

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CONTROLLING
EMERGENCY ROOM USE:
STATE MEDICAID REPORTS**



**Richard P. Kusserow
INSPECTOR GENERAL
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INTRODUCTION

PURPOSE

This report describes six States' procedures for controlling emergency room use by Medicaid recipients, obstacles they encountered in developing the controls, and self-evaluations of their success.

BACKGROUND

The non-emergency use of emergency rooms by Medicaid recipients has long been recognized as a costly problem. In September 1983, the OIG reported a very high misuse of hospital emergency rooms by Medicaid recipients.¹ Studies continue to show that Medicaid recipients consistently make a higher proportion of non-emergency visits ranging from 17 percent² to 61 percent.^{3,4} In contrast, recent studies show non-emergency visits for the general public range from 11 percent⁵ to 38 percent^{6,7} of all emergency room visits. The OIG report also found that emergency room visits normally cost at least three times the charge of a community-based physician for the same care.

States attempting to control emergency room use must consider several Federal requirements. Medicaid recipients have the right to choose their health care providers.⁸ If access to care of adequate quality is not denied, Medicaid agencies can restrict recipients in choice of providers. However, a State must request a freedom of choice waiver.⁹ States must also obtain waivers for a Medicaid demonstration project.^{10,11} Finally, Federal anti-dumping legislation prohibits an emergency room's refusal to treat patients who cannot pay for services, and requires screening examinations of patients presenting for care.¹²

METHODOLOGY

We chose six States from the nine presented in the companion report, "Use of Emergency Rooms by Medicaid Recipients", OEI 06-90-00180. The sampled nine States had mature programs¹³ of utilization control. The six States selected illustrate a variety of emergency room controls developed, implemented and/or discarded. The sites include a mix of rural and urban populations.

We collected descriptive and quantitative data from each sampled State. Using a structured interview guide, we interviewed Medicaid managers and/or staff directly responsible for establishing the emergency room controls. Topics covered were specific details of States' procedures, reasons for implementation, barriers and opposition overcome, perceived successes and utilization statistics. In addition, States provided copies of internal documentation that describes and evaluates their programs.

FINDINGS

As a context for the individual State reports, the following briefly summarizes key findings in our companion report, "Use of Emergency Rooms by Medicaid Recipients."

Heavy Emergency Room Use By Medicaid Recipients Is A Continuing Problem.

Medicaid recipients still use the emergency room for non-emergency care at high rates. Among the study States, the mean of non-emergency use as a percent of all their 1990 Medicaid emergency room visits was 55 percent. Figure 1 shows the individual non-emergency rates for the nine sample States.

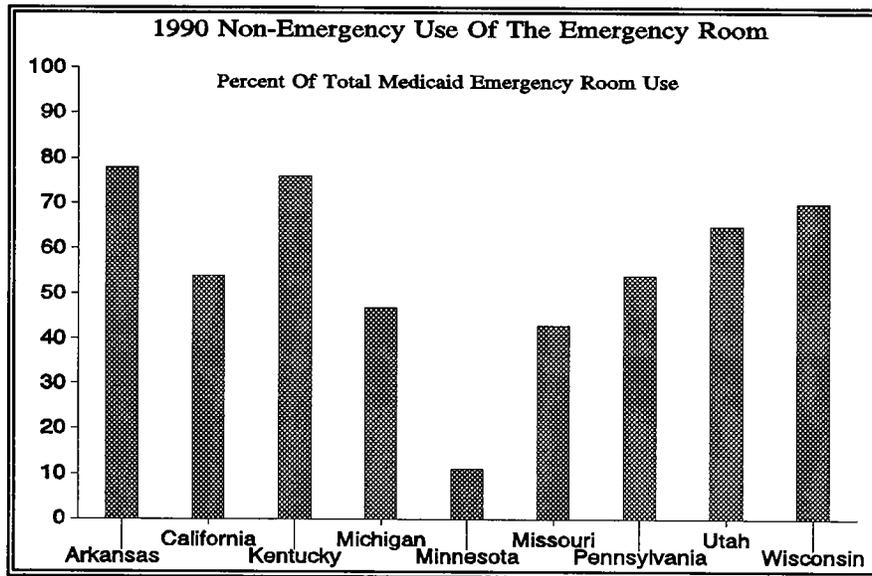


Figure 1 -- Data source: State reported (6 sites); HCFA MSIS program (3 sites).

Substantial Medicaid Savings Could Be Realized By Redirecting Non-Emergency Visits To More Appropriate And Less Costly Care Sites.

If four sample States had reduced non-emergency visits to 40 percent, the highest rate for the general public noted in the literature, they could have saved \$39.5 million in 1990.¹⁴ This assumes that patients originally seeking non-emergency care in the emergency room were diverted to less expensive community care.

States Developed Controls To Improve Access And Continuity Of Care, As Well As To Reduce Costs.

Staffs knew Medicaid recipients were using the emergency room for primary care which increased expenditures. Thus, improving access to and continuity of alternative medical care was imperative to decreasing non-emergency use of the emergency room. States also listed cost savings as a major concern leading them to develop program controls.

Since both recipient and provider behavior caused non-emergency use of emergency rooms, States developed controls that attempted to change both. Sampled States had developed 23 controls of emergency room use summarized in the following table.

