Oklahoma Health Care Authority

HOUSE BILL 2906 ER UTILIZATION STUDY

Prepared by the Oklahoma Health Care Authority

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Introduction

According to administrative claims data collected by the Oklahoma Health Care Authority (OHCA) approximately fifteen million dollars a month, One percent of the total OHCA budget, is being spent on emergency room (ER) visits by SoonerCare members. Since 2004, the OHCA has implemented various intervention methods and has overseen several studies on non-emergent ER utilization by SoonerCare members. The topic of non-emergent ER utilization has been, and continues to be, of interest to state elected officials especially as budget constraints are requiring additional pressure to reduce cost points. In addition, increased national attention has been given to non-emergent ER utilization rates among all state Medicaid programs. During the 2014 regular session of the Oklahoma Legislature House Bill 2906, authored by Representative David Derby and Senator Rob Standridge was introduced as written below:

> *A. In accordance with Section 5010 of Title 63 of the Oklahoma Statutes, the Oklahoma Health Care Authority shall conduct a study of current and potential emergency department diversion models for persons who are enrolled in Medicaid that may be implemented in the state and explore options for cost containment and delivery alternatives that are consistent with the existing Patient-Centered Medical Home program. Study results shall include, but not be limited to:*
>
> *1. An assessment of the present environment in the Medicaid population for emergency department utilization;*
>
> *2. Opportunities to leverage and partner with current community-based resources, including community health centers, the Oklahoma State Department of Health and the Oklahoma Department of Mental Health and Substance Abuse Services, in order to reduce emergency department utilization;*
>
> *3. Analysis of current initiatives, both statewide and nationwide, with the aim of more cost-effective, coordinated care for persons with overutilization of the emergency department. This shall include a feasibility analysis of other state approaches with special attention paid to applicability to Oklahoma infrastructure and waiver and/or state plan authorization from the Centers for Medicare and Medicaid Services (CMS); and*
>
> *4. Development of recommendations accompanied with any associated projected expenditures or cost savings.*
>
> *B. The Authority shall prepare and deliver the study to the Chair and Vice Chair of the Senate Health and Human Services Committee and the Chair and Vice Chair of the House Public Health Committee no later than December*

31, 2014. The following report has been developed as result of Oklahoma House Bill 2906 that was written by legislative interest, a need to identify more appropriate and higher quality access to care for SoonerCare members and to address the rising cost of health care that is being exacerbated by the inappropriate use of the ER by SoonerCare members.

The following report has been written as a result of legislative direction, a need to identify access to quality, and more appropriate, care for SoonerCare members and to address the rising cost of health care that is exacerbated by non-emergent use of the ER by SoonerCare members.

National

Nationally, non-emergent use of the ER by Medicaid enrollees only accounts for four percent of total Medicaid spending (MACfacts, Revisiting Emergency Department Use in Medicaid). Unfortunately, due to the fact that Medicaid enrollees utilize the ER more than their privately insured and uninsured counterparts and the fact that the program is state and federally funded, Medicaid programs across the nation tend to monitor ER use closely (MACfacts, Revisiting Emergency Department Used in Medicaid). There are numerous factors that result in the non-emergent use of the ER nationally; however an often cited reason is the lack of access to primary care. It is known nationally that the Medicaid population has poorer health outcomes and also disproportionately suffer from severe cases of chronic disease (i.e. diabetes, high blood pressure, COPD, etc.) and disability. As these conditions are expensive to treat, the cost of care can quickly escalate as many chronic disease/disability patients may present in the ER in an acute state, although not emergent enough to be admitted to the hospital resulting in multiple visits to the ER to receive care. In July 2014, the Medicaid and CHIP Payment and Access Commission (MACPAC) produced a brief entitled "Revisiting Emergency Department (ED) Use in Medicaid" that examined commonly held beliefs about ER visits to determine the truth of the statements that are consistently heard across the nation. The MACPAC report included assertions such as "much of the ED use among Medicaid enrollees is unnecessary" and "frequent ED use could be avoided if those users had greater access to primary care" among others.[1] The brief also examines delivery system factors (i.e., doctors sending patients to the ER for workups) that are driving ER use and programs to reduce ER use (i.e. copayments for non-emergent

[1] Please see appendix A for a complete review of the commonly held beliefs about ER visits as published in the July 2014 MACPAC report entitled "Revisiting Emergency Department Use in Medicaid."

visits and programs for super utilizers.[2] Non-emergent ER utilization is topical across the nation, and as such, states are increasingly finding different ways to address the topic.[3]

EMTALA

In 1986, as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA) was passed. The federal statute governs when and how a patient that presents to a hospital must be (1) examined and offered treatment or (2) transferred from one hospital to another when he/she is in an unstable medical condition.[4] As a result of these regulations and potentially associated fines and sanctions, hospitals have implemented policies to ensure compliance with the law. Under the law, hospitals are required to conduct a medical screening exam by a qualified medical practitioner (emergency room practitioner, physician's assistant, nurse practitioner) to determine whether a patient is emergent or non-emergent and to medically stabilize them. Once the patient has been medically stabilized and determined emergent or non-emergent they can be informed of the cost of further treatment. If a patient has been determined to have an urgent medical condition, the patient may be consequently admitted to the hospital and treated. If no emergency exists, hospitals are no longer required by law to treat the patient beyond the EMTALA required medical screening and stabilization. At this point, hospitals can inform the patient of the cost of further treatment and any community resources that are available. EMTALA continues to be an often cited reason by hospitals as reason to not divert non-emergent patients for fear of fines and sanctions. In an effort to better understand the compliance or noncompliance of EMTALA regulations by hospitals the OHCA recently held a meeting with the Oklahoma State Department of Health (OSDH) regarding their role in the oversight of EMTALA. The OSDH has been contracted by the Centers for Medicaid and Medicare Services (CMS) to perform EMTALA complaint investigations and to inform CMS regarding a hospital's compliance with EMTALA to them. The OSDH stated to OHCA that they are not responsible for levying fines and sanctions against hospitals as a result of their investigations. The CMS is

[2] Please see appendix A for a complete review of the delivery system factors affecting ER visits and programs to reduce to ER usage as published in the July 2014 MACPAC report entitled "Revisiting Emergency Department Use in Medicaid."
[3] For a list of emergency room utilization topics found within national literature please see appendix B.
[4] Please see appendix C for the full statutory language of EMTALA. For more information on the complete history of EMTALA visit www.EMTALA.com.

