

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**USE OF EMERGENCY ROOMS BY  
MEDICAID RECIPIENTS**



**Richard P. Kusserow  
INSPECTOR GENERAL**

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**OEI 06-90-00180**

# EXECUTIVE SUMMARY

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## **PURPOSE**

This report describes programs or procedures developed by nine States to control the non-emergency use of emergency rooms by Medicaid recipients and evidence of their success.

## **BACKGROUND**

During the last decade, Medicaid agencies have felt the financial pinch of program expansions and rising costs. Medicaid Programs have sought to control program costs through various means while maintaining quality care. One method has been tighter controls on the use of Medicaid services, including hospital emergency rooms.

The non-emergency use of emergency rooms by Medicaid recipients has long been recognized as a problem. In September 1983 the OIG released a report (OAI-"Non-emergency Use of Hospital Emergency Departments by Medicaid and Medicare Beneficiaries") which found a very high misuse of hospital emergency rooms by Medicaid recipients. Studies continue to show that Medicaid recipients consistently make a higher proportion of non-emergency and marginally appropriate emergency room visits ranging from 17 percent to 61 percent. In contrast, recent studies show non-emergency visits for the general public range between 11 percent to 38 percent of all emergency room visits. These findings indicate significant potential for containing costs and improving the quality of care through reducing non-emergency utilization and redirecting recipients to more appropriate care sites.

We interviewed 17 Medicaid directors and managers in nine different States about the programs/procedures they have established to control non-emergency use of the emergency room, their motivations for development, and their perceived and actual success. In addition we obtained utilization and charge data from the States and the Medicaid Statistical Information System (MSIS) program at the Health Care Financing Administration (HCFA). States were selected on the basis that they had "mature" controls in place. Mature was defined by length of establishment, comprehensiveness and/or likelihood of having cost and utilization data available.

## **FINDINGS**

### **Heavy Non-Emergency Use of Emergency Rooms By Medicaid Recipients Is A Continuing Problem.**

- *Over one-half to two-thirds of Medicaid emergency room visits are non-emergency.*

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

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

*States in our sample had developed 23 programs/procedures to control non-emergency utilization of the emergency room. These include:*

- Managed Care
- Co-payment
- Emergency Room Claims Review
- Pre-paid Health Plans
- Lock-in
- Emergency Room Visit Limit
- Payment Differentiation
- Other (Nurse Phone Line)

**The Majority Of Programs/Procedures Considered Successful Address Access To Care Through Managed Care/Pre-paid Programs.**

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

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

**RECOMMENDATIONS**

**Each State should develop a comprehensive initiative to reduce costly non-emergency use of emergency rooms.**

**The HCFA should encourage States to develop initiatives to review and reduce non-emergency use of emergency rooms by Medicaid recipients and assist them through data analysis instructions, expedited review of waiver applications for managed care and dissemination of effective emergency room control practices.**

## **AGENCY COMMENTS**

We received comments from the Health Care Financing Administration (HCFA) and the Public Health Service (PHS). HCFA concurred with the parts of the recommendations related to the increased use of managed care for Medicaid recipients and expediting the review of State applications for waivers to implement managed care efforts and emergency room controls. They stated that the President's proposed Comprehensive Health Care Program would go beyond our first recommendation. Further, they stated they had implemented a streamlined Waiver Application in November 1991. Because of the President's proposed initiative, HCFA did not believe the remaining portions of the first recommendation were necessary. In addition, the HCFA believes providing specific instructions on accessing and using ER data for annual reviews of utilization would require extensive research. The HCFA also provided technical comments pertaining to the methodology used to estimate program savings and savings to society which could result from redirecting Medicaid recipients to community care facilities. (See Appendix G for the full text of the HCFA comments.)

The PHS acknowledged the relevance of the general findings that (1) lack of access to primary care is a major cause of inappropriate usage of the emergency room and (2) access to alternate care is an important component in developing effective control of emergency room use. However, they felt more discussion of problems facing Medicaid recipients in gaining access to more appropriate care would have been helpful. PHS also expressed concern about our use of the word "inappropriate." (See Appendix G for the full text of the PHS comments.)

## **OIG RESPONSE**

The OIG believes the use of a comprehensive coordinated care system by Medicaid, which includes case management, is an excellent proposal and will address both access and non-emergency use of the emergency room. However, we feel that the remaining components of the first recommendation complement this initiative and will help States initiate and maintain a decrease in non-emergency use of the emergency room. The OIG also believes that providing guidance on access and use of emergency room data for annual review is important and would not require extensive research, as many States appear to have data on emergency room visits available. Based on HCFA comments the wording of the second recommendation was changed from "require" to "encourage". In response to technical comments, clarifications were made on the assumptions underlying our methodology and our approach for calculating savings to society.

The PHS comments were considered and resulted in clarifications within the report. With regard to access to alternate care, we agree that this is an important issue warranting continued study. However, this is a broad subject and beyond the scope of this inspection. We agree that it is difficult to define the appropriateness of emergency room visits. However, the focus of this inspection was narrower, examining only non-emergency care. Hence, we changed the word "inappropriate" to "non-emergency" in the few places it was used in this report.

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# INTRODUCTION

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## **PURPOSE**

This report describes programs or procedures developed by nine States to control the non-emergency use of emergency rooms by Medicaid recipients and evidence of their success.

A companion report entitled "Controlling Emergency Room Use: State Medicaid Reports," OEI 06-90-00181, includes profiles for six of the nine study States.

## **BACKGROUND**

During the last decade, medical care costs have increased rapidly, the percentage of Medicaid reimbursement for hospital charges has declined<sup>1</sup> and Congress has mandated expansions of Medicaid's covered population and services. Federal Medicaid costs specifically have risen from \$30 billion in 1988 to \$65 billion estimated in 1992<sup>2</sup>. State Medicaid agencies, feeling the financial pinch caused by these events and others, have sought to control program costs through various means while maintaining quality care. One method has been tighter controls on the use of Medicaid services, including hospital emergency rooms.

### *Prior findings on non-emergency use of the emergency room*

The non-emergency use of emergency departments by Medicaid recipients has long been recognized as a problem. In September 1983 the OIG released a report (OAI-"Non-Urgent Use of Hospital Emergency Departments by Medicaid and Medicare Beneficiaries") which found a very high misuse of hospital emergency rooms by Medicaid recipients. It estimated that at least 50 percent of Medicaid emergency room visits were non-emergency and could be adequately treated in community care settings. Recent studies supporting these findings estimate that Medicaid recipients continue to demonstrate a significantly higher proportion of non-emergency and marginally appropriate emergency room visits of 17 percent<sup>3</sup> to 61 percent<sup>4,5</sup> when compared to other populations. These and other studies suggest non-emergency visits in the general public, including Medicaid recipients, range between 10.8 percent<sup>6</sup> and 37.6 percent<sup>7,8</sup>. The OIG report also found that emergency room visits normally cost at least three times the charge for a community-based physician for the same care. Not only does non-emergency use greatly escalate program costs, it also decreases the quality and continuity of care received, since emergency rooms are not designed to provide on-going primary care.

In a study in St. Paul, Minnesota, welfare patients made a significantly higher proportion (61%) of non-emergency and marginally appropriate emergency room visits over a four week period than did individuals enrolled in other public and private plans<sup>9</sup>. Other

studies in Pennsylvania and Illinois which used less stringent definitions of non-emergency use also found the highest percent of non-emergency use in the Medicaid population. Using these less stringent definitions, Philadelphia Medicaid recipients accounted for 40 percent<sup>10</sup> of non-emergency use during a one year period, and Medicaid recipients in three hospitals in a city in Illinois, during a two week period, accounted for 17.8%<sup>11</sup> of the non-emergency use.

### *Mechanisms for controlling use*

Medicaid policy generally recognizes the need for requiring medical necessity and controlling the utilization of covered services. Likewise most States recognize the specific need to control non-emergency Medicaid emergency room use. Many States have considered and tried a variety of mechanisms to control non-emergency room visits. Included among such State efforts are primary care case management, HMOs and other contracted services, recipient cost sharing or co-payments, non-payment for non-urgent care, denial of non-urgent care after initial assessment and annual limits on individual emergency/outpatient expenditures or visits. Two recent studies in California<sup>12</sup> and Pennsylvania<sup>13</sup> reviewed outcomes of emergency room screening programs implemented to control non-emergency use of the emergency room and determined outcomes for those patients denied service. Study findings showed that non-emergency visits to the emergency room were reduced and the majority of patients received a more appropriate level of care in the community. A federally funded Medicaid demonstration project operating in six States, resulted in the control or reduction of the misuse of emergency rooms. However, cost data for the first year indicated an increase in expenditures due to initial administrative start-up costs.<sup>14</sup>

Medicaid law also requires States to review patient overuse/abuse of services. This is possible through the Medicaid Management Information System (MMIS). However, there is no policy stating the types of abuse that must be reviewed or norms to use in defining abuse<sup>15</sup>. Currently, there is no national data base that can be utilized to determine aggregate numbers of non-emergency Medicaid visits to the emergency room.

