2003 Joint Committee on Audit

ER Services by Medical Assistance Recipients

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State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

January 30, 2004

FEB 02 2004

The Honorable Carol Roessler, Co-chairperson
Joint Legislative Committee on Audit
Wisconsin Senate
Room 8 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882

The Honorable Suzanne Jeskewitz, Co-chairperson
Joint Legislative Committee on Audit
Wisconsin Assembly
Room 314 North, State Capitol
P.O. Box 8952
Madison, WI 53708-8952

Dear Senator Roessler and Representative Jeskewitz:

On behalf of the Department of Health and Family Services (DHFS), I would like to extend our thanks to you and the Legislative Audit Bureau (LAB) for your review of Medicaid recipient utilization of emergency department hospital services.

As the LAB report indicates, DHFS continues its collaborative work with Medicaid providers, including HMOs and hospitals, to create cost-effective, non-regulatory steps to ensure efficient delivery of acute and sub-acute hospital care. We believe the report also outlines recipient utilization data that merits additional clinical analysis by DHFS.

In particular, we are concerned with the small number of recipients that utilize hospital emergency rooms on a frequent basis. According to the LAB report (Table 9 and Table 14), the actual number of recipients with 25 or more ER visits is equal to less than one-half of one percent of recipients that received ER services in state fiscal year 2001-02. Medicaid's quality assurance and care management will examine these patients' histories more closely and assess potential models to address the complex medical and social service needs of these 'high utilization' recipients. Based on our initial reviews, these patients most often suffer from multiple acute and chronic health conditions and are very difficult to manage.

Clearly, the report reflects the commitment by Wisconsin hospitals, physicians, physician assistants and nurses in emergency departments to provide essential medical services to Medicaid and BadgerCare recipients. Perhaps most striking, the LAB data indicates that despite

increased caseloads, the recipient utilization rate of emergency department services in the Medicaid program remained virtually unchanged at approximately 22 percent (see report, Table 6), during the five-year period reviewed by the LAB. While you may have heard from doctors and hospitals that Medicaid ER use is increasing, the LAB report clearly shows that this is primarily due to increases in recipient caseload.

Similarly, Medicaid fee-for-service expenditures for emergency medical services have not increased relative to total Medicaid spending for outpatient hospital services, and remains approximately 30 percent of outpatient hospital payments. Additionally, spending for hospital emergency department and related professional services is not a factor in the recent Legislative Fiscal Bureau expenditure forecast for Medical Assistance.

Thank you, again, for your interest. Please do not hesitate to contact me if you would like to discuss these issues in greater detail.

Sincerely,

Helene Nelson
Secretary

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January 30, 2004

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

At your request, we have compiled information on the use of hospital emergency department services by Medical Assistance recipients.

The Department of Health and Family Services (DHFS) administers the Medical Assistance program, through which health care services are provided to low-income individuals through fee-for-service plans or managed care providers. From fiscal year (FY) 1997-98 through FY 2001-02, the State paid fee-for-service providers an average of $20.1 million annually for emergency department services that did not result in an inpatient stay. Expenditure information for emergency department visits that resulted in inpatient hospital stays and for visits made by those enrolled in managed care plans was not available.

From FY 2000-01 to FY 2001-02, the number of fee-for-service Medical Assistance recipients visiting emergency departments increased by 9.2 percent and totaled 106,126 in FY 2001-02. For those covered by managed care providers, the increase was 23.9 percent and totaled 110,669 in FY 2001-02. These increases are primarily the result of an increase in the number of Medical Assistance recipients. Approximately one quarter of Medical Assistance recipients visited an emergency department in FY 2001-02; however, a fairly small number accounted for a substantial percentage of total visits. For example, 5.5 percent of fee-for-service recipients sought emergency department care six or more times in FY 2001-02, but they accounted for 27.0 percent of all visits.

DHFS, hospitals, and managed care providers are taking steps to study and reduce the number of visits to emergency departments for minor injuries and illnesses. Existing steps include the use of fees charged to patients and the creation of "minor ERs" co-located with hospital emergency departments.

I hope you find this information useful. Please contact me if you have additional questions.

Sincerely,

Janice Mueller

Janice Mueller
State Auditor

JM/PS/bm

USE OF EMERGENCY DEPARTMENT SERVICES BY MEDICAL ASSISTANCE RECIPIENTS

Federal law requires nearly all hospitals with emergency departments to perform a medical examination on all patients to determine if an emergency medical condition exists, regardless of a patient's ability to pay. Emergency department services are a covered service under the Medical Assistance program, which was established by Congress in 1965 to fund health care services for certain groups of low-income individuals. In Wisconsin, the Medical Assistance program is administered by the Department of Health and Family Services (DHFS). The program is supported with state and federal funds; Wisconsin funds approximately 38.5 percent of the total cost of medical services. In fiscal year (FY) 2001-02, a total of $3.6 billion in state and federal funds was spent on Medical Assistance benefits.