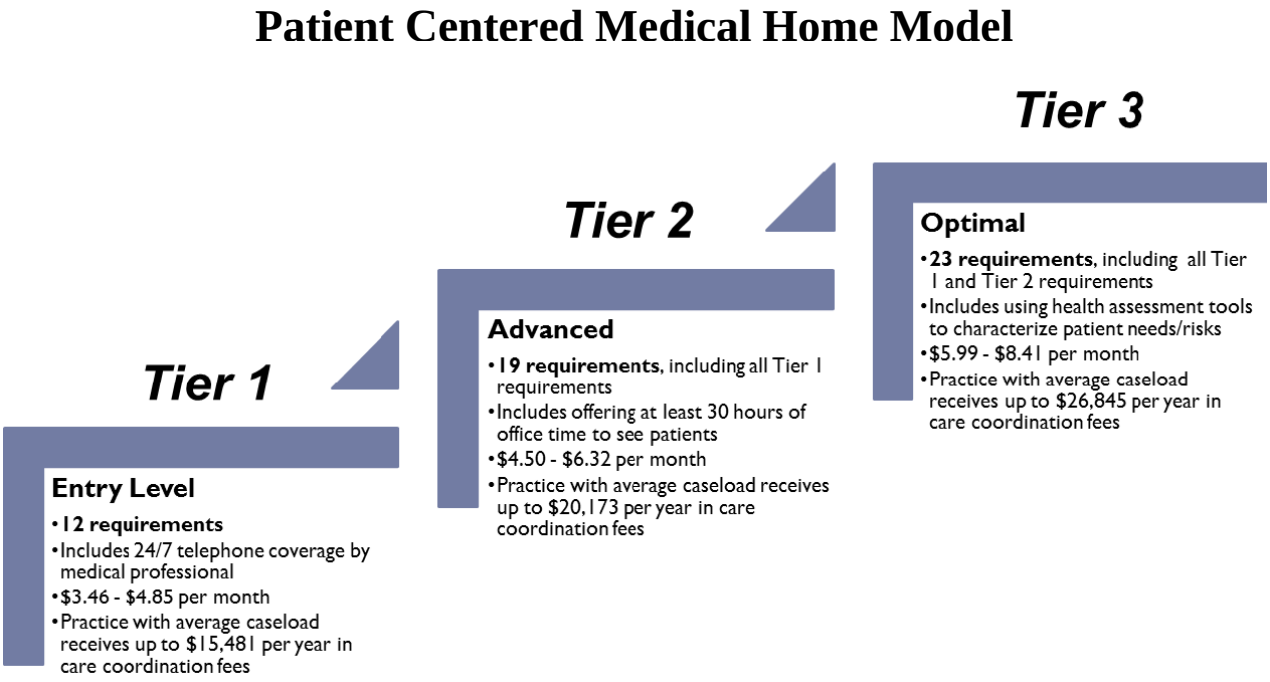
responsible for levying fines and sanctions against hospitals for violations of EMTALA that were discovered through investigations. According to the OSDH less than ten (10) EMTALA complaints were submitted to the OSDH in 2013. None of these complaints were substantiated by the OSDH. As such no fines or sanctions were levied by the CMS.

SoonerCare Choice

Since 2004, even prior to the migration to Oklahoma's patient-centered medical home (PCMH) model, the SoonerCare Choice program has been an integral part of the ER utilization program designed to reduce non-emergent ER utilization by SoonerCare enrollees. SoonerCare Choice is the coordinated care program for OHCA that operates under a federal "Section 1115 Waiver" which allows them to enroll certain groups into coordinated care systems. These systems include the health management program (HMP), PCMH and health access networks (HANs). The HMP care system utilizes predictive modeling to identify SoonerCare Choice members with above average health care costs who have complex medical needs that are usually exacerbated by the existence of multiple physical conditions along with behavioral health co-morbidities. The HMP care system has been effective in addressing non-emergent ER utilization rates for these members who tend to have above average non-emergent utilization of the ER. According to a report by Pacific Health Policy Group[5] the OHCA utilized existing PCMH models that were developed by the American Academy of Pediatrics (AAP) beginning in 1964, and North Carolina's Coordinate Care Network model that was developed in the early 2000s to develop Oklahoma's PCMH model. The model aligns members with a primary care provider that is responsible for meeting access and quality standards.

[5] Please see http://www.okhca.org/research.aspx?id=88&parts=7447 for the 2014 PHPG SoonerCare Choice Program Independent Evaluation Final Report.

The PCMH model is delineated by three different tier levels (see figure below) each with their own standards and reimbursement methodologies.

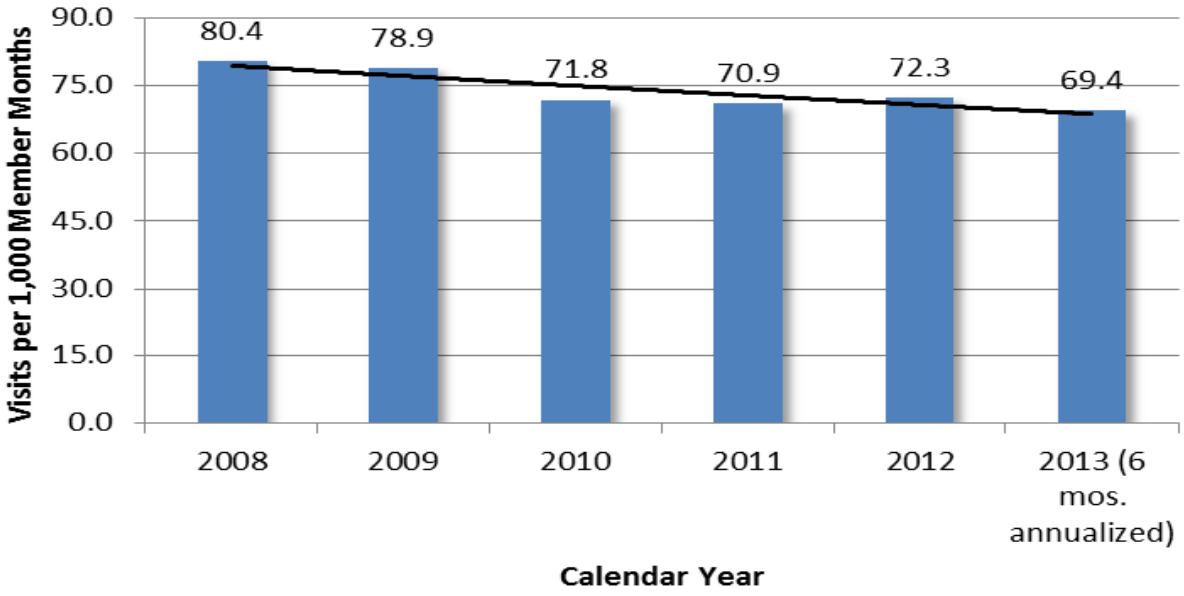


Source: Exhibit 1-2 – Patient Centered Medical Home Model
(2014 PHPG SoonerCare Choice Program Independent Evaluation – Final Report)

All PCMH providers are required to provide 24-hour/7-day coverage by a medical professional. In addition, OHCA requires Tier 3 PCMH providers to provide extended office hours for members who aren't able to visit them during normal hours. OHCA pays PCMH providers a monthly care management fee for their effort, which increases with every tier level. PCMH providers are also incentivized by SoonerExcel payments that are paid to providers for offering increased care coordination support and decreasing member non-emergent ER utilization.

