RIDER 56 REPORT

Reducing Nonemergent Use of the Emergency Department in Medicaid

As Required by the 2012-13 General Appropriations Act (Article II, Health and Human Services Commission, Rider 56, H.B. 1, 82nd Legislature, Regular Session, 2011)

Health and Human Services Commission
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Executive Summary

Pursuant to the 2012-13 General Appropriations Act (H.B. 1, 82nd Legislature, Regular Session, 2011, Article II, Health and Human Services, Rider 56), the Health and Human Services Commission (HHSC) is required to submit a report by August 31, 2012, on steps taken to reduce nonemergent use of the emergency department (ED) in the Medicaid program.

Rider 56 specifically directed that among the steps to reduce nonemergent ED use in Medicaid, HHSC would:

- evaluate whether the cost of physician incentive programs implemented by Medicaid managed care organizations (MCOs) participating in the STAR and STAR+PLUS managed care programs has been offset by reduced use of the emergency department;
- determine the feasibility of amending the Texas Medicaid State Plan to permit freestanding urgent care centers to enroll as clinic providers; and
- use financial incentives and disincentives to encourage Medicaid MCOs participating in STAR and STAR+PLUS to reduce nonemergent ED use among their clients.

This report specifically reviews strategies undertaken by the Texas Medicaid program to reduce nonemergent ED use through targeting initiatives specific to MCOs, providers, and clients. As a component of reporting on steps taken to reduce nonemergent ED use in the Medicaid program, Rider 56 requires specific reporting on an evaluation of Medicaid MCO physician incentive programs intended to reduce nonemergent ED use and the feasibility of permitting freestanding urgent care centers to enroll as clinic providers.

The evaluation of whether the cost of Medicaid MCO physician incentive programs is offset by reduced use of the emergency department is in progress and the physician incentive programs that will yield relevant data have been identified. Reporting on the outcome of the physician incentive program evaluation will occur by August 31, 2013, as a requirement of S.B. 7, 82nd Legislature, 1st Called Session, 2011.

After assessing the feasibility of enrolling urgent care centers as clinic providers in the Texas Medicaid program, HHSC found that given the costs to establish a separate provider type for urgent care centers as clinic providers that it would be more cost effective to provide other mechanisms for clients to identify alternate providers to their hospital emergency department. HHSC has begun allowing providers to self-identify as urgent care centers in the Provider Information Management System (PIMS). Since January 1, 2012, clients have been able to query the Online Provider Lookup tool to identify urgent care centers as alternatives to using the hospital emergency department.

Introduction

The approach to reducing nonemergency use of the hospital emergency department among Medicaid clients includes both short-term and long-term strategies focused on managed care organizations, hospitals, other providers, and clients.

One of the key strategies to reducing nonemergent ED use is to steer clients to more appropriate sources of care. Integral to achieving this goal is ensuring adequate access to prevention and primary care services. The medical home model is a building block to achieving this objective as is promoting the use of urgent care facilities and retail health clinics when clients cannot go to their medical home.

HHSC already has implemented a number of strategies to reduce nonemergent ED use and is in the planning stages of implementation for a number of projects. A description of various nonemergent ED use reduction strategies follow.

Physician Incentive Programs in Medicaid MCOs

Rider 56 requires HHSC to evaluate if the cost of Medicaid MCO physician incentive programs has been offset by reduced use of the emergency department. An example of a physician incentive program includes providing an enhanced reimbursement rate to physicians for routine, after-hours appointments. Another example would be an MCO providing an incentive payment to providers who demonstrate a reduction in ED over time among patients in their panels.

A similar requirement to Rider 56 was included in S.B. 7, 82nd Legislature, 1st Called Session, 2011. S.B. 7 directs HHSC to conduct a study to evaluate physician incentive programs that attempt to reduce hospital ED use for nonemergent conditions by Medicaid recipients. Each physician incentive program evaluated in the study must be administered by a STAR or STAR+PLUS MCO and provide incentives to primary care providers who attempt to reduce ED use for nonemergent conditions. The study must evaluate the cost-effectiveness of each component included in the physician incentive program and any change in statute required to implement each component within the Medicaid fee-for-service payment model. The S.B. 7 report is due to the governor and Legislative Budget Board by August 31, 2013.

An initial survey of STAR and STAR+PLUS MCOs conducted prior to March 2012 found the following:

- Ten plans already had a functioning physician incentive program to reduce ED use prior to March 1, 2012.
- Five plans were planning on implementing an ED physician incentive program in March 2012, or later.
- Four plans had no plans for a physician incentive program to reduce ED use.