### *Legislation affecting development of control mechanisms*

States attempting to control non-emergency use of emergency rooms must consider several Federal requirements. Medicaid recipients must have the right to freedom of choice of a health care provider as stated in Section 1902(a)(23) of the Social Security Act. However, the Social Security Act has provided for exceptions to this ruling, if access to care of adequate quality is not denied. When recipients are restricted in choices of providers a waiver under section 1915(b) must be obtained. Other sections may also be waived and 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. If involvement in alternative health provision programs is voluntary, no waiver is required. A waiver for a Medicaid demonstration project can be

obtained under section 1115 of the Social Security Act. The Omnibus Budget Reconciliation Acts of 1981 and Section 4102 of OBRA 1987 expanded the waivers mentioned above<sup>16</sup>. Waiver programs have been used by several States to implement programs to reduce non-emergency use of the emergency room.

Additional concerns regarding access to care are expressed in patient anti-dumping legislation<sup>17</sup>. This restricts hospital emergency rooms in refusing treatment to patients who lack the ability to pay for services, and requires the provision of screening examinations for patients presenting for care<sup>18</sup>. Due to the reduced numbers of physicians participating in Medicaid, recipients may feel compelled to seek care in the hospital emergency room. The anti-dumping legislation has caused State Medicaid agencies to proceed carefully when developing programs to limit non-emergency use of the emergency room.

## **METHODOLOGY**

### ***Scope/sample selection***

The inspection focused on the specific procedures implemented by selected State Medicaid agencies to control non-emergency use of hospital emergency rooms (either as a primary or secondary objective). Since our purpose was to examine successes or failures of these procedures, States with mature procedures were purposely selected. For the purposes of this report, mature was defined as:

1. Having examined this issue since the early 1980s, which demonstrated a lengthy history in this area.
2. Having comprehensive procedures, either in terms of scope of the procedure (geographical locations covered) or in terms of number of procedures developed.
3. Having a greater likelihood of having data available on cost and utilization due to the development of programs/procedures that require annual or bi-annual reporting.

The selection process was based on several criteria. In addition, a two tier selection system was used to determine which States, from an original universe of 36 States, met criteria at each level. Appendix A depicts factors considered and the two tiers of review in the selection process.

Nine sample States were selected: Arkansas, Kentucky, Michigan, Minnesota, Missouri, New York, Pennsylvania, Utah and Wisconsin, with California selected as an alternate. Early in the inspection, New York dropped out of the sample and California was substituted.

### ***Data collection***

Data was collected by phone, in person and by mail from individuals who had a major responsibility for the Medicaid program and/or individuals directly responsible for programs/procedures established to control emergency room utilization. Interview guides were structured to capture descriptive information about each State's procedures, reasons for implementation, systems capabilities, barriers and opposition overcome, perceived successes and recent management decisions affecting the control of emergency room use. Site visits were made to two States, Arkansas and Kentucky, and phone interviews were conducted with five States, Missouri, Pennsylvania, Wisconsin, Michigan and Utah. Discussion guides were completed and returned from Minnesota and California, with subsequent phone interviews to clarify the information. In addition, we were provided with excerpts from the policy manuals and/or written descriptions of each site's program control policy(ies). Copies of Medicaid waiver reports from States having waiver programs were also obtained.

Quantitative utilization and cost data were requested from each State. Utilization data were requested for multiple years during the tenure of the program/procedure to detect any noticeable programs impact on total emergency, and when available, non-emergency visits to the emergency room. Charge data was requested on the average charge for a visit to a private community physician, community clinic, and out-patient hospital clinic based on Medicaid billings. Additional average charge information was requested on visits to the outpatient emergency room facility, emergency room physician, emergency room ancillary charges and total emergency room visit based on Medicaid billings. Where data was collected for emergency and non-emergency visits, emergency room charge information was obtained for each category.

# FINDINGS

## Heavy Non-Emergency Use Of Emergency Rooms By Medicaid Recipients Is A Continuing Problem.

*Over one-half to two-thirds of Medicaid emergency room visits are non-emergency.*

Medicaid recipients continue to use the emergency room for non-emergency care. The mean of non-emergency use as a percent of total Medicaid emergency room visits reported in 1990 for the study States was 55 percent<sup>19</sup>. Excluding Minnesota (the only State reporting non-emergency use below 40%) from this list would result in a mean of 61 percent. The mean for non-emergency use of five additional States not contained in the sample was 67 percent. The data for these States were obtained from the HCFA Medicaid Statistical Information System (MSIS).

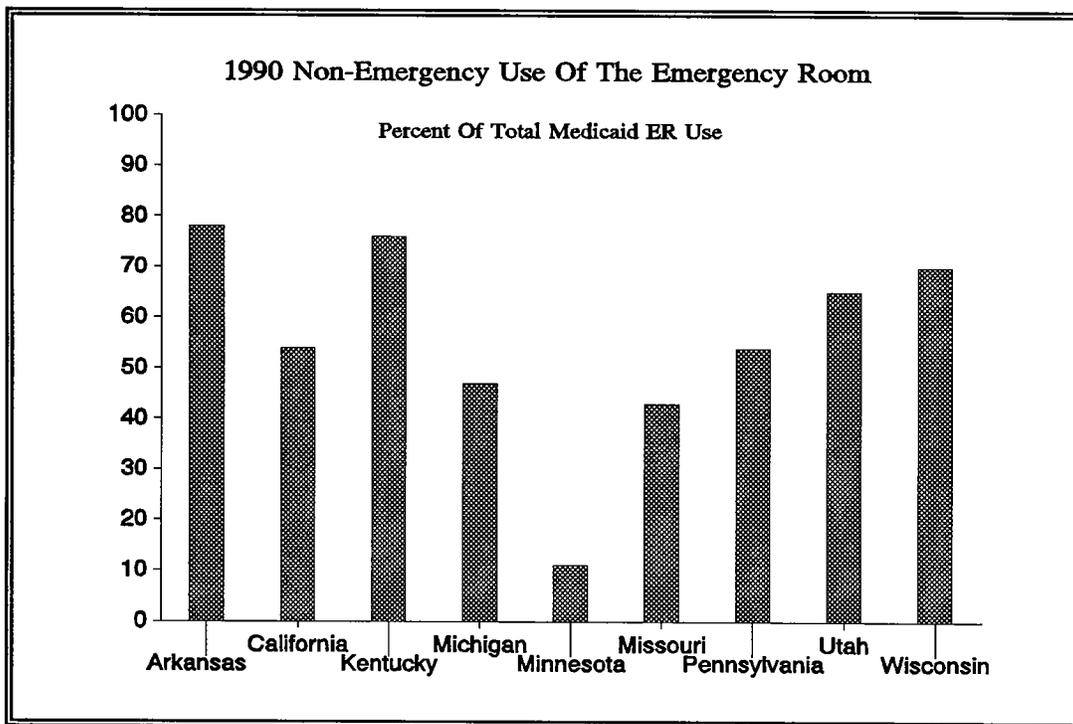


Figure 1

Reasons reported for non-emergency use of emergency rooms are consistent across States. Such use continues to result from recipient lack of access to primary care during or after office hours. This lack of access may be related to either general access issues related to

proximity of care, or transportation problems or after working hours access due to being unable to reach a physician in a timely manner, or lacking a telephone. Physicians and hospital providers also continue to exacerbate the problem by their behavior. Physicians refer recipients to the emergency room after office hours, or verify the need for non-emergency care in the emergency room when contacted by the hospital. Additionally, hospitals do not always contact physicians before treating patients enrolled in managed care programs.

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

Non-emergency care can be provided at less cost in the community. Average charges for non-emergency care provided in the emergency room ranged from 1.2 to 5.4 times the average charge of a Medicaid visit in the community (See Appendix B). While Medicaid reimbursement for non-emergency care in the emergency room ranges from 16 percent to 67 percent of billed charges in the sample States, these levels are still greater than average charges in the community in all but one State. Assuming non-emergency visits could be reduced to 40 percent of all Medicaid emergency room visits, the rate for the general public based on previous research, and individuals could be redirected to community care, we estimated potential Medicaid savings. In 1990, \$39.5 million could have been saved in just four<sup>20</sup> of the sample States by redirecting non-emergency care. This estimate applies a community reimbursement rate of \$24.75, the highest of the four State Medicaid physician reimbursement rates for an office visit. Even if the redirected visits were reimbursed at the average charge billed to Medicaid for a community clinic visit, program savings of \$27.2 million could still have been realized. Likewise, \$16 million could have been saved by reimbursing average charges for a physician office visit in the community. (See Appendix C for a sample calculation)

Additionally, we believe significant savings to society may also be realized by reducing the number of non-emergency Medicaid visits to the emergency room, and redirecting recipients to alternative community sites. These savings would accrue through averting shifts of unreimbursed emergency room costs to other payers. Because of the difference that exists between emergency room costs and the low amounts reimbursed by Medicaid, hospitals have a strong incentive toward cost shifting. Those costs, not paid by Medicaid, cannot be billed to recipients and may become uncompensated care costs. Typically, these uncompensated costs are shifted to society in the form of higher health care costs for the entire population, higher insurance premiums, or redirection of charity dollars. We have made a rough calculation of societal savings by using emergency room charges as a proxy for costs.<sup>21</sup> Using this method, we estimate savings to society might have been as high as \$83.8 million in 1990 in four sample States (see Appendix C).

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

*States in our sample had developed 23 programs/procedures to control non-emergency utilization of the emergency room.*

<b>CONTROL PROGRAMS/PROCEDURES</b>			
<b>TYPE OF PROGRAM/PROCEDURE</b>	<b>NUMBER DEVELOPED</b>	<b>NUMBER IMPLEMENTED</b>	<b>NUMBER REMAINING</b>
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
<b>TOTAL</b>	<b>23</b>	<b>21</b>	<b>18 (1 altered)</b>

Information regarding the impact of these programs/procedures are contained within the body of this report. Additional information regarding the implementation of these programs/procedures by States and definitions are presented in Appendix D.