EMERGENCY ROOM CONTROLS DEVELOPED BY STATES

EMERGENCY ROOM CONTROLS			
NAME OF PROGRAM/PROCEDURE	NUMBER DEVELOPED	NUMBER IMPLEMENTED	NUMBER REMAINING
MANAGED CARE	8	8	8
CO-PAYMENT	4	3	2
ER CLAIMS REVIEW	2	2	1 (1 altered)
PRE-PAID HEALTH PLANS	3	3	2
LOCK-IN	1	1	1
ER VISIT LIMIT	1	0	0
PAYMENT DIFFERENTIATION	3	3	3
OTHER (NURSE PHONE LINE)	1	1	1
TOTAL	23	21	18 (1 altered)

Recipients had used the emergency room for primary care, during and after physician office hours, because they lacked access to an ongoing relationship with a primary care provider. Further, physicians and hospitals frequently encouraged Medicaid recipients in this usage pattern. States developed controls that provided recipients either mandatory or voluntary access to an ongoing relationship with a primary care giver, or referred a patient to an appropriate setting based on screening of symptoms. States also altered behavior by limiting access to the emergency room. They limited numbers of emergency room visits, required recipient co-payments, and denied/reduced hospital payments for non-emergency care.

Prior to 1982, State systems did not distinguish between emergency and non-emergency care and/or did not differentiate reimbursement rates. Without this data, States could not determine the cost of non-emergency care and the extent of the problem. By defining levels of emergency room care and by establishing payments based on the level of care provided (tiered pricing), some States could control costs and document non-emergency use. Also, paying triage fees to hospitals for assessing patients encouraged them to refer non-emergency patients to more appropriate settings.

The Majority of Program/Procedures Considered Successful Address Access To Care Through Managed Care/Pre-Paid Programs.

Thirteen of fifteen program controls, still in place and considered successful, address access to care. The controls provide recipients with ongoing primary care and referral to other services. Nine are managed care or pre-paid health plans. The other four address

access based on patient's age and condition, or lock-in to a physician. Data indicate a greater reduction in non-emergency visits might be possible if more Medicaid recipients were enrolled in managed care/pre-paid programs. These programs control referrals to care outside the normal setting and decrease the number of non-emergency visits. Further, comprehensive programs that include managed or pre-paid care appear to be more effective in controlling emergency room use.

States Have Been Successful In Overcoming Opposition To Controls On Non-Emergency Use Of Emergency Rooms.

Opposition to program controls came primarily from three groups: providers (both physicians and hospitals), the Medicaid population and advocacy groups. The opposition focused on payment and administrative problems for providers, and access to care and freedom of choice issues for recipients. For the most part, States reduced opposition over time as all parties gained experience and refined procedures. Anti-dumping legislation was not significant to developing controls of emergency room use.

Despite The Positive Actions Taken By Study States, Non-Emergency Use Of Emergency Rooms Is Still A Problem.

State data tend to describe overall trends in emergency room use and program savings, but data do not always link either to specific program controls or reduced non-emergency use of the emergency room. Available information shows some successes and some continuing problems in controlling emergency room use. The development of tiered pricing and corresponding procedure codes has enabled some States to demonstrate program savings. However, data describing patterns of emergency room use, in some instances, is still flawed. While savings cannot always be directly attributed to a reduction in non-emergency use, seven States reported, for 1987 through 1989, savings of \$181,969,699 from implemented controls. Some States did not, in fact, reduce emergency room utilization; they simply denied or reduced payment.

STATE MEDICAID REPORTS

ARKANSAS

State Medicaid Population: 221,139

Reasons For Developing Controls Of Emergency Room Use

The primary impetus was the Agency's lack of policy distinguishing emergency from non-emergency care. The consequences, as Surveillance and Utilization Reviews (SURS) in late 1983 showed, were Medicaid recipients over-utilizing emergency room services and providers billing too many emergency room services. Related to these concerns was the Agency's desire to contain program costs. Thus, the Agency decided to curb what it described as "a wide open program with no controls." It also wanted to improve continuity of care by discouraging use of the emergency room for primary care.

Description of Controls

▶ *Emergency room claims review*

First, the Agency defined emergency care. With assistance from State and national associations of emergency room specialists, the Agency developed specific criteria to determine a patient's need for emergency services. The criteria are: significant trauma, fever of 103 degrees or above, reduced mental alertness, drug or substance overdose, respiratory distress, substernal pain, onset of labor, shock, and significant bleeding. Children under two years of age are not screened.

Next, the Agency contracted with a professional review organization (PRO) to review all claims for emergency services. Since 1984, PRO staff compare medical record documentation for each emergency room claim with the Agency's emergency criteria. If the medical documentation does not appear to meet the criteria, a physician consultant also reviews the case for a final determination. With two exceptions, all claims not meeting the criteria for emergency care are denied. Associated claims for emergency room supplies and drugs are also denied. The exceptions allowed are an out-patient hospital's provision of non-emergency services in the emergency room when community-based physicians are not available, and care provided to children under two. Length of time symptoms have been evident and potential problems of further delaying treatment are considered in claim adjudication.

▶ *Other improvements*

Over time the Agency has improved its control procedures. It established an "8-hour observation bed" to determine if a true emergency exists in some cases (primarily for threatened labor). Hospitals bill this service at a non-emergency rate. The Agency also plans to notify emergency rooms of over-utilizers of emergency care and to investigate whether they could obtain services elsewhere.

Implementation

Implementation of the control proceeded quickly. The Agency developed its policy in three months, made systems changes and immediately implemented the control State-wide. In fact, the Agency did not report any legal or resource barriers to the initiation of the program control. It experienced some opposition from emergency room physician groups that provided services to various facilities. The strongest resistance came from a group that worked in both Arkansas and Louisiana. The physicians did not want to deal with two sets of State criteria, and they felt they had not been allowed input when the Agency developed its emergency care criteria. However, when they learned that one of their own physicians had been involved in the control's development, they dropped their opposition.

