Diversion of Utah Medicaid Non-Emergent Emergency Department Usage

Funding Opportunity Title:
Grant Funds for Establishment of Alternate Non-Emergency Services Providers

Funding Opportunity No.
HHS-2008-CMS-ANESP-0005

By
The State of Utah
Utah Department of Health
Division of Health Care Financing

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Acknowledgement of Support
The State Medicaid Director, Michael Hales, fully supports this grant proposal and is the primary contact person for it. Mr. Hales is eager to realize the potential budget savings that should result from this project. He also sees this as a sustainable program, because of the huge potential for savings to the program.

Abstract

Proposal: The State of Utah proposes an expansion to its Medicaid Care Coordination and Restriction Program. The Care Coordination and Restriction Program currently identify recipients who use the Emergency Department (ED) three or more times in a 12-month period for non-emergent care. Those persons are placed in the Care Coordination and Restriction Program and must work through specific protocols to receive services.

The proposed expansion will add two additional FTEs, some consulting services, and printing and mailing costs to allow the State early identification of recipients receiving non-emergent ED care. These employees will monitor non-emergent use of the ED and make contact in a timely manner to educate recipients on appropriate use of the ED. The program staff will then assist these recipients in finding a primary care home. Preference of primary care homes may be given to participating community health centers, which include Federally Qualified Health Centers, in statewide communities. This program will allow staff to contact and educate non-emergent users of the ED after the first offense. These recipients may be placed in the Care Coordination and Restriction Program at that time.

Goals:

- Educate recipients on appropriate use of the EDs.
- Reduce the volume of non-emergent use of the ED and especially target "frequent flyers" of the ED.
- Save budget dollars as a result of transitioning recipients to more appropriate, less costly, primary care alternatives.

Budget Summary: Projected costs for this program are $985,000 over the fours years of this grant.

Expected Outcome:

- Non-emergent utilization of the ED will decrease.
  - Conservatively, even if only 5% of the visits were diverted, the Medicaid program would save approximately $1,000,000 annually. The State is optimistic and believes the actual number diverted will be higher and will save even more dollars.
- Recipients will be diverted to more appropriate primary care homes.
- This diversion of the recipients will result in savings to the Medicaid program that will allow for the long-term sustainability of the program.

Applicant Preference

The State of Utah requests consideration for preference on the following bases:

1. This proposal will target all State Medicaid enrollees, including rural and underserved areas. Inclusion of the specific target data is not deemed necessary, as this program will serve the entire State of Utah.

2. The Association for Utah Community Health, which represents the community health centers in the State is supportive of this program and will work in partnership with the State to see that the program is a success.

3. The State has implemented cost sharing provisions into its State Plan for non-emergency services received in emergency departments.[1]

[1] Utah State Plan, Attachment 4.18-C, Page 1.

Project Narrative

Statement of Project/Need: The State of Utah proposes an expansion to its Medicaid Care Coordination and Restriction Program. The Care Coordination and Restriction Program currently identify recipients who use the ED three or more times in a 12-month period for non-emergent care. Those persons are placed in the Care Coordination and Restriction Program and must work through specific protocols to receive services.

The proposed expansion will add two additional FTEs, some consulting services, and printing and mailing costs. This will allow the State early identification and education of recipients receiving non-emergent ED care. These employees will monitor non-emergent use of the ED and make contact in a timely manner to educate them on appropriate use of the ED and to assist recipients in finding a primary care home. Preference of primary care homes may be given to participating community health centers. This program will allow staff to contact and educate non-emergent users of the ED after the first offense. These recipients may be placed in the Care Coordination and Restriction Program at that time.

The Care Coordination and Restriction Program has not been expanded to date, because of a lack of resources. This grant funded program expansion will serve as pilot project to test the State's projection of potential savings.

The need for this program expansion is justified when one considers the percentage of ED visits that are non-emergent in nature. In 2005, 26 percent of all Medicaid ED visits were non-emergent in nature.[2] In addition to those visits and in the same year, 25 percent of all Medicaid ED visits were for emergent, primary care treatable issues.[2] That said, overall, there is an

[2] Utah Department of Health, IBIS Data, Emergency Department Encounter for Primary Care Sensitive Conditions Query Module for Utah Counties and Local Health Districts. http://ibis.health.utah.gov/query/module/selection/edpcsc/EDSelection.html. Accessed September 10, 2007

opportunity to redirect over half of the ED visits to primary care settings. Understandably, there are some visits that are seemingly emergent (e.g. presenting for chest pain), but are later diagnosed as a non-emergent condition. As the Care Coordination and Restriction Program staff contact the various identified recipients, they will be able to ascertain the road blocks, if any, for the person to seek primary care rather than present at the ED.