*States found Medicaid recipients were using the emergency room as their primary care source, resulting in increased expenditures.*

States reported that improving access to medical care was imperative in order to provide medical attention in more appropriate sites and eventually decrease non-emergency use of the emergency room. This was based on findings that access to primary care either during or after regular office hours was a problem for recipients, causing them to seek care in the emergency room. States reported considering access to care when developing 20 of the 23 programs/procedures. However, providing access to or continuity of care was reported as the most important reason for implementing six of the programs. The respondent from Kentucky stated that 44 percent of all recipients did not have a regular doctor before enrolling in the managed care program they developed. Thus, providing specific access alternatives was imperative. In an effort to deal effectively with the access issue, Pennsylvania wrote legislation allowing the State to explore and develop provisions for alternative care for Medicaid recipients. This exploration resulted in the development of two pre-paid care programs to provide for the medical needs of specific Medicaid recipients in two urban areas.

The need to control costs was also noted prior to implementing programs/procedures to control non-emergency use of emergency rooms<sup>22</sup>. Four States had specifically noted cost overruns or large expenditures in either the hospital sector in general, or in emergency rooms specifically, before determining that emergency room use was

problematic. States listed cost savings as a major concern when developing 15 of the 23 programs with eleven of the programs reporting this as the most important reason for deciding to implement their program. The potential for savings encouraged these States to develop programs to review claims for the appropriate level of care and corresponding billing or to develop or review their current managed care/pre-paid programs.

***Recipient and provider behavior both caused non-emergency use of the emergency room.***

Recipients were using the emergency room for primary care, both during and after physician office hours, before controls were implemented due to a lack of access to an ongoing relationship with a primary care provider. Three States said that many Medicaid recipients either did not have a primary care physician, or did not know how to access one, and instead chose to use the emergency room. Recipients who historically had a difficult time reaching their physician either due to unavailability or to lack of a telephone, frequently would proceed to the emergency room for medical care. Medicaid recipients would also proceed to the emergency room for care after office hours if their physician instructed them to do so after (s)he was contacted. States also reported that some Medicaid recipients would say they did not have a primary care physician, even when they did.

Physicians and hospitals both acted in ways that did not discourage, and frequently encouraged, Medicaid recipients to use the emergency room for non-emergency purposes. Physicians would refer recipients to the emergency room after office hours or they would not be accessible to patients after office hours. Some physicians would also verify the need for care in the emergency room when contacted by the hospital after office hours, even if the level of care required was not an emergency. Hospitals would often treat a patient before trying to contact their primary care physician, whether the care was an emergency or not. Frequently, hospitals would treat the patient because the individuals indicated they did not have an ongoing relationship with a physician.

***States' controls provided opportunities to change recipient and provider behavior.***

States developed programs that attempt to change recipient behavior by providing access to care in a more appropriate setting. These programs provide either mandatory or voluntary access to an ongoing relationship with a primary care giver, or refer a patient to an appropriate setting based on screening of symptoms. Eleven programs have addressed non-emergency use as a secondary focus by providing access to care through managed and pre-paid plans. One program has addressed this issue through a 24 hour Nurse Line. Three of the managed care/pre-paid programs have reported a decrease in emergency room utilization and the Nurse Line has estimated a decrease in non-emergency visits during its first quarter due to alternative referrals.

States have also developed programs that attempt to change behavior through limiting access to the emergency room in several ways. Eleven programs had as their primary

focus changing behavior through limiting access, sharing of financial responsibility through co-payments and denying or reducing payment to hospitals when non-emergency care is provided in the emergency room setting. Seven of these programs are still in place, but one has been significantly altered. Two of the programs in Arkansas and Michigan have not changed behavior by reducing non-emergency visits. According to respondents, it is not clear whether the remaining programs/procedures have had the desired effect of changing recipient or provider behavior.

***States' lack of specific reimbursement levels and definitions of emergency care permitted non-emergency use of the emergency room.***

Prior to 1982 States lacked policies and diagnosis codes or criteria to differentiate between levels of care and reimbursement rates for levels of care. None of the States interviewed had differentiated levels of care or reimbursements prior to implementing their control programs/procedures. For this reason, data did not distinguish between emergency and non-emergency care provided in the emergency room. Without this data, the amount of non-emergency care provided could not be determined, and the extent of the problem was not clear. Five States reported difficulty in determining if they had a problem because they could not differentiate the level of care being provided in the emergency room before implementing their programs. Five States also reported perceiving a problem with non-emergency use of the emergency room due to high hospital and/or outpatient charges. However, they could not determine how much of these charges were due to non-emergency care due to the lack of differentiation in the data. Providers were also motivated to treat anyone presenting to the emergency room and label the care as emergency to receive a higher reimbursement level for care provided in a less than appropriate setting. This led to greater sums of money being spent on care in the emergency room that could have been provided in a less costly setting.

***Differentiating levels of emergency room care helped some States document non-emergency use of the emergency room.***

States have made efforts to implement procedures allowing them to specify criteria, diagnoses, or codes that differentiate levels of care. While the State definitions of "emergency" care are quite similar, the means of defining other levels of emergency room visits are not consistent among States. Five States have developed definitions differentiating between emergency and urgent levels of care. Four of these States recognize other levels of care, either routine or clinic levels of care, which are referred to other treatment sites. In Michigan and Utah, coverage of urgent level care in the emergency room depends on factors such as time of day and day of the week. During regular office hours, urgent care may be referred to a special clinic or to the private physician's office. Four States have developed definitions differentiating between emergency and non-emergency care. However, two of these States denote non-emergency visits as either outpatient or examination room visits.

***Tiered pricing and triage fees provide opportunities for savings by differentiating payments for levels of emergency room care provided.***

Payments based on level of care provided, or tiered pricing, have been developed by all but one of the States in the sample. Three of the States, Pennsylvania, Missouri and Arkansas specify differential payment rates for care provided to emergency and non-emergency cases in the emergency room. Minnesota differentiates between facility payment rates for care provided to emergency and urgent cases in the emergency room. In California, recipients presenting to the emergency room but determined not in need of that level of care are referred to the examination room which is billed at a lower rate.

Kentucky does not provide different payments for urgent and emergency care provided in the emergency room. While in theory non-emergency cases are not treated in the emergency room, the Kentucky respondent stated that, in fact, this is not always the case. If physicians authorize treatment in the emergency room, this is taken as an indicator that the cases are emergencies. However the State Medicaid agency is aware that not all the cases authorized are emergencies. Kentucky is in the process of establishing a triage fee in an effort to assure only appropriate cases are being treated in the emergency room.

Payment of a triage fee reimburses the hospital for the time spent determining patient need and also encourages hospitals to refer patients needing lesser levels of care to a more appropriate setting. Minnesota provides a triage fee for assessing the level of care required by any patient presenting to the emergency room. Two additional States, Michigan and Utah, also provide a triage fee for patient assessment. Flexibility has been built into the triage system in these States by allowing urgent cases to be seen in the emergency room if the patient presents after hours or on the weekend.

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

Of the fifteen programs/procedures that are considered successful and are still in place, thirteen address access to care. The primary function of these plans is to provide recipients with an ongoing source of primary care and referral to other services. Nine of the 13 programs/procedures addressing access are managed care or pre-paid health plans. Four of the 13 address access based on time, age and geographical location, or lock-in to a physician. Missouri has provided for access to care by recipients who overutilize services by locking them in to a specific primary care physician. Michigan and Utah consider the time until regular office hours, based on day of week and time of day, when determining if urgent care may be provided in the emergency room and reimbursed at a higher level. Arkansas has added availability of physicians in the geographic location to consideration of day and time when determining if non-emergency care will be reimbursed at a higher level. Arkansas and Michigan both consider the age of the individual presenting to the emergency room. Arkansas also makes greater allowances for emergency room visits by children under the age of two, with no reviews being made of their claims.

***A greater reduction in non-emergency visits might be achieved if more Medicaid recipients were enrolled in managed care/pre-paid programs.***

Since 1982, seven of the nine States have implemented managed care/pre-paid health systems to provide opportunities for recipients to establish ongoing relationships with a primary care giver, either on a voluntary or mandatory basis. The total involvement of Medicaid recipients in State managed care/pre-paid programs ranges from seven percent to 71 percent. These programs require 24 hour phone access to a care giver for the purpose of providing an assessment of the appropriate site for care. By having an individual or group act as a gate keeper, and controlling referrals to care outside the normal setting, the number of non-emergency visits to the emergency room can be reduced. Three of the sample States have reported information pertaining to emergency room use by individuals enrolled in a managed care/pre-paid program. In one State, emergency room visits by these individuals have declined despite an increase in enrollment. In a second State, emergency room visits per client have decreased and are lower than those reported for Medicaid recipients in the fee-for-service program. In a third State, the percent of non-emergency visits by enrolled individuals has stayed stable as a percent of total emergency room visits but is lower than that of Medicaid recipients in the traditional fee-for-service Medicaid program.

