisis center managers. A treatment gap exists in the use of inpatient psych services (inpatient psych does not provide oxygen or wound care). A myth exists about the number of inpatient psych beds; there are enough beds but they are saved for those with commercial coverage. Hospitals only does inpatient assessment and if the patient is manic or aggressive they automatically want to send them to inpatient psych.

Organizational - From the perspective of the mental health crisis center managers the fact that ER decides to put behavioral health patients into inpatient psych rather seeking community resources creates a log jam in the ER and is a major challenge to addressing inappropriate use of the ER. Crisis center managers also perceive that MDs and DOs don't fully understand behavioral health and that hospitals don't perceive behavioral health at the same level of ER. It is believed by the crisis center managers that ERs prefer for them to make decision on treatment and psych evaluation/test. ER social worker calls a community mental health center or crisis service center and apperar totally clueless to what community resources there are.

Minor Challenges

Payment - Crisis center managers say that hospitals don't understand that community mental health centers are usually serving the indigent and Medicaid populations and not the private pay population.

Patient Behavior - Patients will lie and say they are suicidal because they don't want to admit they are going through withdrawals and from the perspective of the ER doctor this is a behavioral health issue because they are seeking pain or other psychotropic medications. Patients come back because the ERs triage them and let them drop out of the system and never follow up with resulting in them showing back up in the ER because they leave without an outpatient visit.

Staffing - ER contracted employees have increased turnover which makes it difficult to build behavioral health relationships

Oklahoma Department of Mental Health and Substance Abuse Services
September 3rd, 2014
Recommendations
Education - Provide education to ERs about available community and behavioral health resources. ERs need to understand that they are equipped to deal with depression. In reference to member education there needs to be education about what is emergent versus non-emergent (i.e. patients are presenting with severe pain at the ER to get paid medication (benzo) because the crisis center won't provide it to them). ER doctors need to be trained to ask their patients that are seeking medications if they are addicted and offer detoxification resources to allow them to step down off of their unneeded medications.
Payment Reform - ODMHSAS contracted providers need an encounter rate for folks that are going to urgent cares to cover diagnostic screening. Behavioral health patients should be referred to pharmacy to get medications without copay as most are unable to cover copays to receive critical medications.
Facilities - Build more urgent care facilities for behavioral health patients (Oklahoma County opened an urgent care next to an inpatient psych center where they served 500 last year, admitted 75, treated the rest and sent them home with community mental health center community resources links on an outpatient basis). Tulsa, Ardmore and Sapulpa are starting co-located urgent care facilities with hospitals in their respective areas to help embed community mental health centers in hospitals ERs. Behavorial health wants to build the urgent care model to address behavioral health issues rather than beefing up the ER.
Technology - Utilize telemedicince to treat individuals in rural areas without quick access to behavioral health services.

Oklahoma Association of Health Care Providers

September 9th, 2014

Major Challenges

Regulatory Barriers- From the perspective of the facility a facility can't refuse a doctor's orders to send a patient to the ER under federal and state law. Facilities have the ability to treat infections through the use of IVs and to do x-rays in the facility but are hampered by regulations. RNs have obligation under nurse practice act to send patient to ER without physician order if in their assessment knowledge they determine more care is needed than what can be immediately provided. All these have created major challenges for facilities and hamper efforts to keep residents out of the ER.

Family - Facilities experience extreme pressure from family members that feel like their loved one is not receiving the level of care they think they need so they request to send them to the ER.

Access to Care - Readmissions to the hospital are a major challenge for facilities. Hospitals are pushing to keep their 3.4 day average length of stay and inadvertently sending patients home before they are ready to be released. Home health organizations experience the highest rate of readmissions.

Behavioral Health - Facilities are required to have behavioral health specialists taking care of patients. If facilities don't have have behavioral health specialists caring for behavioral health patients they are subject to large fines from violations of state and federal law. If facilities have behavioral health patients that are identified they have to take them to the gerio-psych unit at a crisis center or local hospital (unfortunately facilities can't take these patients as it will cause them to be subject to a deficiency for creating an immediate jeopardy to other residents in the facility). Any resident that says they are going to kill themselves or another resident are automatically discharged from the home.