Some legislators and public health officials have expressed concern about the increasing use of emergency departments by Medical Assistance recipients and the cost of treating patients. At the request of the co-chairs of the Joint Legislative Audit Committee, we reviewed:

- trends in the number of Medical Assistance recipients visiting emergency departments;
- expenditures for emergency department services;
- trends in emergency department care rendered by fee-for-service and managed care providers, and;
- characteristics of the most frequent users of emergency department services.

In conducting our review, we analyzed data for all 969,000 emergency department visits made by Medical Assistance recipients from FY 1997-98 through FY 2001-02 that were paid for on a fee-for-service basis. We also analyzed data related to 356,000 emergency department visits that were paid for by health maintenance organizations (HMOs) during FYs 2000-01 and 2001-02, the only years for which complete data were available. In addition, we attended meetings of a DHFS work group focused on Medical Assistance recipients' use of emergency department services, spoke with emergency department medical providers and organizations representing the interests of emergency department and managed care providers, and observed the operation of a hospital emergency department. It should be noted that our review did not include an analysis of the medical necessity of the services provided.

Trends in Medical Assistance Enrollment

The Wisconsin Medical Assistance program provides health care services for several low-income groups who meet other qualifying criteria:

- individuals receiving Supplemental Security Income (SSI) as a result of age, blindness, or disability;

- pregnant women; and

- children under the age of 19 and their parents or caretaker relatives.

Enrollment in Wisconsin's Medical Assistance program increased 31.5 percent in the five-year period shown in Table 1, from 539,477 individuals in FY 1997-98 to 709,442 individuals in FY 2001-02. The largest annual enrollment increase followed the introduction of BadgerCare, Wisconsin's health insurance program for low-income working families, in July 1999.

Table 1

Enrollment in Wisconsin's Medical Assistance Program

Fiscal Year	Enrollment[1]	Percentage Change
1997-98	539,477	—
1998-99	526,819	(2.3)%
1999-2000	594,645	12.9
2000-01	648,572	9.1
2001-02	709,442	9.4

[1] Represents total Medical Assistance enrollment at any time during the fiscal year.

Medical Assistance recipients receive health care services from providers in one of two ways:

- through a fee-for-service arrangement under which health care providers are paid either a per diem rate or an established rate for each procedure or service they perform; or

- through a managed care arrangement under which HMOs are paid a set rate to provide all care recipients may require over an agreed-upon period.

DHFS officials indicate that the use of managed care encourages providers to practice preventative medicine in an effort to reduce costs associated with chronic illness and preventable disease.

The amount the State pays HMOs is based on monthly Medical Assistance enrollments for each HMO. Fee-for-service reimbursement rates are established directly by DHFS in accordance with amounts appropriated by the Legislature, and DHFS negotiates an annual contract that provides for monthly capitation payments to HMOs for Medical Assistance recipients enrolled in managed care plans. In FY 2001-02, approximately half of Medical Assistance recipients were enrolled in HMOs, and total payments to HMOs were $450.2 million.

Whether Medical Assistance recipients are served by fee-for-service providers or an HMO depends on several factors, including their county of residence and the basis on which they qualify for the Medical Assistance program, such as whether they are elderly, disabled, or have dependent children. In general, nondisabled parents and their dependent children receive services through HMOs unless they reside in an area that is not served by a participating HMO. In contrast, elderly, blind, and disabled Medical Assistance recipients typically receive services on a fee-for-service basis. Overall, 41.7 percent of recipients served by fee-for-service providers were eligible for Medical Assistance because they were elderly, blind, or disabled.

In general, managed care recipients are required to receive treatment from their HMO's member physicians and hospitals. In FY 2001-02, DHFS contracted with 13 HMOs to provide managed health care services to Medical Assistance recipients in 68 counties.

As shown in Table 2, managed care enrollment has increased faster than fee-for-service enrollment, growing by 40.1 percent from FY 1997-98 to FY 2001-02, compared to 24.8 percent for fee-for-service enrollment. Both groups experienced the greatest growth from FY 1998-99 to FY 1999-2000.