***Comprehensive approaches that include managed or pre-paid care appear to be more effective in controlling emergency room use.***

Five States reporting and demonstrating more effective control of emergency room utilization have implemented managed or pre/paid care programs. Four of these, California, Minnesota, Missouri and Pennsylvania, have a more comprehensive network of three or more types of programs/procedures to control emergency room use. The two States who have shown a consistent decrease in non-emergency use of the emergency room over time have implemented a number of managed care and pre-paid programs, 24 in California and 6 in Pennsylvania. Pennsylvania has also differentiated a number of possible levels of care and respective payments for cases presenting to the emergency room. Arkansas and Kentucky, two of three States who experienced difficulty controlling utilization, have only one control program in place.

***Most programs never implemented, terminated or reported as unsuccessful, such as copayment procedures, did not address access issues.***

Programs/procedures that were not successful did not address access to care. Four of the five programs/procedures that were either terminated, changed or never implemented did not address access. Copayment programs generally were not successful due to opposition. Two of the four copay procedures were either never implemented or terminated and one of the two remaining copay programs has been judged to be unsuccessful.

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

Opposition to control procedures came primarily from three groups: providers, both physicians and hospitals, the Medicaid population, and advocacy groups. The opposition focused on payment and administrative problems, access to care and freedom of choice issues. Provider groups were concerned with payment and administrative problems. Hospitals were particularly concerned with the additional mechanisms that would have to be developed to collect co-payments. Many hospitals found co-payments so troublesome they regularly did not collect them. The Medicaid population and advocacy groups were primarily concerned with access to care and freedom of choice issues.

Twelve of 23 programs/procedures reported opposition. Eight of the States reporting opposition were able to overcome it. The only program categories that faced no opposition were the triage fee, differentiation of payment rates, and a lock-in program. Opposition to managed care/pre-paid programs was overcome by time, communication with and acceptance of input from concerned groups, and clarification of governing regulations. While opposition was basically overcome, three managed care programs still face some resistance. One of the programs experiencing resistance was not expanded, and the others continue to modify their programs as necessary. Opposition to other programs was overcome by time, experience, education and clarification of procedures.

Four programs/procedures were unable to overcome opposition. Two of the four programs/procedures were terminated, one was never implemented and one was significantly altered. Only one pre-paid program was terminated due to opposition, however two co-pay programs were defeated by opposition. One State's denial of payment procedure was changed to pay a triage fee.

### ***Resource and legislative barriers were minimal.***

Securing legislative approvals and required resources to implement emergency room controls were only minor problems for most States. Ten of the 23 programs required legislative approval, with two States already having legislation permitting the development of managed care/pre-paid programs. Only one State reported problems related to implementation of their programs/procedures due to the legislature.

Interestingly, anti-dumping legislation was not reported as a significant factor in developing emergency room control procedures. Seven of the nine States reported they had already implemented programs/procedures prior to the implementation of this legislation; thus, it was not an issue. Only two States reported considering anti-dumping legislation when developing control procedures. These States felt they must see all patients presenting to the emergency room, regardless of their condition, due to possible liability issues. Both States later made structural changes to their Medicaid program by implementing a triage fee in order to compensate emergency rooms' for screening

patients. Four States reported resource barriers, related to development of systems for collecting co-payments, budget limits and the waiver application process.

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

*While most States believe implemented emergency room controls have been effective, only some States can produce utilization data to support their perceptions.*

States generally have data on overall Medicaid emergency room visits for the State, but few have data reporting visits for specific programs. Wisconsin reports that emergency room use appears to be going down in two counties where HMO programs were implemented, with a 30 percent drop noted between 1985 and 1988. Two States, Michigan and Minnesota, report their emergency room utilization has remained constant over time. However, they viewed this as a positive achievement, since the overall number of Medicaid recipients had increased during this time of constant emergency room utilization. In addition, during 1990 Minnesota reported the lowest rate (11%) of non-emergency use of emergency rooms of all the sample States.

Five States, Arkansas, California, Kentucky, Missouri and Utah report the overall trend for emergency room visits has continued upward since implementation of their programs. Kentucky, however, said the increase has been at a lesser rate than projected had the program not been implemented. When examining emergency room visits in managed care/pre-paid programs, two States report a decrease in overall emergency room utilization. Missouri, believes that emergency room visits are down in their managed care program, since this program's utilization of medical care is lower than the general Medicaid population. In Pennsylvania, emergency room use is reported to be down in their Health Insuring Organization (HIO) program when compared with fee for service Medicaid recipients. Both of these States, however, stated they are unsure of the accuracy of the data supporting these findings.

States report only mixed results in controlling non-emergency utilization. Data are available for six States, either from the State or the HCFA MSIS data, for reviewing the trend of non-emergency visits as a percent of all emergency room visits. These data exclude emergency room visits made by recipients enrolled in HMOs, pre-paid plans and community health centers. Two States, Pennsylvania and California, have demonstrated a decrease in the percent of non-emergency visits reported from 1986 through 1990. Arkansas has experienced an increase and then a decrease in percent of non-emergency visits since 1987. Missouri has seen a fluctuating non-emergency rate since 1981 with an increase noted in recent years. Wisconsin demonstrated a decrease and then an increase from 1988 to 1990. Finally, Kentucky reported a rise and then leveling off of non-emergency visits as a percent of total emergency room visits from 1988 through 1990.

***Development of tiered payment rates and treatment codes has enabled States to collect data distinguishing emergencies from other levels of care provided in the emergency room and to demonstrate savings. Due to certain exemptions, however, this data does not always accurately reflect utilization of services.***

Differentiating payment based on care required has provided these States with a possible means of assessing cost savings to the Medicaid program from these procedures. Arkansas can easily demonstrate a net saving of \$1.6 million since 1988 by denying emergency room reimbursement rates for non-emergency care provided. In States where tiered payment levels are clearly defined, savings, in theory, can be documented by determining the cost to the program if all patients had been reimbursed at one level.

Although data collection procedures are greatly improved, data do not always reflect true usage. During the 1980's six of nine States began recording data differentiating levels of care provided in the emergency room. However, these data do not always represent all of the individuals covered by Medicaid. Many managed care and pre-paid health programs do not report emergency room visits, or they provide dummy claims that are not considered reliable. In addition, many groups are exempted from emergency room controls, thus specification of the level of care provided them is not questioned. Arkansas exempts all children under the age of two from claims review, Missouri exempts children under 18, pregnant women and family planning services from their co-pay program, California exempts individuals under 21 and pregnant women under their voluntary co-pay program, and Michigan applies a more liberal interpretation of emergency for children.

***Despite developing definitions and codes denoting levels of care, some States continue to have problems with accuracy of coding and quantifying true non-emergency visits.***

Although they have developed definitions and codes for differentiating care, two States feel the coding of these visits may not be accurate. This may be due to the lack of differentiation in payment rates, the inclusion of non-emergency visits with other levels of care, or the incentive to obtain the higher emergency room payment rate. Kentucky is in the process of establishing diagnosis codes for determining if care provided is truly an emergency. Two additional States code non-emergency visits in the same manner as other types of care, outpatient and examination room. This causes difficulty in determining the true number of non-emergency cases that initially come to the emergency room.

***State data to support cost savings resulting from emergency room controls are limited.***

While savings cannot always be attributed to a reduction in non-emergency use of emergency rooms, controls implemented to limit this behavior have reported savings to the Medicaid program. During the years 1987 through 1989 a savings of \$181,969,699 was reported by seven States. Six of the seven States with managed care/pre-paid programs have reported savings based on these programs, although they are not claimed as a direct result of decreased emergency room use.

Upon closer examination of data provided, only three States have cost savings directly attributable to implemented emergency room controls to limit non-emergency use of emergency rooms or reimbursement. An independent review of the Kentucky waiver program projected a savings of \$12 million over what would have been spent in the area of outpatient emergency room services from 1986-89. Arkansas demonstrated a net savings of \$1,624,562 for the period of 1-88 to 6-91. In addition, Arkansas reported the amount saved from the review of the appropriateness of emergency room services in 1990 is almost the same amount as the cost of its review program since its inception in 1984. Minnesota estimated its newly implemented Nurse Line serving one county saved \$12,579 in its first quarter of operation, by diverting non-emergency visits from the emergency room.

While additional States believe savings are resulting from their emergency room controls, they cannot specifically link them to reduced non-emergency use of the emergency room use, and are unable to provide specific data. Missouri feels a portion of its average savings of \$3 million a year would be attributed to reduced emergency room utilization. Michigan stated that if an estimate is made of what 1981 emergency room payments would be in 1990 dollars (\$37.2 million) the program is coming out ahead, since 1990 emergency facility and triage payments are \$27.8 million. Minnesota reports total outpatient costs have decreased due to more specific coding of all outpatient services and that general HMO cost savings include some savings in emergency room services.

Two of the States citing cost savings, Arkansas and Michigan (until recently), did not, in fact, reduce emergency room utilization, they simply denied or reduced payment. The net effect is that care was provided that in some way had to be accounted for, either through cost shifting or write off as charity care. While savings were realized by the program, this resulted in an increased cost to society. Michigan implemented a triage fee in 1989. One of the reasons was to alleviate some of the cost to society that occurred when denying payment to the hospital for non-emergency visits by paying for assessments of the level of care required.