Minor Challenges

Transportation - Facility is not reimbursed for the trip back to the facility from the ER because the resident is no longer emergent.

Reimbursement - A facility is incentivized by an increased reimbursement for a three day inpatient stay required by CMS to bump up to an increased reimbursement rate under Medicare (must be admitted through the ER). No reimbursement for adequate specialized physician support.

Oklahoma Association of Health Care Providers
September 9th, 2014
Recommendations
Payment Reform - Facilities could greatly benefit from the elimination of three day inpatient stay mandate (it would allow them to keep the resident in the facility and out of the ER all while providing better care and eliminiating unintended trauma to the resident from transporting them back and forth between the facility and the hospital. Expand the physician fee schedule to allow for adequate specialized physician support. Reinstate reimbursement for behavioral health treatment (this would allow facilities to hire and retain behavioral health specialists to treat behavioral health residents).
Education - Train existing nursing staff in facilities on higher acuity procedures.
Partnership - Collaborate with hospitals, providers and the continuum of care to better determine treatments.

OK Chapter of American College of Emergency Physicians (ACEP)

September 16th, 2014

Major Challenges

Access to Care - From the member perspective the access to their PCP or a PCP is very limited and they experience difficulty obtaining an appointment therefore creating the major challenge of members inappropriately utilizing the ER. Behavioral health is a huge issue, access to PCP, same doctor sends patients to ER, incentive dollars are misaligned for hospitals to pursue diversion

Organizational - From the perspective of the ER doctor the monetary incentives for hospitals are misaligned with the pursuit of diversion for hospitals. Hospital administration relies on volume and views ER visits as a revenue source.

Behavioral Health - From the perspective of the ER doctor behavioral health is a major challenge because they may sit in the ER for 1 to 2 days before finding a bed and therefore clogging up the ER.

Legal - From the perspective of the ER doctor a major challenge is complaints from patients that are satisified with their care (pain medication seeking individuals not obtaining pain medication). Another challenge is litigation arising from complaints in relation to EMTALA.

Minor Challenges

Staffing - From the perspective of the ER doctor it seems that the same PCP continues to send their patients to the ER instead of accomodating them and scheduling an appointment for them. In addition the ER doctors have said the ER RN is usually not satisfied/comfortable with their diagnosis and they want the doctor to review their diagnosis. Mid-level practicioners such as NPs or PAs are not comfortable with making the call on diagnosis/treatment and are referring patients to the ER in rural communities. ER doctors that are top performers get a bonus of $2000 to $3000 per month and are usually graded on patient satisfaction (increase in narcotics = patient satisfaction). Also there is also usually no feedback on poor patient outcomes.

Facilities - In order to keep critical access hospital status hospitals must transfer patients out of ER observation after 48 hours. Hospital administration wants nice and insured patients that are easier to deal with and will provide a guaranteed return on investment because of a reliable payer source.

OK Chapter of American College of Emergency Physicians (ACEP)
September 16th, 2014
Recommendations
Education - Educate patients and hold them accountable for their health. Increase health literacy. Educate more doctors in primary care and ER, pay PCPs more to attract new ones, increase use of mid-level practicioners
Staffing - Fund external contract employees by the hour and base their performance on the Press Ganey rating system. St. Francis in Tulsa has placed a physician in their triage in addition to increasing volume, decreasing time in the ER and expediting their labs. Increase the use of mid-level practicioners to improve access to care.
Technology - Utilize telemedicine in rural ERs where NP/PAs are present (shown to be very useful in rural areas). Telemedicine has been and can be very useful in performing psych consults.
Payment Reform - Tie reimbursement to Press Ganey outcomes and reimburse for outcomes (begin at birth) instead of volume to increase health of patients thereby decreasing the overall cost of healthcare. Pay PCPs a higher rate to attract new ones to the industry (disincentivize pursuing a specialty track).
Consumer Behavior - Decrease the entitlement behavior of consumers by making the treatment their money, provide them with choices regarding treatment possibilities and begin it at the consumer level instead of at the practicioner level.

Member Advisory Task Force
September 27th, 2014
Major Challenges
Please see survey results.
Minor Challenges
Please see survey results.
Recommendations
Please see survey results.