Results Achieved

The Agency considers its control of emergency room use financially successful. Available data show that since January 1988, it has saved a net of \$1.6 million (after deducting the PRO review expenses) by denying claims for non-emergency care at emergency rates. Deducting the entire cost of the PRO contract since 1984 from program savings of the last three-and-a-half years still puts the Agency substantially ahead. These calculations assume that claims for supplies and drugs accompany each claim for facility emergency services and that the hospitals resubmit claims for non-emergency services. The total number of emergency room visits has increased over the years, and the denial rate for emergency room claims has remained relatively constant.

Transferability

The Agency believes its procedure is transferable. The concept is not complicated nor were the systems changes. The Agency emphasizes, however, that a prerequisite to a successful program like this one is a good relationship between the State and its PRO.

State Contact For Further Information

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Division of Economic and Medical Services
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Little Rock, AR 72203

KENTUCKY

State Medicaid Population: 417,716¹⁵

Reasons For Developing Controls Of Emergency Room Use

The Agency's desire to improve continuity of care, assure access to appropriate care and contain Medicaid costs motivated development of program controls. Prior to implementation of the controls, 44 percent of Medicaid patients had no regular family physician and used the emergency room for primary care. Even patients with a regular physician used the emergency room for primary care after hours. Cost and utilization information revealed an increase in outpatient hospital visits with 65 percent to 80 percent of emergency room admissions being routine care. Patients often cited 24-hour availability of emergency room care without an appointment as the primary attraction. Furthermore, after hospital anti-dumping regulations became effective, emergency room staffs felt increasingly obligated to treat everyone who presented for care.

Description of Controls

▶ *Pre-paid health plan*

The Agency first tried a pre-paid health plan called Citicare. A small program that contracted with a private health insuring organization, Citicare covered about 40,000 AFDC eligibles in Jefferson County (Louisville). The State allotted limited funds as pre-payment for patient care. Citicare arranged for primary care case management with local physicians who received \$44 per month for each patient they managed regardless of whether they delivered services. Medicaid recipients required their case manager's prior authorization for emergency room use. However, the program did not distinguish between emergency and non-emergency care.

▶ *Managed care program*

After Citicare, the Agency developed its own managed care program called Kentucky Patient Access and Care Program (KenPAC). This program does not use a capitation fee nor contract with a private for-profit company for patient case management. Instead, the Agency pays doctors a monthly case management fee and also reimburses them on a fee-for-service basis. The program covers about 265,000 AFDC or AFDC-related eligibles in all but 11 counties. Enrollment is mandatory, but most recipients select their own physician or clinic rather than having one assigned.

KenPAC doctors provide patient care, authorize other service and make referrals as needed. They also should provide 24-hour access to medical care. Recipients who believe they are ill are asked to contact their case managers first, rather than presenting at the emergency room. Urgent care requires prior authorization unless the hospital cannot

reach the primary care physician. Hospitals may treat true medical emergencies without prior authorization. In any event, case managers must eventually authorize emergency or urgent care provided in the emergency room. Routine care in the emergency room cannot be authorized by the physician, and is not payable under the program.

► *Future improvements -- triage fee and revised diagnosis codes*

The KenPAC program plans several improvements. The first is a triage fee to compensate hospitals for screening patients and providing non-emergency care. This would apply when the primary care physician has not prior-authorized care or when the emergency room's assessment and the primary care physician's assessment of the patient do not agree. A second improvement is establishing more specific diagnosis codes to assure that emergency room treatment is truly an emergency.

Implementation

The Agency implemented Citicare in July 1983. Physicians and welfare rights organizations, however, opposed the program. Under Citicare, with limited funds for patient care, doctors felt they had little control over the allocation of services. They also believed they had to make care decisions based on available funds. Interested parties generally perceived a limited access to care and an inherent incentive to deny needed specialty care.

Implementation of KenPAC proceeded smoothly in 1986. The Legislature approved administrative regulations, but did not require budget approval since it assumed the program would save money. In fact, the Agency did not report any barriers or opposition to the program.

Results Achieved

The Agency did not renew the Citicare contract after the first year. The public continued to believe the program was not effective in that it was poorly designed and operated. Cost was also a factor. A State revenue shortfall in 1984 led to many budget cuts, but the Agency was unable to renegotiate the Citicare contract. Thus, expenditures for the pre-paid health plan exceeded what the Agency would have spent for the target population in the absence of Citicare.

The Agency believes KenPAC has been a successful program. In 1989 an independent evaluation forecast savings for KenPAC by comparing its program costs to what costs would have been without it. Total savings to Medicaid from May 1986 to June 1989 were estimated at \$69.4 million after adjustments for administrative costs and management fees. Gross savings for outpatient emergency services were \$12.1 million, second only to gross savings for physician services of \$72.6 million. A client survey conducted for the

evaluation suggested most KenPAC clients understood how to arrange office visits with their case managers and knew to call their case manager for emergency room treatment.

