Emergency Medicine Quality Subcommittee Report
February 8, 2018

General Philosophy:

The ED subcommittee was asked to review the quality metrics contained in Appendix J “Performance Measures Reporting” for the Medicaid managed care plans. The group agreed that the most relevant measure to the subcommittee was #5 Ambulatory care/ED visits, which measures ALL ED visits (both emergent and non-emergent) that do not result in a hospital admission. The committee determined that in order to impact non-emergent patient utilization of the ED, it would be useful to more fully appreciate the specific strategies and interventions implemented by each of the managed care organizations (MCOs) by reviewing and evaluating specific data associated with each program. The group would then be in a better position to evaluate the level of success, address opportunities, and make recommendations on actions that could be undertaken to leverage the MCO efforts in service of higher quality, reduced overall cost and better patient experience. We are also open to reviewing and evaluating the health plans’ current, historical and proposed approaches from a clinical, practical and data-driven standpoint, to insure that such approaches have the greatest probability of success.

Emergency medicine supports reasonable efforts to provide the “right care, in the right place, at the right time, for the right cost”. We believe this is in the best interests of the patient, the provider, and the future of our health care system.

We agree with Medicaid managed care entities that *“our experience shows that members have the most positive outcomes when they are regularly engaged and connected to their PCP.’* **(Amerigroup RealSolutions letter 9.25.2014)**

Despite the appeal of these general philosophies, there are underlying challenges that must be addressed and other principles that must be respected in the process. Accordingly, we support patient-centered efforts to provide high-quality, cost-effective patient care, provided that:

- Important and longstanding patient protections are preserved (the Prudent Layperson Standard, etc.), and
- Emergency medicine providers are not at increased risk of performing their obligations under law (e.g. EMTALA), and
- Any rewards and/or consequences are applied to the party that is *most accountable for solutions and outcomes* (versus parties who are unlikely to affect meaningful change)

Discussion:

As practicing emergency physicians we know that, in order to meet the requirements of EMTALA while also responding to the patient protections provided by the Prudent Layperson Standard, there is far more required than a superficial review of a patient's ED visit, even when the final diagnosis is not life threatening. Assigning a hospital and/or provider a markedly reduced fee for ruling out an emergency condition solely penalizes providers and hospitals for addressing a patient care demand required by federal law (EMTALA), does little or nothing to rectify the core issue, jeopardizes patient care and will fail to produce the process-oriented solutions required to achieve the objectives noted above.

While ED providers are happy to educate patients on alternatives to ED care, this makes no practical difference for the index visit. If a "triage fee" is assigned for this perceived non-emergent visit, the provider and/or the hospital now has the burden of the visit itself, the education of the patient, and referral to an often nonexistent primary care network. Providers and/or hospitals receive fewer dollars for performing many of the responsibilities that belong to the MCOs.

LDH should assign responsibility and accountability to the party that can make a material difference; that being care coordination and primary care network-building responsibilities of the contracted managed care organization. Additionally, the patient and the PCP is responsible for choosing an appropriate venue for care and making office hours available for primary care demands. After over 5 years of claims experience with the MCOs, LDH should be able to determine time frames associated with primary care needs of this patient population.

<u>Recommendations:</u>

MCOs should be held accountable for their ability to manage the care and the cost of Medicaid beneficiaries. Since patient connections with, access to and utilization of primary care is critical to a patient's choice not to use the ED for non-emergent care, we believe that LDH should enforce this requirement of the managed care organization contracts, and that incentives or disincentives should be constructed accordingly.

The current MCO contracts with LDH delineate characteristics of a special needs population requiring additional care management, including individuals who present in the ED multiple times within a specified time frame. Those individuals are to be assessed and offered specific case management services, as appropriate. Additionally, the MCOs have each submitted robust proposals to effectuate strategies to decrease inappropriate ED utilization by their beneficiaries.

MCOs should be required to report monthly on an array of data to demonstrate

the success of their strategies, including targeted interventions such as the readmission reduction program, interventions to divert care for preventable ED diagnosis to settings more aligned with the member's needs, and the variety of ED diversion programs detailed in their proposals.

The ED subcommittee has determined that the following data would be very helpful to develop a comparative/management view of overall ED utilization and results, per MCO:

1. The number and percent of Medicaid patients seen by a primary care physician: within 3 days of an ED visit, within 7 days of an ED visit, within 14 days of an ED visit, and within 30 days of an ED visit.
2. The number of ED visits per 1000 Medicaid patients per month, quarter, and year
3. The number of hospitalizations per 1000 Medicaid patients per month, quarter, and year
4. The number of Medicaid patients with chronic diseases that have personal contact with case management services per month, quarter, and year.
5. The number of Medicaid patients with chronic diseases that have been seen by a primary care physician within 3 days of an ED visit, within 7 days of an ED visit, within 14 days of an ED visit, and within 30 days of an ED visit.
6. The number and percent of Medicaid patients who have made and kept an appointment with their PCP within the past year.

To impact non-emergent ED utilization, we will employ a construct to examine factors and interventions that occur before, during, and after an index ED visit. Factors relevant before an ED visit include Medicaid members' engagement with primary care, adequacy of PCP networks, and access to alternative care sites (participating Urgent Care or Retail Clinics). During an ED visit, it would be useful if ED providers had point-of-service access to accurate patient information, such as:

1. Current diagnoses
2. Current medications
3. Primary Care Provider and date of last visit
4. Is patient assigned to case management and is the care plan accessible to ED providers.
5. Recent or prior ED visits
6. Recent hospitalizations.

We are examining ways in which this information can be shared or accessed in real time by providers during an ED visit. Analysis of the requested data listed above will help us understand whether the entire delivery system, including the ED, is working effectively to promote the ideals of providing the right care, in the right place, at the right time, for the right cost.

The reporting of the measures should not cause an undue burden on the MCOs, as they are already providing some of the data points to LDH or to the external

quality reviewers. The source for all the measurements can be found in the claims or their systems which track case management interaction with the patient. We respectfully request that reporting be provided to the subcommittee to review at least quarterly, to allow visibility into the effectiveness of the management initiatives, and to identify additional opportunities for emergency departments to further assist or collaborate with these initiatives. This will also allow the MCO to institute corrective action with additional guidance and accountability for results.

As the committee is provided information on the patient population and specific data relative to the MCO programs and case management efforts, we will be in a better position to identify points of intervention and opportunities to support their success.