Pediatricians

September 29th, 2014

Major Challenges

Access to Care - From the perspective of both the peditrician and the member there is a large lack of after hours access to PCPs. Poor care provided by urgent care due to care by undereducated NPs/PAs, lack of after hours access to PCP

Quality of Care - From the perspective of the pediatrician the quality of care provided is poor because the care is mainly being provided by undereducated NPs and PAs. Incorrect diagnoses from urgent care clinics are causing patients to visit their PCP days later because they did not receive quality care from the urgent care practitioners (costs are underestimated by OHCA).

Cost/Location - Pediatricians report that it is difficult to maintain enough volume to cover costs and ensure that staying open after hours is beneficial to the practice (to maintain volume pediatricians are calling other practices offering their afterhours services to their patients). Also noted is that depending on the location the clinic can be beneficial or underperforming (i.e. Kids First clinic is South OKC is beneficial while the Edmond clinic is underperforming). Costs for incorrect diagnoses are underestimated by OHCA. Although the afterhours model is viable in urban settings it is not viable in rural areas because of the lack of volume.

Minor Challenges

Staffing - Pediatricians report that they experience high turnover in support staff for afterhours clinics such as Kids First compared to regular clinics. Pediatricians also report that the comfort level for diagnosing and treating patients is very low among mid-level practitioners. It is reportedly more expensive and difficult to staff after hours because they can't predict how many patients they are going to see.

Education - From the perspective of the pediatrician a minor challenge is members not knowing about afterhours clincs such as Kids First and others.

Pediatricians
September 29th, 2014
Recommendations
Education - Get the word out to members that Kids First clinics and other afterhours clinics are an option for not going to the ER. Educate member parents that they will see a pediatrician if they go to a Kids First/afterhours clinic (may not see a pediatrician in the ER and also won't have to see a mid-level provider such as a NP or PA). Utilize social media (Facebook) to get the word out about Kids First and other afterhours clinics.
Payment Reform - As it is more expensive to operate an afterhours clinic the OHCA should provide a higher reimbursement to cover the added costs of operating after hours and to incentivize PCPs for working after hours. Analyze total costs including pharmacy, ancillary and the cost of repeat visits.
Facility Reform - Develop core measures for urgent cares that they can be measured by. Make PCPs follow up immediately after their patients have been to an urgent care to ensure they are receiving the best treatment possible.

Saint Francis Hospital System

October 3rd, 2014

Major Challenges

Regulatory Barriers - From the perspective of administration EMTALA liability is a major challenge because of the fines and cost associated with not complying with the law. As a result administration doesn't want to divert or educate public about utilizing other more appropriate settings for obtaining health care.

Behavioral Health - From the perspective of both administration and the ER doctor behavioral health is a major challenge on a daily basis especially with adults both on the ER side and the inpatient side. The unavailability of crisis services further hinders the major challenge of treating behavioral health patients.

Minor Challenges

Staffing - From the perspective of the ER doctor they have no time to educate on alternative uses.

Access to Care - Adults with elderly parents present in the ER because they are unsure of how to get them placed in a long term care facility.

Recommendations

Payment Reform - From the perspective of administration if the reimbursement amount stayed the same by sending the patient to an urgent care they would be supportive of sending them there and unbundling services. Social worker in ER to advise patients on community resources, push to urgent care as long as reimbursement is the same

Staffing - Combine the efforts of an FQHC, hospital and HAN along with bundled/grant payments to place a social worker in the ER to help patients navigate the health system and educate them on the other resources available to them that are more appropriate for obtaining care. Obtain inpatient psychiatric consulting service to address issues in treating behavioral health.

Obstetricians

October 6th, 2014

Major Challenges

Access to Care - Open scheduling is not always available for members. If member needs to be seen afterhours they are sent to the ER and are usually seen by an OB hospitalist or on another floor in the labor and delivery department of the hospital. Obstetricians state that money is not the issue of driving care to the office and that it really is a major challenge to get patients into a busy office. Fear/resistance to have non-OB serve pregnant moms for respiratory or other illnesses

Staffing - From the perspective of the obstetrician they are already overwhelmed at the moment and are not able to get additional time to see more patients.