Additional benefits of this Care Coordination and Restriction Program are as follows:

1. The Primary Care Provider's (PCP) name prints on the recipient's Medicaid card. This alerts other health care providers through whom to direct coordination efforts.
2. A Primary Care Pharmacy's (PCRx) name prints on the recipient's Medicaid card. Physicians may call the pharmacy for information about prescriptions presented by the recipient from other prescribers. The PCP has a single point of contact for coordination and consultation regarding medications, their side effects, drug-to-drug interactions and alternative recommendations when possible problems are identified.
3. The Nurse Case Managers at the emergency department have good working relationships with the Care Coordination and Restriction Program staff. They routinely contact program staff to report misuse of the ED and to discuss strategies to divert patients to the appropriate level of care.
    a. A letter has been developed by Medicaid that is a companion to a letter sent by hospitals to patients who are using the ER inappropriately. The ER Nurse Case Manager currently contacts program staff to notify when they are sending this type of letter to a patient. Program staff then sends a follow-up letter as well.

b. This project's program expansion will allow for more timely identification of offending recipients for quicker follow-up and education efforts. The program expansion will also include mailings and personal communication from program staff.

4. Additional coordination and education efforts will be done among the various health care providers and Medicaid. These efforts will be overseen by the Care Coordination and Restriction Program staff and other resources.

5. Community health centers, including eleven FQHCs, are located throughout the state, encompassing both urban and rural settings. They are a significant resource for providing primary care for recipients enrolled in the Care Coordination and Restriction Program. Many community health clinics have extended hours of operation. This makes them ideally suited for serving as PCPs and filling a gap for Urgent Care access.

6. Community health clinics are already capable of meeting diverse ethnic and cultural needs of the Medicaid population. They have multi-lingual staff who are usually well aware of ethnic and cultural implications for their patients. For example, in many underdeveloped countries, a primary care physician is only available to the affluent. All others must use a hospital for care. This cultural norm is ingrained in many immigrants and their families and requires sensitivity and supportive efforts to channel and redirect people into new ways of thinking about how to access medical care and treatment.

7. The Care Coordination and Restriction Program already work with primary care providers throughout the state. Program staff routinely communicates with physicians and match patients to physicians for a medical home.

    a. Medical home is defined by the Care Coordination and Restriction Program as including an established long term relationship with a PCP, PCRx, and Urgent Care facility.

Project Justification: As noted above, in 2005 over half of the ED visits were for non-emergent or emergent, primary care treatable conditions. This grant will help fund an initiative to more proactively seek out those recipients and help them find and use more appropriate primary care settings for treatment. State Fiscal Year 2005 FFS data show that the average cost of a non-emergent ED visit is approximately $250, whereas the average cost in a community health center or physician office is approximately $87.[3] This is a difference of $163 per visit. Conservatively and assuming similar costs and volumes, if this project were able to divert only 5 percent of the volume to primary care settings, Medicaid could save approximately $1,014,000 each year. These savings will provide for the ongoing sustainability of the program.

Project Goals and Outcomes:

Goals:

1. Divert Medicaid recipients from seeking treatment in the ED for non-emergent conditions.

[3] Utah Department of Health, Division of Health Care Financing, MMIS Data Warehouse Data extraction.

2. Educate targeted recipients on proper use of the ED, through more timely contacts.

3. Locate primary care homes for these targeted recipients.

Outcomes:

1. Decrease inefficient use of health care resources.

2. Decrease non-emergent ED utilization.

3. Decrease overall Medicaid payments.

Estimate of Impact to Beneficiaries: This program will be implemented statewide. As such, it has potential to affect all recipients. However, since the program will target approximately 25 percent of the total ED visits, the actual number of recipients directly affected is greatly reduced. Additionally, the "impact" to recipients will be minimal as the program seeks only to divert recipients to more appropriate care settings, not to deny the recipients care.

Description of Magnitude of the Impact to Medicaid: The scope of this project is far-reaching. It will target recipients in all areas of the State who use the ED improperly. The re-education and placement of each recipient in a proper primary care home is set to reduce utilization of the ED for Medicaid recipients. Such a reduction in volume to the EDs may help to reduce average wait times for those persons with more emergent conditions.