# RECOMMENDATIONS

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During the past decade the issue of non-emergency use of the emergency room has been addressed in several ways by the nine States reviewed. The major finding of interest from this inspection is the importance of providing access to care to Medicaid recipients when trying to reduce the use of the emergency room. All but one of the States reviewed had developed managed care or pre-paid care programs that provided access to care. Six of the States with managed care/pre-paid programs have been able to identify cost savings from the implementation of these programs. In addition, several of the programs have demonstrated some reduction in emergency room use for individuals enrolled in these programs. Involvement of a greater number of Medicaid recipients in managed care/pre-paid programs could lead to further reductions in non-emergency use of the emergency room. This, in turn, would result in significant cost savings to the Medicaid program and to society in general.

Sample States have also clarified the levels of care provided in the emergency room and established differential payment rates coinciding with these levels of care. This has enabled them to reduce expenditures on emergency room care, by paying for reduced needs at reduced levels. Differentiating levels of emergency room care has also led to the collection of better data for use in reviewing non-emergency use of the emergency room.

The programs/procedures discussed in this report to control the non-emergency use of emergency rooms demonstrate both the capacity to improve access to care and achieve savings in the Medicaid program. These savings can be redirected to other Medicaid expansions and existing programs to improve the quality of health care for Medicaid recipients. For these reasons the following recommendations are being made to the States and to HCFA.

## **Each State Should Develop A Comprehensive Initiative To Reduce Costly Non-Emergency Use Of Hospital Emergency Rooms. These Initiatives Could Address:**

- Increased use of managed care/pre-paid options to improve overall care access and quality.
- Community based access to after hours care.
- Increased reimbursements to physicians and clinics who see Medicaid recipients after hours.
- Defining different levels of emergency room care and providing corresponding tiered pricing and reimbursement levels.
- Triage payments to providers for screening patients not treated in the emergency room.

**The Health Care Financing Administration Should Encourage States To Develop Initiatives To Review And Reduce Non-Emergency Use Of Emergency Rooms By Medicaid Recipients And Should Assist States By:**

- Providing instructions on access and use of emergency room data in conducting annual reviews of emergency room utilization.
- Encouraging development of managed care/pre-paid programs and expediting the review of State applications for waivers to implement their managed care efforts and emergency room controls.
- Disseminating annual reports on effective practices for reducing non-emergency use of emergency rooms by Medicaid recipients.

## ENDNOTES

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1. Medicare and Medicaid Guide, #643, Commerce Clearing House February 7, 1991.
2. Testimony of Richard P. Kusserow, Inspector General, U.S. Department Of Health and Human Services, Before the Subcommittee on Oversight and Investigations Committee on Energy and Commerce on The Medicaid Program, June 20, 1991, pg. 1.
3. Gifford, Marilyn J., Franaszek, Jacek B., and Gibson Geoff, "Emergency Physicians' and Patients Assessments: Urgency of Need for Medical Care", Annals of Emergency Medicine, Vol 9, #10, October 1980 pp. 502-507.
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5. Dickhundert, John S., Gjerdingen, Dwenda K., and Asp, Donald S., "Emergency Room Use and Abuse, How It Varies With Payment Mechanism", Minnesota Medicine, Vol 70, October 1987, pp, 571-574.
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14. Freund, Deborah A., Rossiter, Louis F., Dox, Peter D., Meyer, Jack A., Hurlye, Robert R., Carey, Timothy S. and Paul, John E., "Evaluation of the Medicaid Competition Demonstration" Health Care Financing Review, vol 11, #2, Winter 1989, pp. 81-97.
15. Commerce Clearing House, 15,028, Section 36,627, 1987.
16. Commerce Clearing House, Section 14,625, p. 6314.
17. Omnibus Reconciliation Act of 1989, P.L. (101-239).
18. 42 U.S.C. section 1395dd. (1867 of the Social Security Act).
19. The numbers on which these figures are based exclude emergency room visits made by Medicaid recipients enrolled in HMO, pre-paid and community health center programs in the States of California, Michigan, Minnesota, Missouri, Pennsylvania, Utah and Wisconsin. Numbers representing the percent of non-emergency visits for the States of Kentucky, Utah and Wisconsin were obtained from the HCFA MSIS. This clarification also holds for information presented in Figure 1.
20. Due to the limited data, estimates could not be made for the entire sample.
21. Grannemann, Thomas W., Brown, Randall S. and Pauly, Mark V., "Estimating Hospital Costs: A Multiple Output Analysis," Journal of Health Economics, Vol 5, 1986, pp. 107-127.
22. Non-emergency use of the emergency room was brought to the attention of the States in a number of ways. Utilization Review, provider complaints and cost overruns were most frequently cited as means of discovering the problem. Seven of the nine States interviewed reported having data to support the extent to which emergency room use was a problem prior to program implementation. The sources of data were the Medicaid Management Information System (MMIS), Surveillance and Utilization Review Subsystem (SURS) program, Utilization Review, Exception Profiles, Target SURS Report, an emergency room study and a Legislative Audit Report. While data was available, it was frequently not reviewed by States on an ongoing basis. Rather, it was utilized as a tool to investigate the issue when it appeared to be a problem.

# APPENDIX A

## STATE SELECTION PROCESS

### FIRST PHASE

<b>INITIAL UNIVERSE OF STATES HAVING WAIVER, RESTRICTION, LOCK-IN OR STATEWIDE PROGRAM</b>		
AZ, AR, CA, CO, CT, FL, GA, ID, IL, IA, KS, KY, MD, MA, MI, MN, MS, MO, NB, NV, NJ, NM, NY, NC, OH, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WI		
<b>WAIVER PROGRAMS</b>	<b>EMERGENCY ROOM RESTRICTIONS</b>	<b>STATEWIDE PROGRAMS</b>
CA, CO, CT, FL, IL, IA, KS, KY, MD, MI, MN, MO, NV, NM, NY, NC, OH, OR, PA, TN, UT, WA, WI	AZ, AR, CA, GA, KY, MD, MI, MN, MS, MO, NM, NY, OH, PA, SC, SD, UT, VT, VA, WA, WI	AZ, AR, KY, MI
<b>STATES SELECTED IN 1ST ROUND: APPEARED IN AT LEAST TWO CATEGORIES</b>		
AZ, AR, CA, KY, MD, MI, MN, MO, NM, NY, OH, PA, UT, WA, WI		

### SECOND PHASE

<b>1ST ROUND STATES</b>	
AZ, AR, CA, KY, MD, MI, MN, MO, NM, NY, OH, PA, UT, WA, WI	
<b>MATURE PROGRAMS</b>	<b>REFERENCED PROGRAMS</b>
AR, CA, MI, MN, MO, NV, NY, NC, PA, UT, WI	CA, FL, IL, KY, MI, MN, MO, NY, PA, WI
<b>FIRST ROUND STATES APPEARING IN MATURE AND/OR REFERENCED PROGRAMS</b>	
<b>FINAL SAMPLE SELECTION: AR, CA, KY, MI, MN, MO, NY, PA, UT, WI</b>	

## APPENDIX B

### Average Charges And Reimbursements For Non-Emergency Care In The Emergency Room Compared To Alternative Care Sites

STATE	AVERAGE CHARGE PER SITE/RATIO BASED ON TOTAL NON-EMERGENCY CHARGE				
	PRIVATE M.D. IN COMMUNITY	COMMUNITY CLINIC	CURRENT M.D. MEDICAID PAYMENT	TOTAL EMERGENCY	TOTAL NON- EMERGENCY
AR	\$30.84/3.6	\$39.62/2.8	\$24.75/4.5	\$193.71/.57	\$111.47
CA*	\$50.92/3.2	\$36.75/4.4	\$18.40/8.7	\$287.71/.56	\$161.36
KY	\$60.40/2.7	\$46.52/3.5	\$17.77/9.0	\$161.46	\$161.46
MI	\$41.62/1.2		\$16.60/3.1	\$104.00***/.50	\$ 52.00***
MN	\$50.89	\$63.41/	\$20/00/		
MO	\$49.82/4.8	\$41.11/5.8	\$17.00/14.1	\$179.22/1.3	\$240.13**
PA	\$27.80/3.2	\$30.36/2.9	\$18.00/4.9	\$108.68***/.82	\$ 89.56***
UT	\$37.43/5.4	\$38.66/5.2	\$19.65/10.3	\$203.15	\$203.15
WI			\$16.88/		

STATE	AVERAGE CHARGE PER SITE/RATIO BASED ON PERCENT NON-EMERGENCY AMOUNT REIMBURSED				
	PRIVATE M.D. IN COMMUNITY	COMMUNITY CLINIC	CURRENT M.D. MEDICAID PAYMENT	PERCENT OF NON- EMERGENCY CHARGE REIMBURSED	AMOUNT OF TOTAL NON- EMERGENCY CHARGE REIMBURSED
AR	\$30.84/1.15	\$39.62/.90	\$24.75/1.4	32%	\$ 35.67
CA*	\$50.92/1.23	\$36.75/1.7	\$18.40/3.4	39%	\$ 62.93
KY	\$60.40/1.7	\$46.52/2.25	\$17.77/5.9	67%	\$104.94
MI	\$41.62/0.20		\$16.60/0.48	16%	\$ 8.12***
MN	\$50.89	\$63.41/	\$20.00/		
MO	\$49.82/2.45	\$41.11/2.97	\$17.00/7.2	51%	\$122.46**
PA	\$27.80/	\$30.36/	\$18.00/		
UT	\$37.43/2.9	\$38.66/2.8	\$19.65/5.6	54%	\$110.50
WI			\$16.88/		