Minor Challenges

Treatment - Fear/resistance to have non-OB serve pregnant moms for respiratory or other illnesses because of the lack of knowledge of treating pregnant women versus regular persons.

Inappropriate Use - Obstetricians note that large number of women coming into ER with complaint to obtain an ultrasound to check the sex of the baby but ERs doctors have started to decline the ultrasound if it is not clinically needed.

Recommendations

Payment Reform - Strong support for eliminating the global payment for obstetricians. Creation of a fee for service for private obstetricians. Push for a global payment at the hospital. OHCA should pay extra for visits outside OB scheduled hours. An ER diagnosis code for pregnant women should be created.

Staffing - PAs/NPs/RNs can see patients for visits. Obstetricians should take care and follow patients through the hospital system and should understand the need to do that to keep everyon'e liability down.

Access to Care - Determine at the point of service whether or not member is PCMH or not and if they aren't assign them a PCMH and make sure they stay in that PCMH until they have a reason to change. A part of being a PCMH needs to be that they provide open scheduling, return calls and decrease the number of members going to the ER. Look at common elements on increased ER utilizers and perform care coordination.

Technology - Utilize telemedicine for rural providers that are unsure or need reassurance on diagnosis or course of treatment.

Patients First

October 6th, 2014

Major Challenges

Member Behavior - From the perspective of the doctors associated with Patients First members associate the ER with instant gratification and the ability to obtain care without having to wait for their PCP to get them an appointment. Almost 2/3 of patients utilize the ER as the first degree of care.

Minor Challenges

Regulatory Barriers - Under federal law doctors cannot refuse treatment for members due to the inability/refusal to pay their copay. Members are aware of this stipulation and utilize the ER to avoid copays that their doctors may try to charge them.

Recommendations

Regulatory Reform -Reduce and enforce the PCMH regulations to incentivize doctors to do what they are supposed to do.

Education - ER doctors should pursue diversion and reeducate patients at point of service in the ER.

Access to Care - Have afterhours available for pediatric clients as they are the majority of ER visits. In Enid there is a ER that is open afterhours and double staffed so that they can get patients in/out of the ER quicker than they can be seen by in the ER. Align members with their PCP and support engagment with their PCP to reinforce the need to utilize PCP rather than ER.

Staffing - Have a community health worker/social work planted in the ER to help members and patients navigate the system and identify appropriate places to obtain medical care.

Oklahoma Primary Care Association

October 16th, 2014

Major Challenges

Organizational - The ER is a "catch 22" in the fact that from the perspective of administration ER is a revenue (public hospitals need ER as charity care). Competition among ER users as hospital drives ER marketing and use

Members - As hospitals continue to drive ER marketing and use (i.e. ER appointments, 30 minute guarantees, etc.) the competition among ER users continues to drive this marketing.

Budget Cuts - A decrease in the amount of funding provided for uncompensated care and trauma funds has resulted in an increase in ER use because fewer resources are being dedicated to safety net providers

Minor Challenges

No minor challenges were identified by the Primary Care Association.

Recommendations

Members - Focus on member that are the highest utilizers and get them into some sort of care management such as an FHQC. From the perspective of the FHQC the ER is an inappropriate place to obtain medical care and they want shift those members to the FHQC for more comprehensive, appropriate care. co-location in hospital, identify practices/clinics with additional supports to serve high utilizers, increase PPS rate, embed social worker to help patients get needs addressed.

Payment Reform - Reinstate provider rate cut to FQHCs and allow them to charge multiple services in 1 day (have the FHQC be a one stop shop for all medical needs as many members struggle with transportation to and from appointments).

Facilities - Co-locate an FHQC in a hospital in Oklahoma Cityas a pilot and evaluate it for efficacy and viability. Identify practices/clinics with additional supports and the ability to high utilizers of the ER. Transfer savings from hospital to FHQC for accepting patients and keeping them out of the ER to cover the costs of those patients.

Partnership - Build relationships and gain trust with community partners and also align incentives among providers to collaborate and provide better access to care.