KenPAC could benefit from further improvements according to the same 1989 evaluation. While most emergency room nurses and physicians at 15 sample hospitals felt overall emergency room utilization was reduced, they believed large numbers of KenPAC recipients still used the emergency room for primary care. The Agency noted, however, that emergency room staffs do not always distinguish between KenPAC patients and other Medicaid patients. In contrast to emergency room personnel, 54 percent of KenPAC physicians believed the program was doing an "above average" to "excellent " job in preventing inappropriate use of hospital emergency rooms. Many suggested that KenPAC clients needed to be better educated about when and how to use health care, and implied they did not see this as being the case managers' responsibility. Clients reported very good success in reaching their case managers during regular office hours, but many had problems when the doctors closed their offices. As a result, a large number of clients by-passed their case managers and went directly to the emergency room.

Transferability

The Agency believes the KenPAC approach is transferable. Many States have already contacted Kentucky for information, and subsequently, modeled their programs after KenPAC. The program is a simple concept requiring no additional paperwork for physicians and few Agency staff to administer, eight in this case. The program is feasible in urban and rural areas. Case management is easier, however, in urban areas where competition for medical services is greatest. In sparsely populated areas, finding physicians who are able to accommodate a larger patient caseload is more difficult. The Agency also suggests consulting with physicians and medical organizations to ensure their support and participation.

State Contact For Further Information

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Department for Medicaid Services
Cabinet for Human Resources
275 East Main Street
Frankfort, KY 40621-0001

State Medicaid Population: 1,100,000

Reasons For Developing Controls Of Emergency Room Use

Data from 1977 and 1978 postpayment utilization reviews indicated a problem existed. Payments for emergency room care, which were sizeable and too high, led the Agency to identify over-users of emergency services. The Agency staff put these clients into a lock-in program, but they realized other clients still used costly emergency care services for non-emergency care. At the same time, cost containment for medical services in general concerned State officials.

Description of Controls

▶ *Emergency room claims review*

By a Governor's Executive Order in December 1981, Medicaid stopped covering any non-emergency services provided in an emergency room. Cost savings were the primary motivation for the order. The claims payment system was modified to recognize a list of acceptable emergency diagnoses. Unlisted diagnoses suspended the claim for review even if the hospital had marked a literal description of emergency on the claim form. The payment system denied suspended claims still considered non-emergency services after review. The Agency also intensively educated the hospitals about the change and encouraged the hospitals, in turn, to educate patients.

▶ *Liberalized "emergency" for children; hospital triage fee*

After initial implementation, the Agency adjusted some procedures. Staff developed a more liberal interpretation of "emergency" for children. They considered such factors as the time of day or a doctor's recommendation of an emergency room visit. Beginning in 1989 the Agency allowed hospitals to claim a triage fee for assessing the condition of non-emergency patients. The triage fee is one procedure code which hospitals can only bill alone and not in connection with another procedure.

Implementation

Implementation of the Executive Order proceeded quickly. The new policy and procedures were fully operational by January 1982. The Legislature had already approved the measure, and the required changes to the claims payment system were not labor intensive. The Agency had sufficient staff to review pended claims. Finally, the hospitals did not initially oppose the program change.

Results Achieved

In one sense, the Agency considers this control of emergency room use successful. The estimated number of paid emergency room visits declined from 650,000 in 1981 to 310,000 in 1984. Estimated administrative costs and emergency room facility fees also declined from \$18.7 million in 1981 to \$14.4 million in 1984.

In another sense, however, the Agency says the program was not successful. Non-emergency Medicaid clients were not actually using the emergency room less. When the Agency denied payment to the hospitals for the non-emergency services, the hospitals then tried to bill the client. This proved to be a wasted administrative effort, and eventually, the hospitals wrote off the costs. In addition, the Agency had to address a legal challenge to their policy.

A class action suit filed by Medicaid clients named the Agency. The clients claimed hospitals inappropriately billed them for non-emergency services, and harmed their credit records by seeking collection. Medicaid notice of denial rules required the Agency to give notice, but the Agency believed the hospitals should have done it. To solve the legal question, in February 1989, the Agency started paying triage fees to hospitals as compensation for assessments of non-emergency patients presenting to emergency rooms.

A second reason for instituting the triage fee was also a legal one. Hospital anti-dumping regulations, which prohibit hospitals from refusing to provide emergency treatment, were not in effect when the Agency originally implemented this program. The Agency believed the triage fee would support compliance with the anti-dumping regulations.

The triage fee is worth the cost to the Agency. Estimates of 1990 paid administrative costs, emergency room facility fees and triage fees were \$27.9 million for approximately 690,000 emergency room visits. This compares favorably to their estimated 1981 emergency room payments of \$18.7 million which, in 1990 dollars, would equal \$37.2 million. Staff are satisfied they are coming out ahead in program expenditures for services and avoidance of legal costs.

Transferability

The Agency believes their modified program, which includes the triage fee, is transferable. The Agency notes that refusing to pay non-emergency services provided in the emergency room does cause a drop in claims paid, but does not change client behavior. At least, adding the triage fee helped to solve some program difficulties for the hospitals and the Agency. Systems changes to accommodate the acceptable diagnosis codes for emergency and the one triage code were not difficult.

State Contact For Further Information

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MINNESOTA

State Medicaid Population: 345,573

Reasons For Developing Controls Of Emergency Room Use

A desire to control costs and to improve continuity of care motivated the Agency to develop controls of emergency room use. Disproportionate increases in outpatient hospital expenditures signaled a problem area. In addition, the Agency needed a procedure coding system that clearly identified the actual outpatient services rendered. Specific areas of interest were reimbursing only medically necessary services and assuring recipients' access to quality health care at the appropriate level.