The PCMH model has been effective in reducing non-emergent ER utilization rates by SoonerCare members since its inception. (See figure below).

SoonerCare Choice Emergency Room Utilization – 2008 to 2013



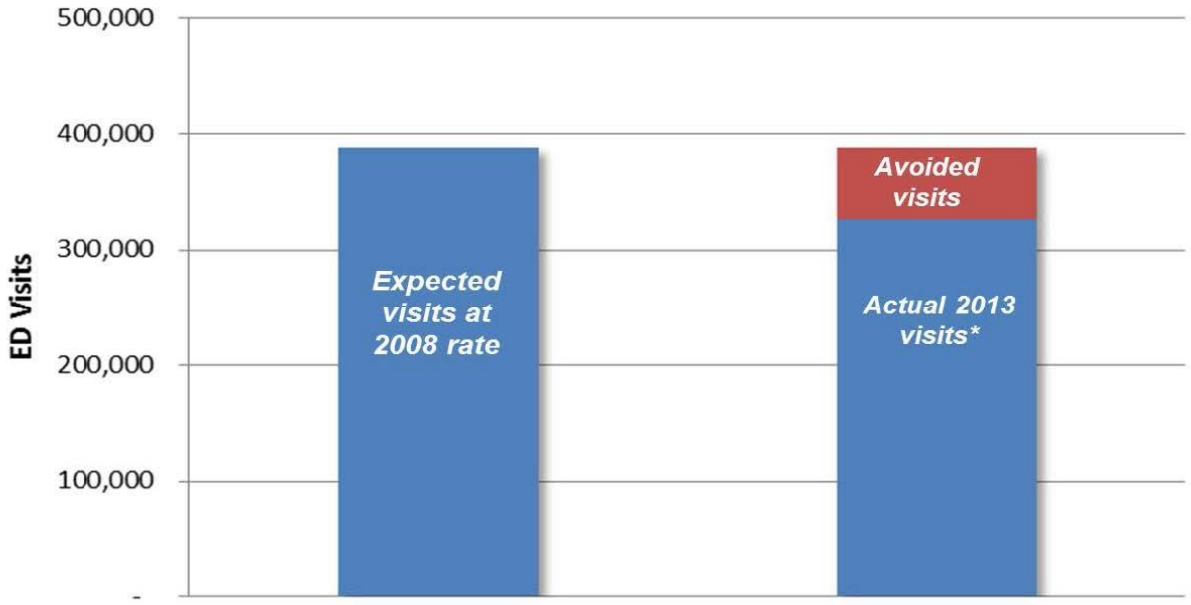
Source: Exhibit 2-8 – SoonerCare Choice Emergency Room Utilization – 2008 to 2013
2014 PHPG SoonerCare Choice Program Independent Evaluation – Final Report

The HAN providers, contracted by OHCA in 2010, were and continue to be an enhancement to the PCMH model that was developed by OHCA in 2009. The HANs are community based integrated networks that offer advanced program access, quality and cost effectiveness goals and increased care coordination to affiliated PCMH providers. (PHPG SoonerCare Choice Program Independent Evaluation)[6]. Currently there are three HANs across the state (OU, OSU and Central Communities) that provide services to SoonerCare Choice members.[7] In the report PHPG states that they found strong evidence that the impact of HAN interventions have been effective in addressing above average non-emergent ER utilizers.

[6] Please see http://www.okhca.org/research.aspx?id=88&parts=7447 for a comprehensive review of the HAN providers as discussed in the 2014 PHPG SoonerCare Choice Program Independent Evaluation Final Report
[7] Please see appendix D for a map of the HAN networks across the state.

Furthermore, evidence in the PHPG report suggests that an estimated 61,000 ER visits were avoided in 2013 as a result of interventions implemented by the HANs. This evidenced in the figure below.

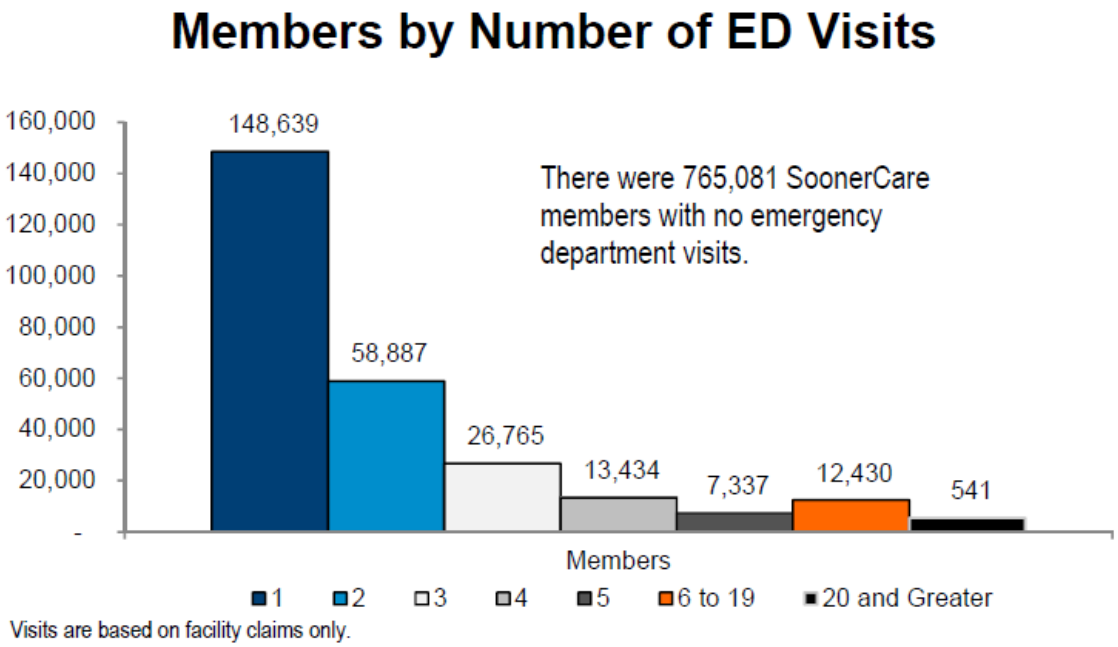
SoonerCare Choice Emergency Room Utilization – Avoided Visits in CY2013



Source: Exhibit 2-11 – SoonerCare Choice Emergency Room Utilization – Avoided Visits in CY2013
2014 PHPG SoonerCare Choice Program Independent Evaluation – Final Report

In the SoonerCare Choice program every member has a primary care provider whose office is considered their medical home. Some members also have a provider that is part of a HAN and therefore have access to increased care coordination. Oklahoma's PCMH model and the HAN networks have been effective in addressing above average non-emergent ER utilization by SoonerCare Choice members.