HHSC is using this information about plans that have existing physician incentive programs to establish those that will have relevant data to assess the cost effectiveness of various types of physician incentive programs. Full reporting on the cost effectiveness of various components of physician incentive programs will be included in the S.B. 7 report due August 31, 2013.

Identification of Freestanding Urgent Care Centers

Rider 56 requires HHSC to determine the feasibility of amending the Texas Medicaid State Plan to permit freestanding urgent care centers to enroll as clinic providers. The intent of such a

change would be that clients could locate urgent care centers in their area for non-emergency situations that would previously have been treated in emergency room settings.

HHSC reviewed the possibility of enrolling freestanding urgent care centers as a new provider type, yet found the state could employ a different strategy that still would allow clients to identify urgent care clinics as an alternative to emergency departments at a cost-avoidance to the state.

Rather than incurring the expense of establishing a separate urgent care provider type, HHSC has met the intent of such a change by allowing providers to self-declare as urgent care centers in the Provider Information Management System. Due to this change, implemented January 1, 2012, Medicaid clients are able to identify self-declared urgent care centers in the provider directory as an alternative to the emergency department, including through queries to the Online Provider Lookup tool.

Other Steps Taken to Reduce Medicaid Nonemergent ED Use

Beyond the initiatives specifically directed for reporting in Rider 56, HHSC has undertaken a number of initiatives to reduce nonemergent ED use among Medicaid clients. These include both short-term and long-term strategies focused on managed care organizations, hospitals, providers, and clients.

One of the key strategies to reducing nonemergent ED use is to steer clients to more appropriate sources of care. Integral to achieving this goal is ensuring adequate access to prevention and primary care services. The medical home model is a building block to achieving this objective as is promoting the use of urgent care facilities and retail health clinics when clients cannot go to their medical home.

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Gathering and Sharing Information on Nonemergent ED Use

The foundation for developing strategies to reduce nonemergent ED use is understanding why clients use the ED and sharing this information with entities that can help curb ED use.

Potentially Preventable Events Focus Studies: The Institute for Child Health Policy (ICHP) at the University of Florida, which is the Texas External Quality Review Organization (EQRO), conducted a study to identify individual, community, and health care delivery system factors contributing to potentially preventable emergency department visits (PPVs) in the Texas STAR and STAR+PLUS programs. In Texas, the cost of PPVs was estimated at $1.2 billion.

Potentially preventable ED visits present a particularly relevant challenge for the efficient delivery of health services in state Medicaid programs. Research has found that Medicaid beneficiaries make up a disproportionate share of ED visits for ambulatory care sensitive conditions (ACSCs), such as asthma, chronic obstructive pulmonary disease (COPD), congestive

heart failure, diabetes, and hypertension. The occurrence of PPVs can be influenced by chronic illness burden. However, compared to the general population, higher rates of PPVs for Medicaid beneficiaries were not entirely explained by differences in disease prevalence or severity. Community factors, including the number of physicians per 1,000 population are also important, suggesting that a reduced likelihood of ongoing primary care may also play a role. Methods for defining and measuring PPVs are, therefore, critical for a comprehensive and effective evaluation of the quality of care in Medicaid.

Using the 3M Health Information Systems software to calculate PPV rates and expenditures, ICHP estimated that overall, 63 percent of ED procedures in STAR, which includes the PPVs, were potentially preventable in fiscal year 2010. Furthermore, they estimated over $79.6 million in excess expenditures was spent on PPVs in STAR. In the STAR+PLUS program, they estimated that 53 percent of ED procedures, which also includes the PPVs, were potentially preventable. The lower PPV rate in STAR+PLUS compared to STAR is largely explained by the differences in the age of their memberships. STAR has a much higher percentage of children age five years and younger. Children in this age group tend to have higher PPV rates than older members.

Texas healthcare Learning Collaborative: The Texas healthcare Learning Collaborative (ThLC) is a web portal designed and run by ICHP and the University of Florida. It is an online learning collaborative that includes the Medicaid MCOs, HHSC, and ICHP and is used as a quality improvement tool.

During 2012, the key focus is on potentially preventable events, including potentially preventable inpatient admissions, readmissions, and emergency department visits. Potentially preventable events are costly and place a burden on members and their families and may reflect a need to improve access to care in outpatient settings. They may also reflect a need to improve continuity of care when members move from one setting to another (e.g., from the hospital to home).