Description of Controls

▶ *Differentiated care and payment levels, including triage fees*

A revised coding scheme for outpatient hospital and emergency room services is the most extensive of three fee-for-service controls. Developed in 1989, the coding identifies three distinct levels of facility fees for outpatient hospital care -- emergency, urgent and clinic. These fees do not include laboratory, radiology or professional component fees, but they do include overhead incurred in an outpatient hospital visit. The emergency room facility fee is reimbursed in 15 minute increments at the lesser of the provider's usual and customary charge or at \$25. The urgent care and clinic care facility fees are flat rates per visit. In 1990, the Agency added a triage facility fee to compensate hospitals for assessing patients prior to the delivery of emergency or urgent care services. While the coding scheme did not ensure recipients access to health care, it and the triage fee did promote better access. The program applies State-wide to all Medicaid recipients not in the Pre-paid Medical Assistance Program.

▶ *Managed care program and telephone triage*

Primary Care Utilization Review (PCUR) and a telephone triage line called Nurse Line, the other fee-for-service controls, are smaller programs. PCUR is a managed care program for Medicaid eligibles who have abused health care services. PCUR participants must select a primary care physician, pharmacy, inpatient hospital and outpatient hospital. In medical emergencies, access to any emergency room is available. However, without a referral from the primary care physician, if the patient is not an emergency or presents for care at a non-designated provider, the Agency would deny the claim. PCUR has approximately 239 participants. Nurse Line, a pilot project implemented in January 1991 in one county, provides 24-hour triage. A nurse answers questions about health conditions, advises of the need for urgent or emergency care and directs the patient to the appropriate care delivery site.

► *Pre-paid health plan*

The Prepaid Medical Assistance Program (PMAP) is the other major program control. The Agency contracts with health maintenance organizations (HMO) to provide all covered services for an established monthly payment. HMOs, concerned with appropriate service use, require recipients to contact them before presenting to the emergency room. Exceptions are "life threatening" emergencies when the recipient may contact the public emergency network (911) for services. The Agency requires the contracting HMOs to provide 24-hour access to health care services. Begun in 1985 as a demonstration project, PMAP now serves approximately 58,755 Medicaid recipients in 8 counties -- 3 counties have freedom-of-choice waivers, and 5 do not since enrollment is voluntary. AFDC eligibles in three counties account for the bulk of the program's population. The Agency recently received approval to extend mandatory HMO enrollment to another county.

Implementation

Implementation of the four program controls was relatively problem-free. Three required the Legislature's approval, which it gave. In fact, the Agency reported no legal or resource barriers to the initiation of the program controls. However, two programs, the revised coding scheme in fee-for-service and the PMAP, faced opposition from groups outside the Agency.

Physicians and outpatient hospitals objected to the revised coding scheme primarily because of reductions in payment rates. Since the Legislature mandated the new coding scheme to be budget neutral, the Agency reduced, by 40 percent, payments for outpatient physician services that are performed more than 50 percent of the time in a physician's office. The Agency reasoned that doctors in outpatient hospitals are not assuming the overhead costs, such as personnel, space and utilities. The 40 percent reduction offset the reimbursement of the facility fees. The Agency also created ambulatory surgical center (ASC) grouper rates and changed rates for some ancillary services to a different coding range at a reduced rate. Physicians and outpatient hospitals also disliked distinguishing emergency, urgent and clinic services.

The concerns of emergency care physicians and outpatient hospitals have been relieved somewhat. Through training sessions and seminars, they have gained a better understanding of the facility fee concept. In addition, they learned the professional services in an emergency department are coded as prescribed by the Current Procedural Terminology (CPT) manual. They still do not regard the payment rates favorably.

Because the PMAP was a new concept in providing health care to public assistance recipients, providers, recipients, counties and some Department staff voiced opposition initially. Recipients in urban areas regarded it as a freedom of choice issue while rural counties and their recipients feared losing physicians. Providers regarded the PMAP health plans as another layer of regulation. Counties resisted the PMAP because, in a few

instances, recipients had to select new providers. Experience with the program has overcome much of the opposition of these groups.

Results Achieved

The Agency believes the controls within fee-for-service have been successful. Staff can now readily identify types of service provided and whether services were billed in the appropriate categories. Units of service and costs for emergency care have remained fairly stable in 1989 and 1990, even though the number of eligible recipients has continued to increase. Total outpatient costs have decreased due to more specific coding and the payment of ASC grouper rates. In FY 1989, before the Agency implemented the revised coding scheme, Medicaid payments for outpatient hospital services were \$31,764,653. In FY 1990, payments for the same service category were \$29,409,906 with only three-quarters of claims submitted using the new coding scheme. The Agency also notes that from CY 1989 to CY 1990, outpatient hospital charges submitted to Medicaid and two much smaller health care programs increased by 25.1 percent while payments increased by only 4.1 percent.

The PMAP has been successful as well. An Agency analysis of cost savings for CY 1987 to CY 1989 showed a total net savings of \$14,282,488. The analysis notes some "serious limitations to the precision of these results," but concludes "the numbers indicate an ability to control health care cost trends through a managed, capitated system of health care provision." The Agency believes savings in the whole program translate into savings in emergency room services. Client satisfaction is another factor for judging program success. Agency surveys of HMO clients indicated an extreme reluctance to change providers or to enroll in health plans, but considerable satisfaction once they had established relationships with health plan providers and understood their methods of providing health care.