In Oklahoma, there are five specific aid categories that are covered under the Medicaid umbrella and include children/parents, SoonerPlan, Insure Oklahoma, Aged, Blind & Disabled and others.[8] Each category has specific qualifications that are stratified by age, income level, diagnosis, employment status and disability.

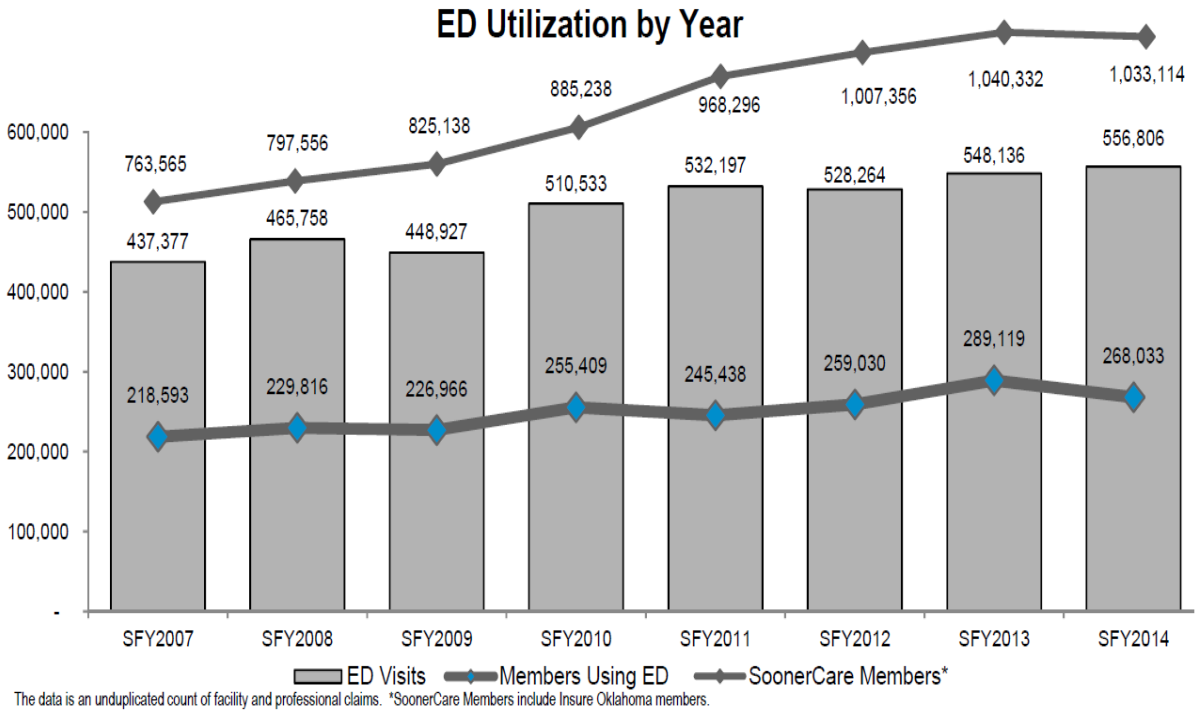


Source: OHCA SFY2014 Emergency Department Fast Facts

[8] Please see Figure 12 from the OHCA SFY2014 Annual Report in appendix F for a percentage breakdown of these groups and their associated expenditures.

SoonerCare

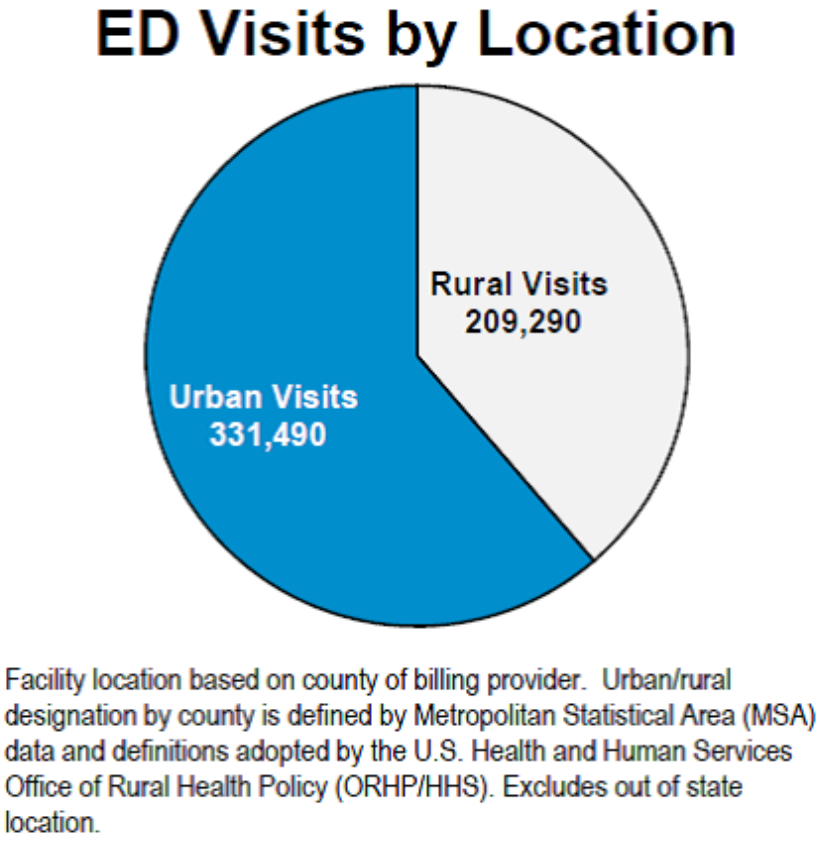
Since SFY2007, the number of SoonerCare/Insure Oklahoma members visiting the ER has been relatively flat with a peak of 289,119 members in SFY2013. In SFY2014, Oklahoma experienced a decrease of approximately 31,000 SoonerCare/Insure Oklahoma members to 268,033 visiting the ER (a total of only 26 percent of the SoonerCare population) and only a slight increase in the number of ER visits (see figure below).[9]



Source: OHCA SFY2014 Emergency Department Fast Facts

[9] Please see appendix G for more information on SoonerCare member ER utilization as published in the SFY2014 OHCA Emergency Department Fast Facts.