\* -- Information based on 5 percent sample and includes all non-emergency and other care provided in the hospital outpatient emergency room and examination room

\*\* -- Based on all non-emergency care provided in either emergency room or outpatient hospital clinic, as of 1985 this figure included outpatient surgeries,

\*\*\*-- Based on emergency room facility fee only

# APPENDIX C

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## SAVINGS CALCULATIONS

### ASSUMPTIONS:

- Potential total savings to both the Medicaid Programs and society were estimated for Arkansas, California, Kentucky and Utah based on the following assumptions:
  1. Non-emergency visits to the emergency room could be reduced to the upper range of non-emergency visits for the general public, which includes Medicaid recipients, based on findings in the literature. The upper limits cited in the literature are 38 percent, which we rounded to 40 percent. Thus Medicaid non-emergency visits to the emergency room could be reduced to 40 percent of all Medicaid emergency room visits.
  2. Some patients originally seen in the emergency room as non-emergency care could be redirected to care in the community. Thus, a range of savings based on lower average charges for community physicians and clinics would be realized.
  3. To construct a more conservative model where Medicaid physicians are not reimbursed at the rate of their full charges, savings were also estimated based on the highest Medicaid physician reimbursement rate among the four States (\$24.75 per Physician Payment Review Commission 1991 Annual Report to Congress). This rate would be a more realistic reimbursement fee for redirected Medicaid recipients.
  4. Non-emergency visits are reimbursed at a percentage of actual charges. The average amount reimbursed for these charges would represent the amount spent by the Medicaid program on non-emergency care in the emergency room. Savings would result from calculating the difference between these charges for the number of patients redirected and average charges for their care in the community.
  5. Savings to society might also be generated from diverting non-emergency cases from the emergency room. These savings were calculated based on the difference between the amount charged by the emergency room and the amount reimbursed by the Medicaid program for the non-emergency care provided. It is reasonable to consider this as a possible savings to society based on the reality that low levels of care provided in the emergency room still incur high costs due to the expense of the setting and the greater number of procedures performed. The costs associated with these items must be accounted for, as they are not diminished simply by distinguishing between levels of care.

● **Medicaid Program Savings Calculations Formula**

1. 
$$\frac{\# \text{ True Emergency Visits Reported From State}}{.60} = \# \text{ New Total Emergency Visits With Non-Emergencies Equaling 40\%}$$
2. 
$$\# \text{ New Total ER Visits} - \# \text{ Reported True Emergency Visits} = \# \text{ New Non-Emergency Visits}$$
3. 
$$\# \text{ Non-Emergency Visits Reported} - \# \text{ New Non-Emergency Visits} = \# \text{ Visits Reduced by Redirecting All But 40\% of Non-Emergency Visits to Alternative Sites}$$
4. 
$$\# \text{ Visits Reduced} \times (\text{Avg Non-ER Charge Reimbursed} - \text{Avg Community M.D. Charge}) = \text{State Savings Obtained by Redirecting Visits to Community M.D.}$$
5. Repeat using average clinic charge, obtain State savings by redirecting visits to community clinics
6. Repeat using high Medicaid reimbursement for sample States (\$24.75), obtain State savings by paying a more conservative rate for visits directed to community M.D. or clinics
7. Add the four State savings from redirecting visits to community M.D. to obtain total low range savings figure
8. Add the four State savings from redirecting visits to community clinic to obtain total high range savings figure
9. Add the four State savings from redirecting visits to community M.D. or clinic and paying conservative payment rate to obtain total conservative savings figure

● ***Example of Savings Calculations for the State of Kentucky  
Based on State and MSIS Data for 1990.***

1. 
$$\frac{52,565}{.60} = 87,608$$
2. 
$$87,608 - 52,565 = 35,043$$
3. 
$$166,455 - 35,043 = 131,412$$
4. 
$$131,412 \times (\$104.94 - \$60.40) = \$5,853,090$$
5. 
$$131,412 \times (\$104.94 - \$46.52) = \$7,677,089$$
6. 
$$131,412 \times (\$104.94 - \$24.75) = \$10,537,928$$

● **Societal Savings Formula**

1. 
$$\frac{\text{Average Non-Emergency Charge}}{\text{Average Non-Emergency Reimbursement}} = \text{Savings to Society Per Case from Not Treating In the ER}$$
2. 
$$\text{Savings to Society Per Case} \times \# \text{ Redirected Non-Emergency Cases for State} = \text{State Savings to Society from Not Treating in the ER}$$
3. Add the four State savings to society to obtain total savings to society from not providing treatment in the emergency room

● ***Example of Societal Savings Calculation for the State of Kentucky  
Based on State and MSIS Data for 1990***

1. 
$$\$161.46 - \$104.94 = \$56.52$$
2. 
$$\$56.52 \times 131,412 = \$7,427,406$$

# APPENDIX D

Program/ Procedure	STATES IN SAMPLE								
	AR	CA	KY	MI	MN	MO	PA	UT	WI
Managed Care (Voluntary and Waiver)		D/I 1973 Voluntary and Waiver,	D/I 1986- Waiver,		D/I, 1985, waiver and voluntary D/I, 1989	D/I 1986 fully operating, Waiver	D/I 1976, voluntary	D/I 1983 fully operating, voluntary and waiver	D/I 1986 fully operating, voluntary and waiver,
Co-Pay		D/I 1981 (voluntary)				D/I 1988	D/N 1984	D/I/T 1982-82	
ER Claims Review and/or Denial	D/I 1984			D/I/A 1982/ A 1989	(part of 1989 M.C.)				
Pre-Paid Health Plans (Health Insuring Organization, Community Health Center)		(D/I part of M.C.)	D/I/T 1983-84 Waiver,				D/I, 1986 fully operating waiver D/I, 1988 fully operating voluntary		
Lock-In						D/I, 1990			
ER Visit Limit						D/N 1982			
Payment Differential					D/I, 1989		D/I 1985	D/I 1990	
Other (Nurse Phone Line)					D/I 1991				
Additional Innovations	STATE RESPONSE								
Triage			developing	included in ER review/ denial	part of ER review & payment differential			part of payment differential	
Coding Differentiating Levels of Care	ER and Non-ER	ER and Non-ER (examination)	ER and Urgent	ER, and Urgent	ER, Urgent and clinic	ER and Non-ER (outpatient)	ER and Non-ER	ER and Triage	ER and Urgent
Differential Payment for Levels of Care	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Do Not Know

D= Developed I= Implemented

N= Never Implemented

T= Terminated

A= Altered

## PROGRAM DEFINITIONS

1. **Managed Care** Health care provided under the direction of an individual or group, requiring recipients to obtain referrals for specialists, the emergency room or hospital care from their primary care physician. Generally, a monthly management fee will be paid to the case manager, whether the recipient receives care during the month or not. Managed care may be provided by HMO's, private physicians, or clinics.
2. **Co-payment** Payment of a minimal fee by the individual receiving care for non-emergency care provided in the emergency room.
3. **Emergency Room Claims Review** Review of emergency room claims marked "Emergency" to determine if the care provided was truly an emergency condition. All claims marked "Emergency" may be reviewed or only claims not meeting specific emergency criteria. If the claim is determined to be for non-emergency care, payment may either be denied, reduced, or reimbursed at a triage fee level.
4. **Pre-paid Health Plans** Form of pre-paid health plan, other than an HMO, providing care to Medicaid recipients. These plans do not receive a monthly management fee for recipients. For the purposes of this study this includes Health Insuring Organizations and Community Health Centers.
5. **Lock-in** Medicaid recipients identified as overutilizers of emergency rooms for non-emergency purposes are required to receive care from only one physician or health plan. Assignment may be made by the Agency, or the recipient may be allowed to select a health care provider.
6. **Emergency Room Visit Limit** Medicaid recipients will be allowed to make only a specified number of reimbursed non-emergency visits to the emergency room each month. After the specified number is reached, all visits to the emergency room will be reviewed. If care provided is for a non-emergency, the recipient will be responsible for payment.
7. **Payment Differentiation** Care provided in the emergency room is differentiated by levels of severity. Payment for the care is billed at different rates according to the level of severity. Triage fees may also be included as a level in order to reimburse the hospital for assessing the condition of the patient.
8. **Other (Nurse Line)** A 24 hour phone staffed by a nurse to provide information to Medicaid recipients. The service involves determining the nature of the health problem and providing information regarding the nearest facility that can provide treatment at the most appropriate level of care.

# APPENDIX E

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## STATE CONTACTS FOR FURTHER INFORMATION

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Arkansas Division of Economic and Medical Services  
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# APPENDIX F

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## *SUMMARY OF HCFA'S COMMENTS TO SPECIFIC RECOMMENDATIONS AND OIG'S RESPONSE\**

### SUMMARY: RECOMMENDATION 1

Each State should develop a comprehensive initiative to reduce costly non-emergency use of hospital emergency rooms (ERs). These initiatives should address:

- Increased use of managed care options to improve overall care access and quality;
- Community based access to after-hours care;
- Increased reimbursements to physicians and clinics who see Medicaid recipients after hours;
- Defining different levels of ER care and providing corresponding tiered pricing and reimbursement levels; and
- Triage payments to providers for screening patients not treated in the ER.