Behavioral Health - Fully integrate behavioral health treatment through the embedment of social worker support in the ER (have that person follow up to make sure the patient gets their needs addressed like establishing transportation and addressing scheduling/other barriers).

Technology - The need for HIE and HIT infrastructure is highly needed.

OSU Osteopathic School
October 22nd, 2014
Major Challenges
No major challenges were identified.
Minor Challenges
Regulatory Barriers - Copay triggers are not effective for addressing member behavior because under federal law members can't be denied care as result of the inability/refusal to pay their copay.
Facilities - In rural settings urgent cares aren't always available. Co-location with a hospital is a possbility but some of the minor challenges associated with that are that different shifts don't cover costs to have 2nd round with PCP, you have to have to have security that will be willing to stay late 1 or more day late in the evening and you must have enough volume of patients seen (contingent upon getting referrals from other practices to increase volume).
Payment - PCMH tier differential doesn't pay for the staffing required to decrease point of service at ER.
Recommendations
Facilities - Incentivize hospitals to establish onsite urgent care centers to help divert non-emergment members/patients and allow them to receive more appropriate care. Co-locate an urgent care that could made to be a resident clinic that has at least one faculty present.
Education - Educate members to not go to the ER and try to advise them that it's the not appropriate place to obtain medical care that could be provided by a PCP (adjust the member behavior away from the instant gratification mentality).
Technology - Require the state to interface with HIE and hospital EMR systems for real-time data exchange (when a patient goes to the ER a notice can be sent to their PCP).
Payment Reform - Adjust SoonerExcel rates to decrease ER use and shift patients being directed to another point of service at urgent care. Prevent the setup of a vastly different payment system for Medicaid members (SPIN - built team, have visits, increased manpower to do 2 years <50 patients FHQC compete and private doctors get increased reimbursement, prescription breaks; sweet deal - require FHQC to stay open late and provide more after hours. Pay different rate to PCP for urgent care; increase for E&M. Look at a pilot for alternative access patient (would work only if provider could capture same margin for the Medicaid patient; within hospital for ER; Medicaid payment must cover staffing for ER (Guthrie model)(If patient becomes using alternative clinic - would need to be transferred to PCMH or HAN with case management function).
Staffing - Residents could moonlight (possible credentialing of a location).

Health Access Networks

November 3rd, 2014

Major Challenges

Organizational - From the perspective of the HANs there is no disincentive to have ERs redirect or divert because ER want to keep easy patients and send on the tough patients with behavioral health comorbidities (fever and stomach aches never get referrred outside ER - they are easy). Since OU HAN doesn't have an associate ER they have to cover all 4 ER which is a major staffing challenge; also time to make relationships with ER staff is limited; and they would have to have immediate open appointments; transport issues from ER to PCP.

Behavioral Health - According to Canadian County HAN mental health comorbidity has a tendency to increase ER use.

Access to Care - So many groups coming to hospital with care management supports (public, private, Medicare)(private payers offer care management to hospital; hospital is more responsive to private payers than OHCA or HANs. (OU) Canadian County HAN said it is difficult to get brochures handed out at ERs. Canadian County and OU HANs say PCPs don't always work to get patients in.

Data - PCPs don't always work to get their results turned in. OSU patients tend to go to many different ERs; ER data is 6 weeks old when sent to the HAN so it is difficult for them to pinpoint, in a timely manner, those folks that are going to the ER. According to Canadian County HAN ERs are very cautious to share information with the HAN.

Minor Challenges

No minor challenges were identified by the Primary Care Association.

Recommendations

Facilities - Establish urgent care in proximity to ER to have cross referral and triage in ER (major barrier is revenue)

Partnership - PCPs need to have relationships with afterhours clinics for individuals not working the normal 9 to 5 work schedule. Care managers and PCPs need to develop good working relationships. PCPs could partner together and have their businesses related with an urgent to provide additional hours of care, share patient information, etc. and the HANs will facilitate the network.