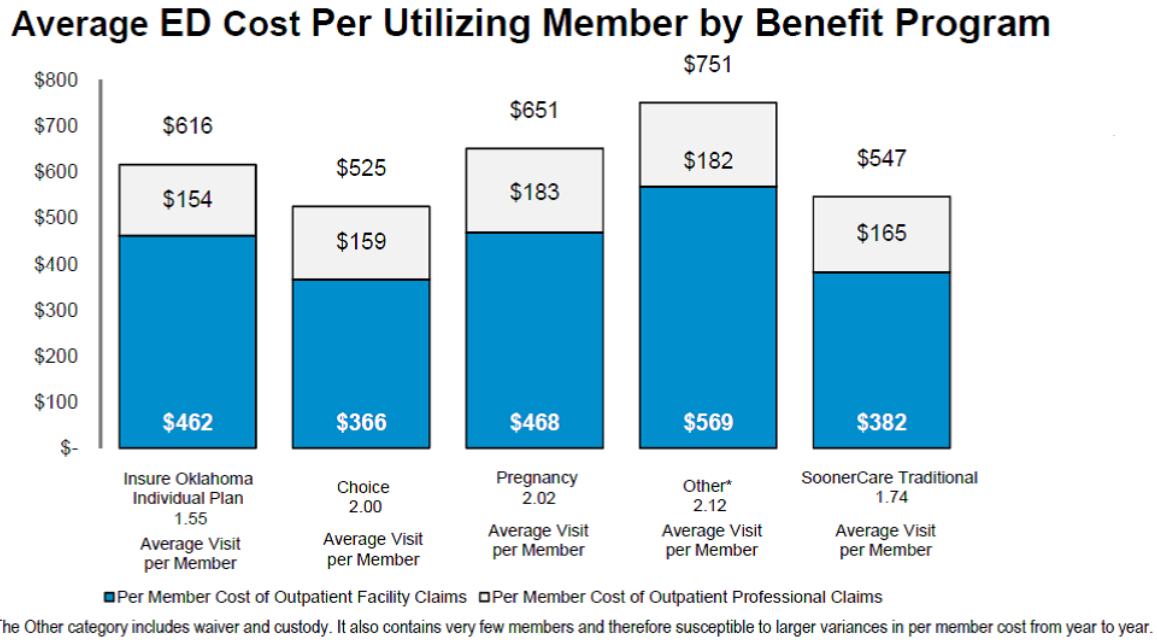
A total of 556,806 ER visits were made in SFY 2014 of which 540,780 were specifically made by SoonerCare members of which 61.3 percent were urban ER visits and 38.7 percent were rural ER visits (see figure below).[10]



Source: OHCA SFY2014 Emergency Department Fast Facts

[10] Please see appendix G for more information on urban versus rural visits as published in the SFY2014 OHCA Emergency Department Fast Facts.

The total cost for paid ER claims last year was $151,584,802 (without ancillary services; $190,540,765 with ancillary services) with an average per visit cost of $264.98 and 2.08 visits/per utilizing member (see figures below).[11]



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.

Source: OHCA SFY2014 Emergency Department Fast Facts

[11] Please see appendix G for more information on ED total cost as published in the SFY2014 OHCA Emergency Department Fast Facts.

The annual cost of ER visits by all SoonerCare members is a relatively small part of the overall cost of health care for Oklahomans covered by Medicaid. However, the appropriateness of an individual receiving non-emergent or primary care services in the ER is of tremendous concern. The top ten listed diagnoses for children for SFY2014 included upper respiratory infections, ear infections, fever and urinary tract infections among others.[12] The top ten listed diagnoses for adults for SFY2014 included abdominal pain, urinary tract infections and headaches among others.[13]

Social Determinants

Social determinants of health care are an important topic in today's society. Social determinants can have an adverse effect on a person's ability to access the medical care they need and are also a significant cause of increased non-emergent use of the ER by SoonerCare members. According to the Centers for Disease Control and Prevention (CDC) "social determinants of health are economic and social conditions that influence the health of people and communities." (cdc.gov/social determinants/FAQ). These conditions are largely affected by income, social status and the availability of community resources in addition to policies that are set in place by communities, states and the federal government. As Medicaid is a safety net program for low-income individuals needing health insurance, SoonerCare members generally have social determinants that affect their ability to access primary care. In addition, SoonerCare members in low-wage jobs tend to hold positions that require them to work an inconsistent schedule and don't offer time off. As a result, SoonerCare members are not always able to visit their primary care provider during the normal hours they are open from 8 a.m. to 5 p.m. and their only option is to visit the ER to receive treatment for low-acuity diagnoses. The lack of after-hours and urgent care clinics in certain communities exacerbates this situation. The OHCA continues to incentivize SoonerCare PCPs in the community to stay open after hours as a way to address this concern. Social determinants and their impact are apparent in Oklahoma as well as across the nation.

[12] Please see appendix G for more information on the top ten listed diagnoses for children as published in the SFY2014 OHCA Emergency Department Fast Facts.

[13] Please see appendix G for more information on the top ten listed diagnoses for adults as published in the SFY2014 OHCA Emergency Department Fast Facts.

Assessment of Other State Approaches

As mentioned previously, the topic of non-emergent ER utilization rates of individuals covered by Medicaid is receiving national attention, and as such, states have taken varied approaches to address the topic. Recently these approaches have included imposing co-payments for non-emergent visits to the ER, limits on service days and prior authorizations among others. Among federal and state policymakers the topic of non-emergent ER utilization is not new and has been a struggle for well over a decade.

In 2008, the Centers for Medicare and Medicaid Services (CMS) awarded ERdiversion grants to twenty (20) states[14] as authorized by Section 6043 of the Deficit Reduction Act of 2005 that authorized $50 million in Federal Grants to states. The $50 million in Federal grants were used to establish non-emergency service providers and/or networks of such providers. Summary templates from twelve (12) states were submitted to CMS detailing their efforts and findings. [15] The states' efforts centered around three main categories of ER diversion that included collaboration with alternate care sites/extended hours of operation, education/outreach/in-person interventions and health technology (although not all states used all three strategies). Collaboration efforts included partnering with local, urgent care clinics, federally qualified health centers (FQHCs) and primary care practices to offer extended hours and easier access to more appropriate medical care. Education strategies included development of pamphlets, brochures, advertising and other educational materials that were provided in the ER and through media outlets. Outreach efforts and in-person interventions included the use of community health workers (CHWs), patient navigators, case managers, ER physicians and mid-level providers to educate patients about the appropriate use of the ER and also steering them towards available resources that provided access to more appropriate medical care. The combination of these efforts saw mixed results but overall was a success in addressing the topic of non-emergent ER utilization. Health technology strategies included the use of electronic appointment systems, electronic medical record (EMR) systems as well as the use of telehealth technology for treating behavioral health patients. A majority of these systems were already in place but helped solidify efforts to reduce non-emergent ER utilization.

[14] States that participated were CO, CT, GA, IL, IN, LA, MA, MD, MI, MO, NC, ND, NJ, OK, PA, RI, SC, SD, TN and WA.
[15] Please see appendix H for a full overview of each participating state's summary template(s).

