

Policy Change DRAFT
Emergency Department Triage Assessment Fee
Phase I: DRG Hospitals
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1. Describe the change that is planned for the program.

In order to save money and treat clients in a medically appropriate manner, OMAP will be implementing a triage assessment fee for clients presenting with non-emergent conditions in the emergency department (ED) as a mechanism to encourage hospitals to refer clients with non-emergent conditions to seek treatment in the medically appropriate settings. OMAP will publish a list of diagnosis codes that are generally used for non-emergent conditions. This list is based on diagnoses identified by CareOregon as usually non-emergent and the John Billings list used in the external quality review study. This list has undergone extensive review by DHS clinicians.

OMAP will initially pay a triage assessment fee of \$42 on these codes billed on ED claims. The payment is calculated based on the estimated FFS OMAP payment of the condition in an office setting. If the visit turned out to be emergent, the hospital would submit records to OMAP documenting the emergency in which case the claim would be paid as other outpatient hospital services are paid. OMAP will also work with our nurse advice line contractor to automate the payment process to pay the regular outpatient rate in instances where the advice line referred clients to the ED.

This policy will be rolled out in DRG hospitals first. Because of limited access to primary care in some rural communities, we will be phasing in a modified program after the DRG hospitals are implemented. This does not apply to out of state hospitals since they are currently paid less than in-state hospitals.

2. Why is the change happening?

The 2005/07 Legislative Adopted Budget includes unspecified fee for service savings of \$4 million general fund. This is an action intended to contribute to these savings.

3. What will the impact of the change be on clients:

This policy applies to Plus and Standard clients. It does not apply to CAWEM clients since their services are reimbursed using a much stricter program.

Clients that have relied on the emergency department for non-emergent care will be encouraged to use the appropriate setting for care. This will come from client education provided by the Nurse Advice line that was implemented in December. Hospitals may choose to refer clients to the appropriate setting after it has been determined that the client's condition is non-emergent.

Clients will not be responsible for payment of treatment of non-emergent conditions provided by the hospital if the hospital chooses to treat the condition after conducting the triage assessment. The hospital should refer the client to the medically appropriate setting for treatment.

In the future, OMAP may apply a nominal copay to appropriate client populations. This is still under analysis.

Clients were invited to participate in the public stakeholder meetings to discuss this policy. There was some client participation in these meetings. Client concerns were noted and considered in the development of this policy.

4. What will the impact of the change be on providers:

DRG hospitals will no longer be paid for treatment of non-emergent conditions in the ED. This will result in a loss of revenue. Hospitals will be paid less than current reimbursement to conduct the triage assessment since the rate is based on what OMAP pays in the office setting.

Providers were invited to participate in the public stakeholder meetings to discuss this policy. Providers were well represented at these meetings. Provider concerns were noted and were considered in the development of this policy.

5. What will the impact of the change be on managed care plans:

FCHPs and PCOs use a variety of mechanisms to manage inappropriate ED utilization. Some plans use OMAP's fee for service hospital rates as a reference point in their contractual negotiations with hospitals. There is concern that OMAP will set the rates too high for the triage assessment. However, the assessment fee is less than what fee-for-service usually pays for these conditions. Plans have also noted that they appreciate OMAP's efforts to manage utilization more closely to their efforts.

MCOs were invited to participate in the public stakeholder meetings to discuss this policy. There was some MCO participation in these meetings. OMAP staff updated MCOs on the progress at Contractors and Medical Director's meetings. OMAP surveyed health plans to get their concerns and received a few responses which have been taken into consideration.

6. Will OARs, State Plan, protocols or contracts need to be established or revised to implement this change?

OMAP will need to amend the state plan and receive CMS approval prior to the implementation date. Administrative rules will need to be amended. No contracts will need to be changed.

OMAP will need to establish a review process to determine whether additional payment is appropriate in cases where the visit was emergent.

7. What is the planned effective date of this change?

September 1, 2006

8. Are there any other actions that have been implemented or are under consideration to address inappropriate ED utilization?

Yes, the nurse advice line to direct clients to appropriate care was implemented December 2005. Other ideas under consideration are nominal copays and client education.