Description of Sustainability of the Project: If the anticipated results for this program are achieved, the project will be easily sustainable through the savings offset. A portion of the savings realized through this program will be used to retain the FTEs and continue the program.

The potential for savings is substantial and the State anticipates that ongoing funding of this program will not be an issue. This program will fit very well into the State Legislature's effort to control and, if possible, reduce Medicaid spending. As such, Legislative support for ongoing funding of this program should not meet with resistance. The State sees only the ED providers as potential opponents to this effort, since they will see a reduction in revenues.

The State also plans to sustain the program by adding a health IT application to the program's operation. Specifically, the State plans to integrate this ED project with the Utah Medicaid Transformation Grant's information application development through contracted services with the University of Utah (UofU). Currently the UofU Transformation Grant Team has been developing an electronic Pharmcoepidemiologic Risk Management (ePRM) trigger system for the Utah Medicaid Program. The ePRM links prescriptions to their ED or clinical visits and sends risk triggers to the intervention group for actions. The State will expand the contract with the ePRM team to add non-emergent ED use triggers to the informatics application for this projects use. The triggers will be presented as a part of personal health records to provide a patient's comprehensive health history for intervention personnel.

Evaluation Plan: The success of this program will be evaluated annually by using the Utah Department of Health, Indicator-Based Information System for Public Health (IBIS-PH) Emergency Encounter Data Query System at http://ibis.health.utah.gov/query/module/selection/edpcsc/EDSelection.html. Specifically, the "Emergency Department (ED) Encounter for Primary Care Sensitive (PCS) Conditions Query Module for Utah Counties and Local Health Districts." Currently the ED-PCS system uses the New York University's (NYU) algorithm to classify non-emergent care and primary care

sensitive conditions. The NYU classification overlaps but is not identical with the Utah Medicaid definition of non-emergent ED visits. The Utah Department of Health's Center (CHD) for Health Data will add the Utah Medicaid definition into the ED-PCS query system to support this grant.

The CHD IBIS staff will update the data, conduct analysis, and develop an annual evaluation report. The annual evaluation reports will include:

1. Baseline of non-emergent care use of the ED by type of patients, geographic area, and hospitals;
2. Reduction or changes of non-emergent care use of the ED by type of patients, geographic area, and hospitals;
3. Potential risk factors for non-emergent care use;
4. The above analysis will be presented in comparison with non-Medicaid population in the State of Utah; and
5. Recommendation for targeted intervention.

The annual evaluation reports will be jointly developed by the HCF, AUCH, and CHD teams. The CHD will submit each of annual reports at the end of Quarters 2, 5, 9, 13, and 17 during the grant period.

Description of Project Implementation Readiness: Upon award of the grant funding the State is ready to proceed as follows:

Task #	Quarter	Task Description
1	Q1	Recruit and hire 2 new FTEs
2	Q1	Enhance administrative procedures for targeting, educating and referring ED abusers.

3	Q1	Develop tool to more timely identify target recipients
4	Q1-Q2	Train new FTEs
5	Q1-Q2	Update baseline data for comparison (UDOH IBIS)
6	Q2 (and ongoing)	Enhance relationships with Community Health Centers and other providers for placement of identified recipients
7	Q5	Compare current to baseline data
8	Q9	Compare current to baseline data and prior year
9	Q13	Compare current to baseline data and prior years
10	Q2-Q16	Ongoing efforts to divert non-emergent use of the ED
11	Q17	Evaluation of the impact of the program.

Budget

	FFY 2008	FFY 2009	FFY 2010	FFY 2011	Total
2 FTEs	$81,558	$84,005	$86,525	$89,121	$341,209
Benefits	$53,386	$54,988	$56,638	$58,337	$223,349
Travel	$600	$618	$637	$656	$2,511
Equipment	$3,000	$3,090	$3,183	$3,278	$12,551
Supplies*	$64,481	$51,357	$41,264	$33,516	$190,618
Contractual					
Construction					
Other**	$40,000	$40,000	$40,000	$40,000	$160,000
Indirect Charges	$13,090	$13,482	$13,887	$14,303	$54,762
Grand Total	**$256,115**	**$247,540**	**$242,134**	**$239,211**	**$985,000**

* This contains printing and mailing funding for an aggressive mailing campaign.
** Intervention Trigger development, CHD – IBIS staff support services.