Oklahoma's participation in the grant yielded many lessons learned influencing future decisions regarding interventions for non-emergent ER utilization. Oklahoma's primary strategies revolved around the use of community health workers (CHWs) to help patients navigate the health care system and to ensure the appropriate level of health care services that are being utilized by them. Educational and informational materials were developed to support these efforts.[16] The major lessons learned from these efforts were that the above average turnover for CHWs exacerbated the inability to form patient relationships and that the relationship between the CHWs and the hospital was continually strained due to unclear rules and responsibilities among staff. The OHCA continues to explore methods to incorporate CHW assistance at the hospital and practice level, and encourages HANs to make this service available to their network PCPs.

In the past few years with federal budget cuts, increased insurance rates and even more rapidly increasing health care costs states have begun to look at ways to reduce the cost of health care for all citizens in the United States. Although reimbursement for non-emergent ER visits is a small part of their overall health care budgets, a social stigma still exists because of the availability of numerous other avenues to obtain health care in a more appropriate setting and at a much lower cost. Recent efforts to stem the increase in health care costs and to lower the rate of non-emergent ER utilization by Medicaid members have centered around the implementation of copayments for non-emergency ER visits, prior authorizations on specific procedures[17] and services in addition to limits on service days. Copayments have been somewhat effective at addressing non-emergent ER utilization rates but have been hampered by the inability to charge higher than the copayment limits that are set by the CMS for Medicaid enrollees. [18] According to a report by the Kaiser Family Foundation on outpatient hospital services provided through Medicaid, approximately thirty-six (36) states charge a nominal copayment for non-emergency services provided in

[16] Please see appendix H for a full overview of Oklahoma's ER diversion grant summary.
[17] Please see appendix I for the full Kaiser Family Foundation (KFF) report on outpatient hospital services provided under Medicaid and a list of states that require prior authorization on specified procedures and services.
[18] For populations that are at < 100% of the federal poverty limit (FPL) the maximum copayment amount allowed is $3.90 and for populations that are between 101% and 150% of the FPL the maximum copayment is $7.90. In addition copayments are only applicable to beneficiaries age 18 that are not on the exempt list of those individuals that can't be charged copayments (children, terminally ill individuals and individuals residing in institutions). Copayments can also not be charged for emergency services, family planning services, pregnancy-related services or preventive services for children.

an ER.[19] In the report, with the exception of a few states, there were no attempts to increase copayments above the federally set copayment limits for Medicaid enrollees. Higher copayments have not been shown to significantly decrease the number of non-emergent ER visits by Medicaid enrollees. In addition, according to the Kaiser Family Foundation report, approximately eighteen (18) states have prior authorization requirements for specified services and surgical procedures. Oklahoma is one of the eighteen (18) states that require prior authorization for specified services and surgical procedures performed outside of the ER. Requiring prior authorization increases the chances that unnecessary procedures or services are not performed and thus save the state money. Again, according to the Kaiser Family Foundation report on outpatient hospital services, approximately twenty-six (26) states have limits on service days. Each state has its' own interpretation of limits on service days of which are admittedly quite varied. Currently, the only limits on service days that Oklahoma requires are that OHCA does not cover outpatient behavioral health services for nursing facility residents and OHCA does not pay for two (2) ER visits on the same day if a SoonerCare member leaves the same facility and returns later with the same diagnosis. A few highlights regarding limits on service days are included below:

- Alabama – Three (3) non-emergency visits/year unless outpatient surgery, lab, dialysis, radiation or chemotherapy is involved. Non-emergency visits to the emergency room count toward both outpatient and physician visit limits
- Arkansas – Twelve (12) non-emergency visit/year
- Florida – Six (6) emergency room (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 occupational therapy and physical therapy
- North Carolina – Twenty-two (22) ambulatory visits/year included in limits with other specified practitioners – limits are set annually by the legislature

[19] Please see appendix I for the full Kaiser Family Foundation (KFF) report on outpatient hospital services provided under Medicaid and a list of states that charge nominal copayments for non-emergent services provided in an ER.

Although these are just a few highlights of the many approaches states have taken in regards to limits on service days there are many more included in the full Kaiser Family Foundation report on outpatient hospital services provided under Medicaid.[20] Furthermore, if states wish to participate in and claim federal financial participation (FFP) they must gain approval from CMS. While many states have sought alternatives to address ER utilization including increasing ER copayments and visit limits they have been largely unsuccessful.

Assessment of Current OHCA Environment

On January 1st, 2004 the OHCA HMO contracts were terminated requiring the OHCA to terminate enrollment for approximately 187,000 SoonerCare Plus members from their contracted managed care plans and to enroll them into the SoonerCare Choice primary care case management (PCCM) system; effectively doubling the existing SoonerCare Choice program population. As a result of this transfer, the OHCA also expanded the quality initiatives for the program through the expansion of the quality assurance and care management units. An important and relevant intervention arising from this transfer is the development of the ER utilization program by the OHCA to address both member and provider factors related to members with above average ER utilization. The program has had multiple iterations since its inception and has been effective at addressing the topic of overutilization of the ER by SoonerCare members. In the bullets below you will find a chronological timeline of the ER utilization program:

- 2004 – Provider profiling was created to review annual office visit and non-emergent ER visit utilization rates of SoonerCare members assigned to each SoonerCare practice and to provide education to providers.[21] Referral mechanisms for referring SoonerCare members to care management from ER providers at the time of the non-emergent ER visit and from internal sources using claims data were also developed.

[20] Please see appendix I for the full Kaiser Family Foundation (KFF) report on outpatient hospital services provided under Medicaid.
[21] Please see appendix J for comprehensive information on provider profiling objectives, methods and examples.

Care management initiatives were implemented and included outreach (up to three phone contact attempts) to beneficiaries with increased non-emergent ER utilization (≥ 6 visits/quarter), follow-up on nurse advice line calls that directed members to the ER and also following up on referrals from external sources. (Source, Board Retreat Presentation by QA/QI Unit, September 2005)

- 2005 – In April 2005, the number of non-emergent ER visits that designated a SoonerCare member an above average utilizer was decreased by one visit per quarter to ≥ 5 visits/quarter and then decreased again to ≥ 4 visits/quarter beginning in October 2005 essentially doubling the size of the intervention group. Reducing the number of visits and expanding the size of the intervention group allowed for more focused intervention and better disaggregation of groups that are considered above average non-emergent utilizers of the ER.