Through the ThLC, HHSC and the EQRO share monthly and quarterly reports with the MCOs about the different potentially preventable events. The EQRO also provides member registries of those seen in the ED or who were readmitted to the hospital so the MCO can follow-up and coordinate care.

The EQRO plans to develop and place “Change Packages” on the web portal, which summarize evidenced-based practices to reduce potentially preventable events. The hope is that the MCOs will use the “Change Packages” to choose and implement evidence-based practices to improve health care quality in their organizations. Periodically, ICHP will gather information from the MCOs about their experience implementing the new practices and the results they are seeing.

In addition, there are moderated listserv discussions, scheduled webinars, and scheduled online chats to facilitate sharing among the ThLC members about their experiences in using the reports and strategies to enhance the collaborative.

Managed Care Organization Strategies

Each Medicaid MCO has unique strategies to address nonemergent ED use. Strategies include outreach to frequent users through mail or direct client contacts; monitoring of use by people with certain health conditions, such as asthma or diabetes, who could benefit from disease and case management; and 24-hour nurse help lines to direct clients to the appropriate source of care. There are also a number of overarching strategies impacting all MCOs:

Performance-based capitation rate – 5 percent at risk: HHSC places MCOs at-risk for 5 percent of the capitation payment based on their ability to meet certain performance criteria. An MCO that does not meet all of the performance expectations loses some or all of the at-risk portion of their capitation payment. These funds are reallocated to fund the MCO Program's Quality Challenge Award, which rewards MCOs for superior performance. One of the performance measures used in the calendar year 2012 Quality Challenge Award will be HEDIS® ambulatory care–ED use. For the purposes of the Quality Challenge Award, MCOs are ranked relative to each other based on their performance.

Network urgent care clinics: The managed care contracts that went into effect March 2012 require that MCOs have urgent care clinics in their provider network. Urgent care clinics offer clients alternatives to visiting the ED for their urgent, after-hours care needs. Also, as of January 2012, clients were able to identify urgent care providers in the provider directory.

Reduce potentially preventable emergency visits as directed by S.B. 7: Among activities authorized by S.B. 7 is allowing HHSC to grant flexibility to Medicaid and Children's Health Insurance Program (CHIP) MCOs to implement quality initiatives to reduce potentially preventable emergency visits and develop quality of care and cost-efficiency benchmarks based on reducing PPVs. HHSC intends to include potentially preventable events in its performance-based at-risk and Quality Challenge Award measures in calendar year 2014.

Reporting rates of Ambulatory Care Sensitive Conditions: Ambulatory care sensitive conditions (ACSCs) include conditions that result from certain diagnoses, such as asthma, diabetes, and hypertension, that are potentially avoidable with better access to preventive care in the outpatient setting. The annual MCO Quality of Care reports for STAR, STAR+PLUS, STAR Health, and CHIP measure emergency department utilization. The Ambulatory Care ED measure shows the rate of ED visits for ACSCs. For the fiscal year 2010 measurement period, STAR members had 59 ED visits per 1,000 member months, which is lower than the national HEDIS® mean of 67 per 1,000 member months.

Performance improvement projects: Health care quality performance improvement projects (PIPs) are used to assess and improve MCO processes, and thereby outcomes, of care. Eleven of 14 STAR Health plans and 12 of 15 CHIP health plans are conducting PIPs related to reducing ED use through improved treatment of ACSCs. Some of the PIPs concern reducing ED use related to all ACSCs, while others focus on only one or a few. For example, for STAR Health, Superior HealthPlan Network has a PIP to reduce ED use rates related to uncontrolled asthma.

Hospital Strategies

Hospital strategies involve engaging hospitals in the process of directing Medicaid clients to receive the most appropriate care in the most appropriate setting.

Hospital facility charge reimbursement reduction: As of September 1, 2011, hospital facility charges for nonemergent services delivered in the ED are reduced to 60 percent of billed charges. The classification of a service as nonemergent is based on the Evaluation and Management (E/M) code.

Hospital education and outreach: HHSC will undertake education efforts with hospitals and perform outreach with the hospital associations in Texas to increase hospital awareness and understanding of the following issues:

- The limits of a hospital's responsibility to treat patients with nonemergent conditions under the Emergency Medical Treatment and Active Labor Act (EMTALA): EMTALA requires hospitals to perform a medical screening to determine whether an individual needs emergency services. If the screen determines that the condition is nonemergent, the hospital does not have to provide treatment and can refer the patient to a more appropriate outpatient clinical setting.