Transferability

The Agency believes all four program controls are transferable. The coding scheme to identify specific services does not require extensive systems changes if a State's management information system can accommodate the implementation of procedure codes. The initiation of specific service codes did not require extensive Federal or State legislation. Any State considering this coding scheme, however, must have the flexibility to create HCPCS¹⁷ codes or their own codes. For PCUR the Agency notes that other States already have in place the basis for PCUR through their recipient SURS programs. A program similar to Nurse Line only requires a State to contract with an organization that can provide a 24-hour telephone triage service. Finally, in areas where HMO or primary care case management networks exist, the Agency's model is transferable.

State Contact For Further Information

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MISSOURI

State Medicaid Population: 409,223

Reasons For Developing Controls Of Emergency Room Use

Initially, the Agency developed controls of non-emergency use to improve recipients' continuity of care and linkage with primary care physicians. Although it had not fully documented the problem, the Agency knew Medicaid recipients could easily obtain non-emergency care at the emergency rooms. Thus, it specifically wanted to deter recipients from using the emergency room for primary care, to reduce the number of recipients over-utilizing emergency room services, and to provide access to care at an appropriate level. An added benefit of these efforts was cost savings resulting from reduced emergency room utilization. Cost containment efforts also needed to address lower reimbursement for non-emergency care in the emergency room.

Description of Controls

▶ *Limiting emergency room visits*

In 1982 the Agency developed a State-wide control to limit non-emergency visits to two per month. This control applied to both outpatient hospital clinics and emergency room services. For any visit over the limit, a claims review determined payment based upon medical necessity. However, the Agency allowed exceptions to the limit for recipients with both Medicaid and Medicare coverage, and for certain services: pre-natal care, physical therapy, chemotherapy, radiation therapy, psychotherapy, and chronic renal dialysis.

▶ *Recipient co-payments*

To lower costs, the Agency has required co-payments of all Medicaid recipients since 1983. Subject services are outpatient clinic and non-emergency use of emergency rooms, as well as physician care in these settings. With exceptions, the recipient co-payment is \$2 for the facility fee and \$1 for the physician fee. Providers must submit charges reduced by the co-payment amounts. However, a recipient's inability to pay cannot be used to deny or reduce services.

▶ *Recipient lock-in*

Administrative lock-in, a small program, applies to recipients who over-utilize hospital emergency room services. Developed in 1990, the program requires over-utilizers to select a medical provider from which they must obtain all medical services or referrals, except in the case of a true emergency. The Agency identified these recipients from computer-generated utilization reports and by examining the medical service history of 300

possible over-utilizers reported by providers. Currently, about 48 recipients participate in the administrative lock-in program.

► *Managed care program*

The Jackson County Managed Health Care program is mandatory for those county AFDC recipients determined eligible. Originally a Federal demonstration project in 1982, the Jackson County program now operates under a freedom-of-choice waiver. Thirty-six physician sponsors and four health plans (one State HMO, two clinics and one hospital qualified as a Federal HMO) provide enrollees with primary care services and referrals to specialized care. The program guarantees 7-day-a-week provider availability and 24-hour telephone contact. Recipients may select their managed health care plan, or the Agency will randomly assign them to one. Currently, 29,000 recipients (7 percent of State Medicaid eligibles) are enrolled. The Agency emphasizes recipient education to promote better understanding and more efficient use of services. For example, recipients are aware of their financial liability for non-emergency care if it is not authorized by their provider.

Implementation

The Agency did not implement the monthly limit of non-emergency visits due to administrative concerns and changes in physician reimbursement. The Agency determined the monthly limit was too complex and too expensive to manage. In addition, shortly after development of the monthly limit, but not as part of it, the Agency raised physician office fees to encourage them to treat clients there. However, the Agency did not raise physician fees for comparable care provided in an outpatient hospital clinic or the emergency room. Further, new procedure codes were developed to differentiate charges and settings, and to differentiate non-emergency visits in the emergency room and outpatient clinics.

Implementation of administrative lock-in faced no resistance, but co-payments encountered some. Providers have been very supportive in reporting over-utilizers of emergency room services for potential inclusion in administrative lock-in. However, providers did not understand the co-payment requirements which, in turn, caused confusion over the systems process needed to deduct and collect fees. Some hospitals wrote off uncollected fees. Some objected to the extra administrative work and the difficulty in getting people to pay. The Agency alleviated these problems by drawing on experience with co-payments in other areas before implementing them in the emergency room and by disseminating clarifications to the co-payment requirements.

The managed health care program in Jackson County did not face opposition. The Legislature provided statutory guidance to the Agency for developing the program. When the Agency attempted to expand the program to St. Louis, however, providers there opposed it. They feared losing Medicaid participants to competing managed health care

plans. Physicians also believed the monthly case management fee of \$1.50 per participant was too low. Due to these objections, the Agency did not expand the program.

Results Achieved

The success of co-payments and administrative lock-in is not certain. The total number of emergency room visits continues to increase, but the rate of non-emergency use has fluctuated over the years and is currently rising. While the Agency reports co-payments are important, the program's results are unclear. The Agency believes MMIS data may be unreliable due to provider coding errors. The administrative lock-in program has been reported as "somewhat successful"; however, data is not available to determine if emergency room use by program participants has decreased.

The Agency believes the managed health care program in Jackson County has been successful. According to a cost effectiveness report, the Agency has realized savings of \$2 million to \$3 million per year from 1987 through 1989. Quality assurance reviews show that continuity of care has improved, and is as good or better than that of the general population. Additionally, emergency room visits appear to have decreased. Although the Agency is not sure about the reliability of data on which this emergency room information is based, the Agency considers it logical to conclude that emergency room use is being controlled due to the program requirement for physician referrals.