- 2006 – On January 1, 2006 the previously identified nurse advice line (NAL) became the patient advice line (PAL). The PAL was developed to provide SoonerCare members a resource to call to gain advice from a medical professional who will triage them when they are unable to get in with their primary care provider during normal business hours. Primary care providers were required to have telephone messaging systems, answering services and/or office staff to advise SoonerCare members how to access urgent care clinics in the event their primary care provider is unavailable. The services provided by the PAL were available from 5:00 p.m. to 8:00 a.m. Monday through Friday and twenty-four (24) hours/day on weekends and holidays. A program that utilizes the expertise of selected OHCA member services staff to educate and assist members identified as frequent non-emergent ER utilizers to access benefits and coordination with those benefits was implemented in March 2006 (Source, Board Retreat Presentation by Becky Pasternik-Ikard "QI and Performance Measurement in Medicaid Care Management"). As an addition to this program, the OHCA implemented intensive interventions for members that were identified as persistently above average non-emergent ER utilizers (≥ 30 ER visits in

three consecutive quarters).[22] House Bill 2842 was signed by former Governor Brad Henry on June 9, 2006 which directed the OHCA to continue to develop and administer their ER utilization program to encourage proper use of emergency rooms. [23] A total of our four full time equivalent (FTE) employees were allocated to the ER utilization program due to a provision in Oklahoma's Medicaid Reform Act of which two were hired in 2006. One was assigned to the Waiver Development and Reporting unit and the other was assigned to the Member Services unit.

- 2007 – The OHCA initiated the analysis of data related to above average cost members in the ER utilization program ($\geq$ $100,000 in paid claims for all services used in three consecutive quarters). As such a dedicated database for information and intervention tracking on persistent members was created. Two additional FTEs were hired in compliance with the provision in Oklahoma's Medicaid Reform Act with one assigned to the Provider Services unit and the other to the Care Management unit. Beginning in April 2007, all persistent ER utilizers automatically received face-to-face intervention.

- 2008 – Members with twenty to twenty-nine non-emergent ER visits in three consecutive quarters are identified and begin receiving targeted phone intervention. Above average cost member selection threshold is lowered from $\geq$ $100,000 to $\geq$ $80,000 in paid claims for all services in three consecutive quarters.

- 2009 – On January 1, 2009 the SoonerCare Choice program was reorganized and Oklahoma's current patient-centered medical home (PCMH) model was launched. The model and related interventions have been instrumental in decreasing the number of non-emergent ER visits by SoonerCare members.[24]

[22] Interventions included structured face-to-face interviews, two phone calls and letters for providers and members. Please see appendix I for examples of letters sent to frequent and persistent utilizers. Persistent utilizers received both initial and follow up letters.
[23] Please see appendix K for the full text of House Bill 2842.
[24] Please see appendix L for an overview of the PCMH system in the "Reducing Costs and Driving Behavior Change: A Review of OHCA Interventions for Reducing Non-Emergent Visits" report published in March 2014.

As a supplement to Oklahoma's PCMH model incentive payments (SoonerExcel) to PCPs who meet or exceed the non-emergent ER utilization compliance rate and that educate patients on proper ER utilization began in April 2009.[25]

- 2010 – The Health Access Network (HAN) pilot was approved in 2010 and was developed to enhance the SoonerCare Choice program through the creation of community-based, integrated health networks to support patient-centered medical homes. The pilot resulted and still results in increased access to appropriate levels of care and coordination of care for SoonerCare Choice members as well as reduction in costs.[26]

- 2012 – In 2012, the multi-payer Comprehensive Primary Care Initiative (CPCI) was launched to improve health outcomes, improve the delivery of care and reduce costs. The OHCA partnered with Medicare, Blue Cross and Blue Shield (BCBS) and Community Care to implement the system. [27] Although SoonerCare members largely utilize the appropriate level of care there are those few that don't and require specific interventions. The OHCA developed interventions specifically for these individuals which were conducted by Member Services, Population Care Management (PCM), Pharmacy Services and Legal Services.[28]

- Continuous and Ongoing Interventions – The OHCA began addressing the topic of non-emergent ER utilization in 2004 and continues on through the present day. Numerous interventions have been implemented over the past decade with a few continuing on through the present day that have had multiple iterations throughout the years to adapt to changing healthcare innovations. Identification, outreach and reporting on "frequent fliers", those members that utilize the ER fifteen (15) plus times per year, continues through today. Provider reporting is another non-emergent

[25] Please see appendix M for a comprehensive overview of the SoonerExcel incentive payment system.
[26] Please see appendix L for an overview of the HAN system in the "Reducing Costs and Driving Behavior Change: A Review of OHCA Interventions for Reducing Non-Emergent Visits" report published in March 2014.
[27] Please see appendix L for an overview of the CPCI program in the "Reducing Costs and Driving Behavior Change: A Review of OHCA Interventions for Reducing Non-Emergent Visits" report published in March 2014.
[28] Please see appendix L for an overview of the specific interventions in the "Reducing Costs and Driving Behavior Change: A Review of OHCA Interventions for Reducing Non-Emergent Visits" report published in March 2014.

ER utilization intervention that continues through today. As part of this intervention, when a SoonerCare member goes to the ER, the OHCA gives a member's primary care provider notice that their patient went to the ER. Currently, these reports are six (6) weeks in arrears but the OHCA is working towards making these reports timelier to increase their effectiveness when addressing the topic of non-emergent ER utilization. In addition to the aforementioned interventions, the PCMH, HAN and CPCI interventions continue through today and continue to have an impact on the topic of non-emergent ER utilization.

Stakeholder Input

In 2014, per House Bill 2906, the OHCA was directed by the Oklahoma Legislature to gather input from a variety of internal and external stakeholders regarding the topic of non-emergent ER utilization by SoonerCare members in Oklahoma's health care system. As part of that directive the OHCA initially completed an internal exploration of the methods and approaches utilized by the OHCA to obtain an assessment of the current OHCA environment in regards to non-emergent ER utilization rates by SoonerCare members. In addition to the completion of the internal exploration of methods and approaches utilized by the OHCA an external examination of OHCA stakeholder input was completed. As part of this external examination an internal steering committee was formed to provide a forum for sharing known non-emergent ER utilization topics, act as a sounding board, shape recommendations and to identify stakeholders that could provide beneficial input on non-emergent ER utilization topics. The committee was comprised of OHCA leadership/management/employees and also had representation from the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). The committee was able to identify numerous stakeholder groups and beginning on August 28th the OHCA conducted numerous meetings with various community and agency partners to receive input and recommendations on non-emergent ER utilization by SoonerCare members. A total of fifteen stakeholder groups were met with and provided information regarding current non-emergent ER utilization by SoonerCare members. Each stakeholder group was presented with a series of questions and asked to provide their feedback.