- Options for charging a co-payment for nonemergent ED use: When co-payments for nonemergent ED use are implemented, hospitals will be able to charge clients a co-payment if they conduct the EMTALA screening and determine the condition is nonemergent. The hospital either may charge the client the co-payment and provide nonemergency services to the client at the reduced reimbursement rate or the hospital may submit a claim for the $25 triage fee and refer the client to an alternate source of care.

Provider Strategies

Providers, both in hospital and non-hospital settings, can have a great influence on the behavior of clients and their selection of the appropriate care in the appropriate setting.

Hospital-based physician reimbursement reduction: Hospital-based physician reimbursement is reduced to 60 percent of billed charges if the treated condition is nonemergent. This has occurred since requirements of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 were implemented. Effective September 1, 2011, the classification of a service as nonemergent is based on the Evaluation and Management (E/M) code rather than the ICD-9 diagnosis code. This methodology allows the treating physician to assess the severity of the patient's condition, since some diagnoses may be emergencies for some patients but not for others.

Quality-based payment initiatives authorized by S.B. 7: HHSC may implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. The quality-based payment system must base payments made to an enrollee's health home on quality and efficiency measures that may include reducing PPVs. To be eligible to receive reimbursement under a quality-based payment system, a health home

provider would have to provide participating enrollees with access to health care services outside of regular business hours and educate enrollees about the availability of health care services outside of regular business hours.

S.B. 7 also allows MCOs, physicians, and other health care providers to propose strategies to reduce potentially preventable ED visits as a basis to receive payment incentives under quality-based payment systems and other alternative payment methodologies.

Client Strategies

Many clients say they use the ED for nonemergent purposes because of their ability to receive all the care they need in one setting. They may also attribute ED use to a lack of availability of their primary care provider or difficulty traveling to a certain location. The items below represent initiatives directed specifically at educating and incentivizing clients to use fewer nonemergent ED services.

Education and outreach: HHSC will increase efforts to educate clients about appropriate use of the ED. For example, the Fee-for-Service Client Handbook now explains to clients how they can locate an urgent care clinic as an alternative to the ED and directs them to ask if their doctor has extended office hours.

HHSC will explore ways that the Medicaid Eligibility and Health Information Services (MEHIS) can be leveraged to communicate with clients about appropriate use of health care services. HHSC can communicate with clients who establish accounts on the Your Texas Benefits portal through broadcasts and alerts members see when they log into their portal home page. Through their Your Texas Benefits account, clients also may authorize HHSC to send them information by text message and email.

Grand aides: HHSC is exploring options to establish a pilot "Grand Aides" program as authorized by the 2012-13 General Appropriations Act, 82nd Legislature, Regular Session, 2011 (H.B. 1, Article II, HHSC, Rider 69). Grand Aides are senior members of the community, who, under supervision of nurse practitioners or physicians, use telephone and home visits to address simple conditions such as colds, with the intent to reduce unnecessary office and emergency room visits.

Co-payments for nonemergent ED use: HHSC will implement co-payments for Medicaid clients who use the ED for nonemergent reasons. Clients could avoid the co-payment if they were triaged at the ED, determined to have a nonemergent condition, and accepted a referral from the hospital to obtain treatment from an alternate provider.

Because of some of the complexities of implementing Medicaid copayments under the Medicaid State Plan, HHSC will pursue a waiver of certain federal requirements to implement Medicaid co-payments in the most efficient way possible.

Texas Healthcare Transformation and Quality Improvement Program Waiver

The Texas Healthcare Transformation and Quality Improvement Program waiver presents an unprecedented opportunity for regional collaboration to address region-specific needs. Public hospitals and other major regional healthcare providers are spearheading regional planning efforts with other providers in their communities to develop and implement strategies for issues such as increasing opportunities for primary care, providing patient navigation services, improving provider accessibility, and enhancing quality of care. The strategies in many of these regional plans have evidence-based links to reducing nonemergent ED use. The waiver and related projects and Delivery System Reform Incentive Payments will continue until at least 2016.

Conclusion

HHSC is undertaking significant efforts to reduce nonemergent ED use among Medicaid clients. These efforts include strategies targeting MCOs, providers, and clients. HHSC has responded to Rider 56 requirements by analyzing the status of urgent care centers as Medicaid providers and allowing providers to self-declare as urgent care centers so clients can identify alternatives to the emergency department in the Medicaid Online Provider Lookup tool. HHSC also has begun an evaluation of Medicaid MCO physician incentive programs and whether their cost has been offset by reduced use of the emergency department. HHSC has identified MCO physician incentive programs that will yield data that will be analyzed during the next year and reported on by August 31, 2013 as a requirement of S.B. 7.