#### HCFA Comments

The HCFA concurs with the parts of the recommendations that address increased use of managed care options. They believe that the President's Comprehensive Health Reform Program will go well beyond the components of this recommendation. They also state that they will encourage States to develop initiatives to reduce non-emergency use. The HCFA however, does not believe that the remaining components of the recommendation are necessary, due to the proposed health initiative. While they state triage fees are an effective method of ensuring that States do not pay for the provision of non-emergency services at ER rates, they feel there is no need for this or the creation of definitions for levels of ER care when a comprehensive coordinated care system in Medicaid is put in place.

#### OIG Response

The use of a comprehensive coordinated care system by Medicaid, which includes case management, is an excellent proposal for providing access to care and discouraging use of the emergency room for non-emergency care. Nevertheless, the OIG believes the remaining components of the recommendation suggesting definitions of levels of ER care, corresponding tiered payment rates, use of triage fees, and increased payments for after hours care would not only complement successful implementation of the proposed initiative, but yield

continuing benefits until and after it is in place. As the President's proposal has yet to be enacted, and even when enacted will experience a lag time between passage and implementation, these suggestions will help States initiate and maintain a decrease in non-emergency use of the emergency room.

While there is some evidence that various types of managed care programs help in reducing non-emergency use, the change has been achieved very slowly and requires continued efforts over time to significantly reduce the visits. Most of our sample States who have achieved such reductions employ comprehensive control programs that in addition to managed care approaches also include differentiated payment rates, definitions of levels of emergency care and/or triage fees. Finally, because the use of emergency rooms for non-emergency care is a complex issue, even States that have used such comprehensive programs continue to have difficulty controlling non-emergency use. Without some way of determining the level of care provided in the emergency room, either through defining levels of care, or using triage to determine level of care required, the fundamental difficulty of determining whether non-emergency visits are a continuing problem will remain. This inspection found that without adequate data, the true extent of the problem is difficult to measure. Therefore, OIG continues to recommend that States consider development of definitions of levels of care provided in the emergency room, differentiated payment rates for care provided, and triage fees when developing initiatives to control emergency room use.

## SUMMARY: RECOMMENDATION 2

HCFA should require States to develop initiatives to review and reduce non-emergency use of emergency rooms by Medicaid recipients and should assist States by:

- Providing instructions on access and use of emergency room data in conducting annual reviews of emergency room utilization.
- Encouraging development of managed care programs and expediting the review of State applications for waivers to implement their managed care efforts and emergency room controls; and
- Disseminating annual reports on effective practices for reducing non-emergency use of emergency rooms by Medicaid recipients.

### HCFA Comments

The HCFA concurs with the part of this recommendation that encourages the development of managed care options and expediting the application process for State waivers. Once again, they cite the President's health care proposal, which will require States to adopt coordinated care plans for all Medicaid beneficiaries, as being in agreement with our call for the use of managed care. Additionally, they state they have developed a streamlined Waiver

Application, which was released in November 1991, to expedite the review of State waiver applications. The HCFA does not agree with the section of the recommendation to provide instructions to the States on access and use of emergency room data for annual review. They believe that extensive research would be required to effectively provide specific instructions on access and use of ER data in conducting annual reviews of ER utilization. Finally, the HCFA believes the final part of the recommendation, regarding disseminating annual reports on effective practices for reducing non-emergency use, should be addressed by drawing on the experience of States in controlling emergency room use in encouraging other States to implement similar measures.

### OIG Response

The OIG appreciates the autonomy of the State Medicaid programs, and understands the need to encourage rather than require certain program activities. Based on this, the word "require" will be changed to "encourage" in this recommendation. The OIG continues to believe the provision of instructions on access and use of emergency room data for conducting annual reviews of utilization are important. Based on the findings of this inspection, it appears some States have collected data on emergency room utilization, but do not access it on a regular basis. We do not agree that extensive and expensive research would be required in order for HCFA to issue some general guidance regarding the need for collection and annual review of emergency room use data. This action would have the benefit of periodically and systematically focusing State attention on this important information. The OIG believes this guidance would lead to a more in-depth understanding of the problem of emergency room utilization and result in better plans of action for addressing the issue. The HCFA response to the final part of our recommendation expresses the intent of the OIG on the dissemination of information to the States on effective practices for reducing non-emergency use of the emergency room.

TECHNICAL COMMENTS
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### HCFA Comments

The HCFA made technical comments questioning our assumptions and methods for calculating the program and societal savings estimates. The HCFA feels the savings to society, representing the difference in the charges billed to Medicaid and those reimbursed by Medicaid for non-emergency care, would be included in the savings to the program previously calculated. They state that the difference between the average charge and the Medicaid payment would never be realized by the hospital. Furthermore, they stated that the average charge may not be paid by any third party payer, therefore the societal savings would be included in the previous savings calculation.

*\*(The full text of the HCFA comments are contained in Appendix G.)*

### OIG Response

In the text we stated that our estimates were based on the assumption that "...the reported Medicaid non-emergency visits could have been reduced to 40 percent". It appears HCFA misunderstood the meaning of this assumption and thus our method for obtaining the number of emergency room visits that could be reduced along with the resultant savings. This assumption was clarified on page six to indicate that the number of non-emergency visits to the emergency room "could be reduced to 40% of all Medicaid emergency room visits". Furthermore, in developing our estimates it is important to note that the savings calculations were based on four States data, although we used only one in Appendix C as an illustration. We continued to use this method for estimating savings.

Regarding the HCFA comments on the savings to society calculation, the OIG continues to believe that additional savings to society would occur. These savings would be beyond those accruing to the Medicaid program if Medicaid patients were redirected to more appropriate community settings. Savings would be in the form of averting cost shifts to other segments of society since Medicaid reimbursement is lower than actual costs of providing care. Because of the high overhead associated with operating an emergency room (equipment, physicians, etc.), it is more expensive to treat a non-urgent problem in the emergency room than in a community setting. To the extent that such legitimate costs of providing care are not reimbursed by Medicaid, they are shifted to other payers. Our approach to calculating these savings, which we have further clarified on page six, represents a rough estimate of the extent of savings accruing from avoidance of cost-shifting.

### *SUMMARY OF PHS' COMMENTS TO RECOMMENDATIONS AND OIG'S RESPONSE*

<b>GENERAL COMMENTS</b>
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#### ***PHS Comments***

The PHS acknowledged the relevance of the general findings that (1) lack of access to primary care is a major cause of non-emergency use of the emergency room and (2) access to alternate care is an important component in developing effective control of emergency room use. However, they felt more discussion of problems facing Medicaid recipients in gaining access to more appropriate care would have been helpful. Since none of the recommendations were directed to PHS, they did not comment on them. They did, however, provide several general comments. Three of the comments relate to definitions and methodology. The definitional concerns pertained to the word "inappropriate" when referring to emergency room use. The methodological problem concerned combining reports across States, since it was not clear that a uniform definition of emergency was used by all sample States. Additional comments suggested greater discussion of access and quality problems that might arise when redirecting care from the emergency room. (The full text of the PHS comments are contained in Appendix G.)

***OIG Response***

The PHS comments were considered and resulted in clarifications within the report. With regard to access to alternate care, we agree that this is an important issue warranting continued study. However, this is a broad subject and beyond the scope of this inspection. We agree that it is difficult to define the appropriateness of emergency room visits. However, the focus of this inspection was narrower, examining only non-emergency care. Hence, we changed the word "inappropriate" to "non-emergency" in the few places it was used in this report. To address the methodological issue regarding a uniform definition of "emergency", a clarification was made on page nine. The clarification indicates that while definitions for the term "emergency" are very similar, terms used to classify other types of care provided in the emergency room differ.

# APPENDIX G

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***AGENCY COMMENTS:  
HEALTH CARE FINANCING ADMINISTRATION AND PUBLIC HEALTH SERVICE***



*Margaret A. Brown*

**Memorandum**

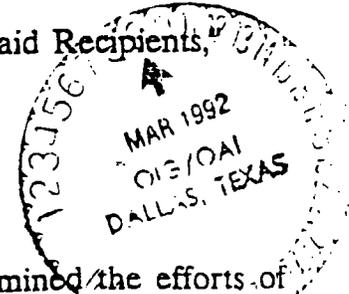
MAR 2 1992

Date

From Gail R. Wilensky, Ph.D. *grw*  
Administrator

Subject OIG Draft Report: "Use of Emergency Rooms by Medicaid Recipients,"  
OEI-06-90-00180

To Inspector General  
Office of the Secretary



We have reviewed the subject draft report which examined the efforts of nine States to control non-emergency use of emergency rooms (ERs) by Medicaid recipients. States have tried to control ER usage to help control escalating program costs.

OIG found that one-half to two-thirds of Medicaid ER visits are non-emergency in nature. OIG estimated that total savings of up to \$39.9 million in four of the sampled States could be achieved if non-emergency room usage was reduced to 40 percent of all Medicaid ER visits. OIG recommends that States should develop a comprehensive initiative to reduce costly non-emergency use of hospital ERs. HCFA agrees in part with OIG's recommendation.