The OHCA received feedback on major and minor challenges as well as recommendations to address those challenges. Major and minor challenges identified by OHCA stakeholders are summarized in the table below[29]:

Major Challenges
Access to Care – Members say that primary care providers (PCPs) are often booked up for two weeks and don't provide access afterhours. Medical professionals themselves often refer patients to the ER for a variety of reasons. As a result, many professionals are contributing to the non-emergent use of the ER.
Behavioral Health – A lack of inpatient beds to provide treatment and a shortage of behavioral health staff in rural counties create barriers to effectively treating an overabundance of behavioral health patients. ER doctors have limited time to be with patients to fully address behavioral health co-morbidities. Additional behavioral health staff are needed in the ER to address this issue.
Organizational – Existing volume-based reimbursement system puts emergency room (ER) doctors and hospital administration at odds because administration views the ER as a revenue source while ER doctors believe non-emergent patients should be diverted from the ER to their PCP or other community resources (i.e. urgent care). Inpatient admissions and re-hospitalizations by SoonerCare members present a larger cost to the OHCA than ER visits as more services/increased levels of care are provided. ERs are a large source of such admissions and hospitalizations.

[29] Please see appendix N for a comprehensive overview of major and minor challenges that were identified during stakeholder meetings.

Minor Challenges
Regulatory Barriers – Federal law prohibits doctors from refusing treatment to members for inability/refusal to pay their required copayment. Recent changes in law have disallowed nurse practitioners from prescribing certain pain medications which inadvertently increased the number of patients to the ER to seek drugs that they need or want.

Development of Recommendations

As previously mentioned, numerous stakeholder meetings were held with community and agency partners to obtain information regarding major/minor challenges associated with above average non-emergent ER utilization rates and their recommendations to address those challenges. In addition to obtaining recommendations from stakeholders, the OHCA also gathered internal recommendations and insights from the internal OHCA steering committee. These recommendations can be condensed into several high-level areas which are presented below:[30]

Member/Provider Education

- Coordinate with federally qualified health centers (FQHCs) and primary care providers (PCPs) to decrease ER visits by educating members on the appropriate levels of care
- Educate members and providers about available community and behavioral health resources (i.e. availability of afterhours clinics) at all points of service
- Educate members on the importance of obtaining non-emergent medical care through their PCP
- Educate ERs that care management services are available for their patients
- Educate members on the importance of engaging with their PCP regarding appropriate ER utilization by utilizing social media platforms along with email and text messaging

[30] Please see appendix N for a comprehensive list of stakeholders and an overview of information that was collected during stakeholder meetings.

- Assist providers with how to utilize quarterly ER utilization panel member reports that are provided by the OHCA
- Coordinate with hospitals regarding timely follow-up and contact with a patient's PCP after being in seen the ER

Alternative Payment Models

- Ensure multiple payer collaboration on establishing alternative payment models and policies to promote appropriate utilization of the ER
- Explore the adjustment of SoonerExcel reimbursement rates to decrease non-emergent ER use and direct patients to a more appropriate point of service (urgent care, PCP office)
- Provide additional reimbursement for urgent care services provided to SoonerCare members afterhours
- Engage the Centers for Medicare and Medicaid Services (CMS) to explore increased member cost sharing

Staffing

- Coordinate community health/social worker support to hospitals in order to decrease the burden on facilities needing to educate patients about community resources and appropriate use of the ER

Technology

- Enhance utilization of telemedicine in the ER
- Recommend interfaces with health information exchange (HIE) and hospital electronic medical record (EMR) systems for real-time data exchange and to get daily reports on ER use by SoonerCare members which would address the need for quicker access to information on ER utilization to care coordination managers

Evaluation

As with any initiative or intervention, metrics must be developed to evaluate the effectiveness of the intervention or initiative. The interventions that the OHCA has implemented over the last decade in response to addressing non-emergent ER utilization

rate for SoonerCare members have been effective. The introduction of the patient-centered medical home (PCMH) model in 2009 and the introduction of the health access networks (HANs) in 2010 as an enhancement to the PCMH model proved to be quite effective in addressing non-emergent ER utilization by SoonerCare members. There have been numerous independent evaluations of these programs conducted over the years to evaluate their effectiveness. Looking forward, the recommendations that have been outlined in this report must contain an evaluation element that will evaluate the effectiveness of the recommendation. One way to evaluate the effectiveness of these recommendations is to tie them to specific Oklahoma Health Improvement Plan (OHIP) goals, objectives and measures. The two specific OHIP objectives that these recommendations can be tied to are preventable hospitalizations and ER utilization. The objectives and the strategies associated with these objectives are stated below.[31]

- Objective 1 – Reduce by 20% the rate, per 100,000 Oklahoma, of potentially preventable hospitalizations from 1,656 in 2013 to 1,325 by 2020
    - Strategy 1: Improve the quality and availability of health care via care coordination, especially for individuals with chronic, behavioral health, or specific co-morbid conditions
    - Strategy 2: Prioritize outcome-driven care
- Objective 2 – Reduced by 20% the rate, per 1,000 population, of Hospital ER Visits from 500 in 2012 to 400 visits by 2020
    - Strategy 1: Use of Clinical Preventive Services (CPS) to reduce the need for emergency care
    - Strategy 2: Use of PCMHs to improve health outcomes
    - Strategy 3: Support practice facilitation in order to train providers to achieve National Quality Forum (NQF) goals
    - Strategy 4: Promote the exchange of EHRs across the care continuum

[31] The OHIP objectives and strategies associated with preventable hospitalizations and ER utilization were developed by the Health Efficiency and Effectiveness OHIP workgroup. For more information on OHIP please contact the Oklahoma State Department of Health (OSDH) or visit http://www.ok.gov/health/Organization/Board_of_Health/Oklahoma_Health_Improvement_Planning_Team_(OHIP)_/index.html.

In addition to OHIP objectives, core measures for established co-located/close proximity urgent care clinics will need to be developed to evaluate their effectiveness and performance related to reducing the number of non-emergent ER visits by SoonerCare members. Lastly, return on investment (ROI) analyses will be used to determine the effectiveness of alternative payment models. An important insight that was gained through the internal and external stakeholder meetings was that above average non-emergent utilization of the ER by SoonerCare members is a perceived problem as evidenced by the low dollar amount that is dedicated to reimbursement for ER visits by SoonerCare members.

Conclusion

The OHCA is acutely aware of the concerns surrounding non-emergent ER utilization and is committed to making continued improvements in reducing the rate of non-emergent ER utilization by its members. This is largely apparent and continues to be proven by our ongoing efforts to monitor and intervene with ER users all the while being mindful of federal policies that limit the use of federal financial participation. OHCA will continue to maximize investments into efforts that result in quality care for members and that provide good rates of return on investment. Patient-centered medical home and care coordination models have provided a demonstrated impact on non-emergent ER use by SoonerCare members. The OHCA will continue to invest resources into these interventions to continue the great work that has been completed to date. Looking forward, the OHCA anticipates exploring the inclusion of additional SoonerCare population groups beyond the current SoonerCare Choice population. These populations include individuals that are pregnant, dually eligible for both Medicaid and Medicare or are aged/blind/disabled. Although serving these additional populations will require an investment in staff and an increased need for resources, as care coordination is time-intensive, the OHCA believes these efforts will be add an enormous amount of value to the health of Oklahomans through the reduction of health care costs.