Table 2

Medical Assistance Enrollment by Service Type[1]

	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	Percentage Change
Fee-for-Service	380,154	364,174	470,055	459,924	474,564	24.8%
Managed Care	295,132	285,009	325,916	363,613	413,506	40.1

[1] The number of recipients does not equal the total Medical Assistance enrollment shown in Table 1 because some of the same recipients were served under both fee-for-service and managed care arrangements within a given year.

We were unable to determine the total cost of Medical Assistance services that are associated with care provided through hospitals' emergency departments because:

- fee-for-service costs for emergency department visits that resulted in hospital stays cannot be isolated from inpatient costs; and
- payments HMOs make to hospitals for emergency department services are proprietary and were unavailable for our review.

We analyzed the best available data in an effort to provide basic information on expenditures for emergency department services. In order to identify trends in usage, we analyzed all visits, including those resulting in a hospital admission. It should be noted that medical professionals

with whom we spoke cautioned that the appropriateness of any visit is difficult to evaluate without a comprehensive review of the individual's medical chart.

Medical Assistance Expenditures for Emergency Department Services

Fee-for-service payments for emergency professional services and for hospital services that did not result in an inpatient stay increased 47.3 percent in the five-year period we reviewed. As shown in Table 3, these payments totaled $25.0 million in FY 2001-02, compared to $17.0 million in FY 1997-98. Overall, they averaged $20.1 million annually. During the period shown, payments to hospitals accounted for 84.9 percent of the $100.3 million in total payments for emergency department services.

Table 3

Fee-for-Service Payments for Emergency Department Services

Fiscal Year	Payments to Medical Professionals[1]	Payments to Hospitals[2]	Total	Percentage Change
1997-98	$ 2,660,565	$14,321,465	$ 16,982,030	
1998-99	2,484,244	14,474,710	16,958,954	(0.1)%
1999-2000	2,894,626	17,370,952	20,265,578	19.5
2000-01	3,216,949	17,856,326	21,073,275	4.0
2001-02	3,841,354	21,177,270	25,018,624	18.7
Total	**$15,097,738**	**$85,200,723**	**$100,298,461**	

[1] Includes medical doctors, physician assistants, doctors of osteopathy, and nurse practitioners.

[2] Excludes charges for emergency department visits that resulted in an admission, because those costs cannot be isolated from inpatient costs. Ambulance and pharmacy charges that may have been associated with emergency department visits are also excluded.

As noted, maximum reimbursement rates for emergency services are established by the State. As shown in Table 4, the average payment to hospitals based on these rates increased by 14.1 percent, to $113 per visit for emergency department visits that did not result in an admission. In contrast, the average payment to medical professionals for all emergency department visits was unchanged at $30 per visit.

Table 4

Average Fee-for-Service Payments to Hospitals and Medical Professionals for Emergency Department Visits

Payment Type	1997-98	2001-02	Percentage Change
Average Payment to Hospital[1]	$99	$113	14.1%
Average Payment to Medical Professional[2]	30	30	0.0

[1] Represents payments for emergency department visits that did not result in an admission.
[2] Represents payments regardless of whether an admission resulted from the visit.

Although proprietary information on payments by HMOs for emergency department visits is not available to us, we found that state payments to HMOs for all services provided under the Medical Assistance program increased 68.7 percent in the five-year period we reviewed and were driven primarily by an increase in enrollment. As shown in Table 5, the State's total Medical Assistance expenditures increased from $266.9 million in FY 1997-98 to $450.2 million in FY 2001-02. This increase is due to an increase in enrollment, which grew 40.1 percent over five years, and an increase in premium payments. In FY 1997-98, monthly Medical Assistance premium payments to HMOs ranged from $103 to $544; in FY 2001-02, the range was $115 to $663.

Table 5

Expenditures for Medical Assistance Recipients Served by HMOs

Fiscal Year	Number of Recipients	Percentage Change	Total Amount Paid	Percentage Change
1997-98	295,132	—	$266,902,075	—
1998-99	285,009	-3.4%	268,890,867	0.7%
1999-2000	325,916	14.4	295,159,295	9.8
2000-01	363,613	11.6	366,271,169	24.1
2001-02	413,506	13.7	450,203,326	22.9

Use of Emergency Department Services by Fee-for-Service Recipients

The number of emergency department visits by Medical Assistance recipients served by fee-for-service providers increased 30.2 percent in the five-year period shown in Table 6, from 174,034 in FY 1997-98 to 226,619 in FY 2001-02. However, a 24.8 percent increase in the number of fee-for-service Medical Assistance recipients, rather than increased usage by existing recipients, was the primary reason for the change. Just over 20.0 percent of fee-for-service recipients visited emergency departments in each year we reviewed, with the greatest percentage in FY 2001-02, at 22.4 percent.