Transferability

The Agency feels the co-payment and managed health care programs are transferable. Missouri suggests other Agencies try co-payments, but notes it is a difficult procedure to implement. A managed health care program requires a freedom-of-choice waiver which is available to any State. In addition, managed health care has many forms and is adaptable. The Agency did not comment on the transferability of the administrative lock-in program.

State Contact For Further Information

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PENNSYLVANIA

State Medicaid Population: 1,400,000

Reasons For Developing Controls Of Emergency Room Use

A need for cost containment and continuity of care motivated the Medicaid Agency to develop controls for non-emergency use. The Agency had been aware that recipients were receiving primary care in the emergency room since the Medicaid program began. Letters from providers, as well as information from Agency advisory committees, heightened its awareness. Limiting emergency room access for non-emergency care, enhancing access to alternative care, and compensating emergency and non-emergency care more fairly were the Agency's goals.

Description of Controls

▶ *Differentiated care and payment levels; recipient co-payments*

The Agency instituted differentiated reimbursement levels and double co-payments for emergency room services to address care access and cost containment under fee-for-service. The differentiated reimbursement levels with corresponding procedure codes aim at more fairly compensating emergency room services. Charges are divided into hospital and physician components for both emergency and non-emergency care. Emergency care receives a higher fee in both components. This tailoring of payments to service intensity, developed in 1985, generally follows the Blue Cross/Blue Shield scheme. The double co-payment, developed in 1984, imposes a fee on recipients for non-emergency care. The co-payment amount, ranging between \$1 and \$2, is double the co-payment for other medical services.

▶ *Managed care program*

In 1976, the Agency designed the HMO program to improve access to health care for Medicaid recipients State-wide. Recipients have 24-hour telephone access to their primary care physician, who must prior-authorize emergency room care. In addition, recipient education cautions them not to misuse high cost emergency room services and informs them of their responsibility to pay for unauthorized emergency room care. Enrollment is voluntary with 77,000 recipients currently participating.

▶ *Pre-paid health plans*

HealthPASS (Health Pennsylvania Accessible Service System) is a health insuring organization (HIO) program that serves as a fiscal intermediary between the Agency and patients in specific sections of Philadelphia. Participating providers of primary care agree to 24-hour telephone access by their patients. When contacted, the provider decides

whether to authorize emergency room care, see the patient after hours, or schedule an office visit the next day. In addition, a HealthPASS Hotline operates 24 hours a day, 7 days a week to provide assistance to recipients. Developed in 1983 under a freedom-of-choice waiver, HealthPASS is the Agency's response to a legislative mandate for managed care of 100,000 Medicaid recipients. Currently, 82,000 recipients participate.

The Community Health Centers Program is a voluntary, pre-paid program concerned primarily with improving access to care in Harrisburg. Recipients receive ongoing health care from community health centers which must provide 24-hour telephone access to a participating provider. The telephone access is monitored to assure 24-hour availability. In addition, site visits are made to the health centers to ensure provision of patient care. Recipients who receive non-emergency care are responsible for its payment. Developed in 1987 and fully operational in 1988, the program currently serves 5,500 recipients.

Implementation

The fee-for-service controls met different ends. The differentiation of reimbursement levels was implemented quickly over a four-month period, without opposition. The differentiated fee schedule was not subject to the regulatory process. The Agency published new fees in the Pennsylvania Bulletin so providers would be aware of the changes. Although not part of this procedure, the Agency also raised physician fees for office visits at the same time. However, the Agency did not implement the double co-payment due to opposition from Medicaid recipients, their legal counsel and hospitals. Opposition focused on the potential limitations on access to care, especially in rural areas. In addition, hospitals objected to the additional administrative activity required to collect co-payments.

The managed care programs also had different implementation experiences. The Community Health Centers Program encountered no implementation difficulties. The HMO program, unfortunately, found HMO's reluctant to participate. Although enrollment of HMOs and recipients continues, the program does not operate in every county. HealthPASS faced opposition from many groups: Medicaid recipients, their advocacy groups, and certain providers. Recipients and their supporters perceived this as a mandatory program disallowing choice, although recipients could choose an HMO over a HealthPASS physician. They also felt recipients might receive less adequate care or were targets of racial discrimination. Providers voiced doubts about the referral process for primary care physicians and the different payment systems.

The Agency has made progress in overcoming opposition to HealthPASS. It has worked through the problems with the advocacy groups and has become more sensitive to client needs. Emphasis on health education has been encouraged as well. Providers now like the program. They have seen they will be paid on time, and have realized their fee for office treatment is often greater than their fee for hospital emergency room treatment.

Results Achieved

The Agency reports that the differentiation of reimbursement levels has been successful. Providers have complied with the program, and rates paid for true emergency care are a higher percent of the usual charge than before. However, the Agency believes hospitals tend to claim more visits as emergencies when payment is higher. Agency quality assurance staff conduct random reviews to determine if this is a problem.

The Agency feels the HMO and HealthPASS programs have been successful, but reserves judgment on the Community Health Centers Program, due to its relative newness. The HMO and HealthPASS programs report increased continuity and access to care from July 1989 to December 1990 while holding the rate of non-emergency use relatively constant. Additionally, the number of HMO participants has more than doubled in the past two years. For HealthPASS, the Agency has estimated State savings of \$40.6 million (\$72.9 million total Medicaid funds) from March 1986 to December 1990. The estimates are based on payments for HealthPASS services compared to the fee-for-service costs for providing the same care. In addition, emergency room use by HealthPASS participants is less than emergency room use by Medicaid recipients receiving fee-for-service care in Philadelphia.

