

## CHCS Network Exchange Call: Q&A

### Addressing the Realities of Emergency Department Use in Medicaid Managed Care

*Pamela Persichilli, Horizon NJ Health; Barry Lachman, MD, Parkland Community Health Plan*

Pamela Persichilli provided an overview of the Emergency Room Outreach Pilot Program which involved face-to-face Social Case Management to intervene with all health plan members who used the hospital emergency department on a regular basis. The project included both educational and outreach/linkage components. In one large facility with high utilization of the ED for non-emergent conditions, the Social Worker rendering the services to members in the ED:

- Discussed and educated members on the managed care process;
- Discuss the member's available health benefits;
- Ensured primary care medical follow up after the ED visit;
- Assisted with the removal of any barriers to primary care;
- Linked members with basic community resources to further assist and support them; and
- Linked members to the various case, care, and disease management programs at HNJH.

The aim of these services was to reduce ED utilization and to promote more appropriate venues for primary care. Ongoing statistical reporting of member utilization has consistently indicated reductions of an average of 27 to 46 percent in ED utilization for all consecutively enrolled members who have received outreach services in the ED, often for non-emergent conditions. The reporting includes the ED utilization of the member 90 days prior to the outreach in the ED and 90 days after the outreach services were received. Reflections of achievements include:

- Success in changing ED utilization by members who have had successful interventions and education;
- Social Case Management satisfaction has increased due to high success rate of member interventions;
- Social Case Management is an accepted, integral part of the ED staff;
- Members have reported a positive experience post-ED intervention; and
- Hospital administration also demonstrated a decrease in the number of plan members with non-emergent conditions using the ED. The health plan was asked to expand the program to another high-volume facility in the system.

#### Key Questions from Participants

**Question:** How do you receive data on members that are in the ED and at what time? Is it at the point of service or is there a daily fax or other communication?

**Answer:** Encounters and claims, the time of visit are on the UB 92.

**Question:** Did Horizon NJ Health make a comparison of ED utilization and cost before and after the intervention before rolling it out plan-wide?

**Answer:** Yes. Our project started as a pilot. We started with the busiest ED and expanded to an additional facility this last summer. As a company we did a corporate wide initiative, we created a project plan of many initiatives that included outreach calls to members who frequent the ED more than 3 times in a quarter.

**Question :** Does the social case manager have access to the plan's networks to allow change in PCP and to set up specialist appointment?

**Answer:** Yes, they have laptops that are connected to the company's claims and case management systems. If the member needs an appointment they set up the appointment via cell phone.

**Question:** How was this paid for?

**Answer:** We moved resources from a community function to this position. It was a very small investment in technology via laptops and cell phone.

**Question:** Were there any hospital barriers to supporting this effort? (The questioner was very frustrated by lack of ED support for similar efforts.)

**Answer:** At first we had to “sell” the concept to the facility involved and confirm with them that this would be a pilot for six months. After the first quarter, when they realized a decrease in the non-emergent visits and “frequent flyers”, they asked us to continue and consider adding an additional hospital within their network.

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**Barry Lachman** presented the intervention strategy used by PCHP to enhance the use of a medical home and thereby decreased utilization. That strategy included:

- Use of the *Best Clinical and Administrative Practices (BCAP)* Typology to develop data needs and interventions;
- Data mining;
- Development of a classification system for avoidable ED use;
- Reinforcement of the Medical Home;
- Use of a letter to frequent ED users;
- Case management intervention through outreach;
- Case Staffing;
- Outreach to providers for “dual frequent users”, i.e., members using the primary care physician and the ED frequently; and
- Use of the state system for Lock-IN and ED Abuse

PCHP's Action Plan called for initiating contact with any member with >3 ED visits in a six-month period. Letters were sent to both the member and the PCP, and the member was linked with the case management program for evaluation. Data from the project indicate post-intervention success across ethnic groups in decreasing ED visits, lowering PMPM ED costs, and the positive effects of the Medical Home. Future directions for Parkland Community Health Plan include:

- Providing incentives to providers
- Developing an urgent care system
- Improving network adequacy
- Expanding the use of letters to members and providers
- Collaborating more with PCPs
- Improving member education on topics such as fever
- Promoting behavioral health interventions for dual frequent flyers

### Key Questions from Participants

**Question:** What do you mean by “lock in” and “member disenrollment” as interventions?

**Answer:** Lock In is a process of restricting the ability to seek access to care to a specific group of providers or pharmacies. For ED use EMTALA, a Federal law, prohibits barring patients from the ED. However, they can be restricted to fill prescriptions to one pharmacy or to have prescriptions written by one physician. For non-ED use patients can be restricted to one or several providers. The Texas Lock In program is not a very robust one because it only locks in to a specific pharmacy and is almost always applied to substance abusers. Member disenrollment means that the member is disenrolled from the health plan and goes back to traditional Medicaid. We view this as a last resort because it only lowers our costs. It does not do the member or State any good. It does carry some sanction in Texas since managed care patients have unlimited prescriptions per month while traditional Medicaid has a three prescription per month limit. Thus, disenrollment has some power as an intervention with controlled substance seeking behavior.

**Question:** What is the length of time between the actual ED visits to the time ED data are available for analysis of the intervention?

**Answer:** Letters are sent monthly. Average claim submission time for ED visits is less than 30 days. We pay 99.8% of clean claims within 30 days. Since most ED claims are submitted electronically, 15-30 days is probably the lag time to claim payment.

**Question:** What criteria are you considering for provider incentives? What kinds of incentives do you have in mind

**Answer:** This is still very much in the formative stage. We have been paying a small PMPM capitation in addition to fee for service per visit. We are considering using these funds to develop incentives based on extended hours, outreach to patients, etc. This would transition in subsequent years to being based on outcomes such as low ED use.

**Question:** What was the cost of the intervention? Was there a positive return on investment?

**Answer:** Total cost is monthly report and letters, one nurse to do outreach, part time nurse for quality monitoring and chart

abstracts. The cost is pennies per member per month. We have not done a formal ROI analysis. However, our avoided cost is indicated in the presentation. Total program cost might reach \$100,000 which suggests ROI or 15:1 to 18:1.

**Question:** Our volume of ED utilization is huge. What percent of members did you actually do outbound calls to? What was done about the members who couldn't be reached by phone?

**Answer:** I suggest that you stratify members making calls to worst offenders first. I am not sure of the actual volume of calls. We have typical 30-40percent of members with no phones. They get a letter and call to PCP if they use PCP in addition to EDR. We also use home health and our asthma vendor where appropriate. The asthma vendor has a very robust program to find contact phone numbers. We do have a small number that we cannot reach through PCP, phone, etc., who continue to use the ED. These are ones that we refer to Lock In or disenrollment from managed care. This happens quite infrequently.

**Question:** What were the barriers associated with the institutions you set up the program with?

**Answer:** We experienced no problems with the EDs since the activity was independent. Providers who received the calls from me were extremely cooperative and eager to help. Typical responses from providers were to either attempt to recall the patient for education or to put a note in the chart to discuss the next time the patient came in. In some cases providers gave us information on the family that helped us understand the origins of ED utilization including psychosocial information. We found that one teaching institution tends to steer follow-ups back to their resident clinic, probably due to resident ignorance of continuity and Medical Home issues. One provider group was offended by the Medical Director direct call to the provider. This group has a history of mistrust about managed care because some providers in the group would rather not see any Medicaid patients.

**Question:** What percent of members actually had "face time" while in the ED?

**Answer:** Our intervention does not have any "face time" component in the ED. However, our health system owned health centers are about to station a nurse in the ED part time.