Health Access Networks

November 3rd, 2014

Recommendations

Education - Education needs to be provided to ERs that care management is available and education needs to be provided to patients that ER alternatives exist (have them call before they go to the ER). Canadian County HAN has created and provided brochures to educate public patients about appropriate ER use. If OHCA could provide contracted urgent care lists to HANs they could be included in patient education materials and shared with HAN care managers (PCPs could hand out referrals and even share urgent care information on voice to voice contact). HANs could all do educational brochure to members with list of sources. OU HAN could get on schedule of OU and be invited to grand rounds periodically to tell what the HAN is, how it works and about the challenges with residents and yearly turnover.

Technology - Use HIE to get daily report on ER use and whose admitted and get real time information to address need for access to quicker information on utilization to pass on to care managers. HIE would also fix issue for PCPs getting records or appointments from urgent care to PCP.

Patient-Centered Medical Homes

October 29th, 2014 and November 5th, 2014

Major Challenges

Cultural - Hispanic culture has a behavior regarding women that they wait until their husband comes home to go as most of the time the husband is the decision maker in the family.

Member Behavior - Members have been known to be sick for up to four days and then decide to come in at 6pm on a weekday as a walk-in and have also been known to leave and go to the ER because they don't want to wait the 30 to 45 minutes it takes as a walk-in patient (10 minute average wait or no wait time in ER pulls the member away from their PCP's office. Some clinics experience no-show rates as high as 25%.

Minor Challenges

Regulatory - Recent changes in law have disallowed NPs to prescribe certain pain medications indavertently sending patients to the ER to seek the drugs that they need or want.

Transportation/Access to Care - Most SoonerCare families struggle with transportation and usually must wait for someone else in the home to come home with the vehicle or other mode of transportation before they can go to the PCP which is usually closed by the time they are able to go. The mandatory 3-day advance notice for SoonerRide is not amenable to acute care.

Communication - Afterhours call lines can be expensive. Health information exchanges can be beneficial for communication but are cost prohibitive.

Organizational - A minimum volume of 5 patients/hour is necessary to stay open and cover costs which include the care team as well as the physician. Most doctors don't want to stay late or work extra hours.

Patient-Centered Medical Homes

October 29th, 2014 and November 5th, 2014

Recommendations

Education/Communication - Letters that follow up on patients should be part of the PCMH measurements and core measures (will identify how well PCPs contact their patients). The member handbook has existing information about ER usage and the PCMH agreement has ER education as well and should be more utilized as a means of educating the member. PCPs should communicate better with their patients about ER visits and patients should know that their PCP and OHCA are talking. Encourage patients to use a hospital phone number for triage versus waiting to go in the morning. Begin using text/e-mail messaging along with social media outreach (Facebook, Twitter, etc.) Have members call a number before going to the ER and require them to get a pre-certification from OHCA if they are already in the ER for further treatment beyond the required medical screening exam under EMTALA (member or hospital would generate the call. If patients knew they would get a call from their doctor every time they went to the ER they would more than likely not go. RN triage line has a list of all urgent care centers and will refer if they are still open.

Technology - Through the use of and HIE utilize instant messaging for real time ER communication with PCP to let them know their patient wen to the ER. Pilot with systems who could do it all (Integris, medical schools, etc.) and then see how to expand to affiliate type agreements for solo doctor and hospital.

Partnership - Look at pulling in behavioral health with PCMH to treat both sides (pull the patients behavioral health and ER history and determine their best course of treatment and partnering with a good PCP). Develop a coalition of Tier 3 PCMHs in a central geographic region (i.e. Kids First) to share resources and costs/risks.

Oklahoma Academy of Family Practitioners
November 6th, 2014
Major Challenges
No major challenges were identified by the Oklahoma Academy of Family Practitioners.
Minor Challenges
Staffing - Traditionally hospitalists choose their practice because of lifestyle (set hours).
Recommendations
Staffing/Facilities - Explore the use of of an "extensivist" which is essentially a hospitalist that would be a support or wrap-around for the PCMH that would essentially be an acute care clinic.
Partnership - Pilot with systems who could do it all (Integris, medical schools, etc.) and then see how to expand to affiliate type agreements for solo doctor and hospital.
Payment Reform/Patient Treatment - Look at various options on how to use and/or reimburse i.e.: assign "frequent flyers to extensivist group or practice. Require follow up and potential home visit upon discharge from either ER or inpatient setting. Payment could be either a withholding arrangement or shared savings.