The OIG also recommends that HCFA should require States to develop initiatives to review and reduce non-emergency use of ERs by Medicaid recipients, and assist States by (1) providing instructions for review of ER usage, (2) encouraging the development of managed care programs, and (3) providing annual reports to States on effective practices for reducing non-emergency use of ERs by Medicaid recipients. HCFA agrees in part with this recommendation. Our specific comments on both recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

- IG
- PDIG
- DIG-AS
- DIG-EI
- DIG-OI
- AIG-MP
- OGC/IG
- EX SEC
- DATE SENT 3/2

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RECEIVED  
OFFICE OF INSPECTOR GENERAL

Comments of the Health Care Financing Administration  
(HCFA) on the OIG Draft Report: "Use  
of Emergency Rooms by Medicaid Recipients."  
OEI-06-90-00180

Recommendation 1:

Each State should develop a comprehensive initiative to reduce costly non-emergency use of hospital emergency rooms (ERs). These initiatives should address:

- o Increased use of managed care options to improve overall care access and quality;
- o Community based access to after-hours care;
- o Increased reimbursements to physicians and clinics who see Medicaid recipients after hours;
- o Defining different levels of ER care and providing corresponding tiered pricing and reimbursement levels; and
- o Triage payments to providers for screening patients not treated in the ER.

HCFA Response

In his Comprehensive Health Reform Program, the President goes well beyond this recommendation by proposing an increased use of coordinated care options within Medicaid to improve access to high quality care. Under the President's proposal, States would be required to enroll all Medicaid recipients in coordinated care plans or receive a waiver to offer the traditional fee-for-service system. This proposal is consistent with the Administration's goals of improving health outcomes and quality assurance through coordinated care and reducing costs.

HCFA believes that State-wide adoption of coordinated care plans for all Medicaid recipients would substantially reduce the non-emergency use of hospital emergency rooms (ERs) that is outlined in your report. For example, under the coordinated care "case management" approach, patients are assigned a primary physician who guides them through the health care system and provides them with 24 hour access by phone if not in person. A number of States already pay primary care physicians an additional monthly fee for this service which reduces need for community based access to after-hours care.

We agree that initiatives such as triage fees are an effective method of ensuring that States do not pay for the provision of non-emergency services at ER rates. However, with a comprehensive coordinated care system within Medicaid, there is no need to mandate that States provide triage payments to physicians in the ERs or to define different levels of ER care.

The increased use of coordinated care would incorporate these and other cost-effective access oriented principles into a continuum of care system that will alleviate many of the problems associated with high rates of inappropriate use of ERs among Medicaid recipients, such as the use of triage fees. In any case, HCFA will still encourage States to develop initiatives to reduce non-emergency ER use. We do not agree that States should be mandated to adopt the specific approaches outlined in the OIG report. Each State's Medicaid program is unique and tailored to that State's needs and resources. It would be inappropriate to require all States to have identical approaches to address the problem of inappropriate ER use.

### Recommendation 2

HCFA should require States to develop initiatives to review and reduce non-emergency use of emergency rooms by Medicaid recipients and should assist States by:

- o Providing instructions on access and use of emergency room data in conducting annual reviews of emergency room utilization;
- o Encouraging development of managed care programs and expediting the review of State applications for waivers to implement their managed care efforts and emergency room controls; and
- o Disseminating annual reports on effective practices for reducing non-emergency use of emergency rooms by Medicaid recipients.

### HCFA Response

HCFA agrees in part with this recommendation because, as stated above, under the President's proposal for health care reform, HCFA will require States to adopt State-wide coordinated care plans for all Medicaid beneficiaries. Additionally, we will encourage States to develop initiatives to reduce non-emergency use of ERs by Medicaid recipients. However, as we stated in our comments to the previous recommendation, we believe it would be inappropriate for HCFA to "mandate" that States develop these initiatives.

HCFA has and will continue to provide States with technical assistance to develop initiatives that will be suitable for their State Medicaid programs. However, we believe that it would be necessary for HCFA and the States to conduct extensive research to effectively provide specific instructions on access and use of ER data in conducting annual reviews of ER utilization. This is not practical within current Federal and State budgetary limitations.

Under the President's proposal for health care reform, HCFA will require development of coordinated care programs. Until that time, HCFA will continue to expedite the review of State applications for waivers to implement their coordinated care efforts and ER controls. We have developed a streamlined Waiver Application for this purpose which was released in November 1991.

In regards to the last part of the recommendation, there are indications in the report that many States are aware of the overuse of ER services and have taken steps to curb the situation by developing programs and procedures to redirect Medicaid recipients and others seeking care to more appropriate and less costly settings. We believe that we should draw on the experience of these States in encouraging other States to implement similar measures.

The OIG report is a strong endorsement for the increased use of coordinated care programs. This approach appears to best deal with the basic problem which is the lack of access to primary care during and after office hours. We believe that the President's proposal requiring an increased use of coordinated care should be HCFA's primary thrust for relieving the use of ERs for non-emergency purposes and providing access to care in the appropriate setting. The President's proposal also addresses the issue of inappropriate use of ERs by the non-Medicaid eligible poor. Under the proposal, if a hospital emergency room is an uninsured tax credit-eligible individual's first point of contact with the health care system, that individual would immediately be enrolled in a health plan. The individual would then have a medical home and would no longer need to rely on the ER for basic health care.

#### Technical Comments

The savings estimate appears to be overstated due to OIG's assumptions and the methodology employed. It would seem that a more reasonable and accurate methodology would be to reduce the total number of reported non-emergency visits (166,455) by 60 percent, or 99,873 visits. These visits would then be multiplied by the difference between the average payment (\$104.94) for all services provided in an ER setting and the average payment made to physicians, community health centers, or by Medicaid for non-emergency services. Using this methodology and the categories of payment specified in Appendix B of the report, the savings estimate would range from \$4,448,343 to \$8,008,816.

When calculating the societal savings, OIG should have considered that the average charge of \$161.46 is never paid by Medicaid. Therefore, the difference between that charge and the Medicaid payment of \$104.94 would never be realized by the hospital. In fact, the average charge may not be paid by any third party payer. Consequently, the societal savings are already calculated in the range provided above.

We also question how the savings of \$39.9 million and \$83.5 million were derived. We are requesting that OIG explain this more thoroughly in the final report.



DEPARTMENT OF HEALTH & HUMAN SERVICES

manyama / 10/05  
Public Health Service  
Region VI

Memorandum

Date • DEC 17 1991

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "Use of  
Emergency Rooms by Medicaid Recipients"

To Inspector General, OS

Attached are the Public Health Service's (PHS) comments on the subject OIG draft report. Although there were no recommendations directed to PHS, we offer general comments and suggestions for your consideration.

*James O. Mason*  
James O. Mason, M.D., Dr.P.H.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR  
GENERAL (OIG) DRAFT REPORT "USE OF EMERGENCY ROOMS BY MEDICAID  
RECIPIENTS," OEI-06-90-00180, OCTOBER 1991

This report describes programs or procedures developed by nine States to control the non-emergency use of emergency rooms by Medicaid recipients. Although there are no recommendations directed to PHS, we offer the following general comments for your consideration.

General Comments

As noted in the report, the major cause for inappropriate usage of emergency rooms by Medicaid recipients is a lack of access to primary and preventive health care services for Medicaid covered patients. For over 25 years, the community and migrant health centers programs (which currently provide care to over 6 million persons from medically underserved areas) have helped provide access to primary care services. When present in a community, these centers have been responsible for reducing usage of emergency rooms for non-emergency care.

The report addresses a complex set of issues involving questions of access to and costs of care for populations with multiple social, economic, and medical problems. We do not disagree with the goal of redirecting Medicaid beneficiaries from emergency rooms to alternate care sites. We believe, however, that the report does not adequately address the range of problems inherent in assuring access to appropriate emergency care for Medicaid beneficiaries. Following are comments, questions and suggestions which we believe could enhance the usefulness of the report.

- o Inappropriate use of emergency rooms should be clearly defined.

The report focuses on the identification of inappropriate use of emergency rooms, but does not present a clear definition of inappropriate (or appropriate) use. Also, since it is not clear that the definitions used by the States included in this study are uniform, combining the reports across States is methodologically questionable. Also, terms like "misuse" and "inappropriate use" do not describe the frustration and concern from the patient's perspective.

- o Additional discussion of the factors that may lead Medicaid recipients to use emergency rooms inappropriately would be useful.

Medicaid patients may have difficulty finding community physicians who will treat them, particularly outside of

regular office hours. Lack of adequate resources may lead to delays in the treatment of patients with acute, usually self-limiting conditions such as sore throats or urinary tract infections, which in turn lead patients to seek care elsewhere. Fear of malpractice may lead some providers to direct Medicaid patients to emergency rooms. Even managed care programs that are supposed to have 24-hour coverage may not always provide easily accessible options to patients who believe they are having a medical emergency.

- o It would be useful if additional questions about what really is inappropriate emergency room care were addressed.

For example, many past studies of emergency versus non-emergency care were based on diagnosis rather than the presenting condition. A chest pain is often not a genuine condition. But to define it as inappropriate based upon a screening which rules out myocardial infarction is spurious.

The critical feature of a true emergency is the importance of the time factor. When a small number of life-threatening conditions end up being delayed in getting appropriate care, this also constitutes a system error. The National Heart Attack Awareness Program has established a subcommittee on access to care; this group is concerned about barriers to appropriate access to emergency room care that might be posed by managed care systems.

- o It would be useful for the report to consider the effects of diverting people from the emergency room on: (1) health outcomes, and (2) the extent to which access to appropriate care was achieved.

For example, do the controls (proposed or otherwise) result in less care - such as denial of services, or more appropriate care - patients actually receiving the care that was needed.

- o It would be useful to have a discussion on the use of the savings achieved.

For example, would the savings to the Medicaid program be used to build an effective system of primary care?