Transferability

The Agency feels all their program controls are transferable. The differentiation in reimbursement levels requires the present availability or future development of procedure codes distinguishing emergency from non-emergency care. The Agency recommends the establishment of payment differentials since non-emergency treatment should use less resources. The HMO program improves access, is cost effective, and requires less work than other options since its voluntary enrollment does not require a waiver. The whole design of HealthPASS is transferable, if State law does not prohibit the formation of HIOs. The advantage of an HIO is its capability to handle risk more creatively. HIOs also permit more flexible health care delivery and can tailor services offered to the health care needs of a target population.

State Contact For Further Information

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ENDNOTES

1. "Non-Urgent Use of Hospital Emergency Departments by Medicaid and Medicare Beneficiaries", Office of Analysis and Inspections, September 1983.
2. Gifford, Marilyn J., Jacek B. Franaszek, and Geoff Gibson, "Emergency Physicians' and Patients Assessments: Urgency of Need for Medical Care", *Annals of Emergency Medicine*, vol. 9, n. 10, October 1980, pp. 502-507.
3. Philadelphia Health Management Corporation, "Emergency Department Use in Philadelphia: Urgent and Nonurgent Health Care", March 1987.
4. Dickhundert, John S., Dwenda K. Gjerdingen, and Donald S. Asp, "Emergency Room Use and Abuse, How It Varies With Payment Mechanism", *Minnesota Medicine*, vol. 70, October 1987, pp. 571-574.
5. Buesching, Don P., Alexander Jablonowski, Ernest Vesta, William Dilts, Charles Runge, Johanna Lund, and Robert Porter, "Inappropriate Emergency Department Visits", *Annals of Emergency Medicine*, vol. 14, n. 7, July 1985, pp. 672-676.
6. Gifford, Marilyn J., et al, *ibid.*
7. Dickhundert, John S., et al., *ibid.*
8. Section 1902(a)(23) of the Social Security Act.
9. Section 1915(b) of the Social Security Act. Other sections may also be waived. Those most frequently cited are 1902(a)(1) for statewideness, 1902(a)(10) for comparability of services, 1902(a)(30) for upper payment limits, 1902(a)(4) for provisions relating to pre-paid health plans.
10. Section 1115 of the Social Security Act.
11. The Omnibus Budget Reconciliation Acts of 1981 and 1987 expanded the waivers mentioned above per *Commerce Clearing House*, Section 14,625, p. 6314.
12. 42 U.S.C. section 1395dd. (section 1867 of the Social Security Act).
13. We defined mature programs as those having several years' experience with their controls, comprehensive in scope or number of controls developed, and able to produce annual cost and utilization data.
14. These calculations require a complete set of charge data. All sample States submitted cost and utilization data, but due to time and resource restraints only four could submit complete sets.
15. Average monthly census for FY 1991.

16. Michigan also has implemented managed care programs in Wayne County (Detroit). They chose not to include their experience with them in this report since they do not believe their managed care programs are directly related to control of emergency room utilization.
17. HCFA Common Procedural Coding System

APPENDIX A

PUBLIC HEALTH SERVICE COMMENTS

Although this report did not make recommendations, the Public Health Service (PHS) provided general comments on other important issues involved in non-emergency use of emergency rooms. The full text of their comments follows. Based on their letter and the intent of this report, we changed the word "inappropriate" to "non-emergency." PHS also urges us to distinguish between State controls that result in less care and those that result in more appropriate care. Although we did not specifically ask States for this information, we did include it in the individual State profiles when they provided it. The other concerns PHS raises are treated in the companion report, "Use of Emergency Rooms by Medicaid Recipients," OEI 06-90-00180, but they were not pertinent to the narrow focus of this report.



*Mangano/Hof
Brown*

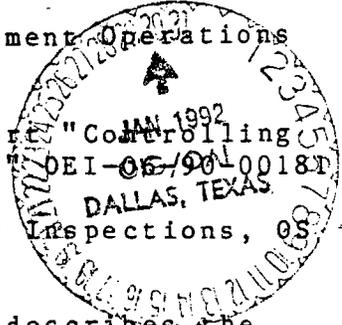
Memorandum

Date • JAN 23 1992

From Deputy Assistant Secretary for Health Management Operations

Subject Office of Inspector General (OIG) Draft Report "Controlling Emergency Room Use: State Medicaid Reports," DEI-05-90-0018D

To Deputy Inspector General for Evaluations and Inspections, OS



The subject report profiles the efforts and describes the obstacles encountered by six State Medicaid agencies in developing controls over the non-emergency use of emergency rooms by Medicaid recipients. It is a companion document to OIG's more comprehensive inspection report entitled "Use of Emergency Rooms by Medicaid Recipients." The Public Health Service (PHS) commented on this comprehensive report on December 17, 1991.

Neither the subject report nor its companion contain recommendations for PHS. However, we believe that some of the issues we raised in our December 17 comments are applicable to the subject report also. For example, to enhance the usefulness of this report, we offer the following suggestions and comments:

- o Inappropriate use of emergency rooms should be clearly defined.
- o Additional discussion of the factors that may lead Medicaid recipients to use emergency rooms inappropriately would be beneficial.
- o Additional discussion of what really is inappropriate emergency room care would be useful.
- o It would be useful for the report to consider whether the controls (proposed or otherwise) result in less care, or more appropriate care.

For a more detailed discussion of these points, please refer to the December 17 PHS comments mentioned above.

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