Table 6

Use of Emergency Departments by Fee-for-Service Recipients

Fiscal Year	Number of Recipients	Number Who Visited an Emergency Department	Percentage of Total Recipients	Total Number of Visits
1997-98	380,154	81,972	21.6%	174,034
1998-99	364,174	79,785	21.9	170,539
1999-2000	470,055	94,888	20.2	193,853
2000-01	459,924	97,216	21.1	203,810
2001-02	474,564	106,126	22.4	226,619
Percentage Change	24.8%	29.5%		30.2%

As shown in Table 7, 23.6 percent of the 106,126 Medical Assistance recipients who used emergency department services on a fee-for-service basis during FY 2001-02 were age 10 or younger, and the majority of fee-for-service recipients who used emergency department services were female. The fee-for-service population that visited emergency departments did not differ significantly from the entire Medical Assistance population served by fee-for-service providers. However, the fee-for-service population is more likely than recipients covered by HMOs to be covered by Medical Assistance because of disability or age.

Table 7

Fee-for-Service Recipients Visiting Emergency Departments
FY 2001-02

	Fee-for-Service Recipients	Percentage of Total	Fee-for-Service Recipients Visiting Emergency Departments	Percentage of Total
Gender				
Female	275,569	58.1%	63,365	59.7%
Male	198,995	41.9	42,725	40.3
Total	**474,564**	**100.0%**	**106,090**[1]	**100.0%**
Age				
Infant – Age 10	137,486	29.0%	24,975	23.6%
Age 11 – Age 20	85,360	18.0	16,723	15.8
Age 21 – Age 30	57,558	12.1	14,354	13.5
Age 31 – Age 40	53,103	11.2	13,892	13.1
Age 41 – Age 50	40,154	8.5	12,230	11.5
Age 51 to Age 60	24,058	5.1	7,981	7.5
Age 61 to Age 70	19,640	4.1	5,552	5.2
Age 71 to Age 80	23,528	5.0	4,909	4.6
Age 81 to Age 89	22,067	4.6	3,827	3.6
Age 90 and Above	11,610	2.4	1,683	1.6
Total	**474,564**	**100.0%**	**106,126**	**100.0%**
Enrollment Type				
Family and Other Types of Medical Assistance	275,341	58.0%	51,120	48.1%
SSI and SSI-Related	121,473	25.6	44,209	41.7
BadgerCare	77,750	16.4	10,797	10.2
Total	**474,564**	**100.0%**	**106,126**	**100.0%**

[1] The individual's gender was not listed for 36 records.

Although information on diagnoses associated with emergency department visits is collected for all Medical Assistance claims, these data are limited by physicians' specificity in coding

individual diagnoses. For example, physicians may use the code "general symptoms," or an emergency department visit may result in more than one diagnosis. We found that in FY 2001-02, 804 different primary diagnosis codes were used to describe the 226,619 emergency department visits made by fee-for-service Medical Assistance recipients in that year. As shown in Table 8, the most common diagnosis category was general symptoms, but it represented only 4.4 percent of all visits. Moreover, the top five diagnosis categories combined accounted for only 18.3 percent of visits.

Table 8

Top Five Primary Diagnoses for Fee-for-Service Emergency Department Visits
FY 2001-02

	Count	Percentage of Visits
General Symptoms	9,929	4.4%
Respiratory and Chest Symptoms	9,853	4.3
Symptoms Involving Abdomen or Pelvis	8,807	3.9
Ear Infection	6,715	3.0
Acute Upper Respiratory Infection	6,144	2.7
Subtotal	41,448	18.3
Other	185,171	81.7
Total Emergency Department Visits	**226,619**	**100.0%**

As shown in Table 9, 58.3 percent of fee-for-service recipients who sought emergency department services in FY 2001-02 did so only once. However, a small group of 5.5 percent visited emergency departments six or more times in that year and accounted for 27.0 percent of all visits. Among this group were 43 recipients who, on average, each visited hospital emergency departments more than once per week during FY 2001-02, and one recipient who made a total of 379 emergency department visits during that year.

Table 9

Frequency of Fee-for-Service Recipients' Visits to Emergency Departments
FY 2001-02

Frequency of Visits	Number of Individuals	Percentage	Number of Visits	Percentage
1	61,891	58.3%	61,891	27.3%
2	21,610	20.4	43,220	19.1
3	9,353	8.8	28,059	12.4
4	4,756	4.5	19,024	8.4
5	2,641	2.5	13,205	5.8
6 to 12	4,760	4.5	36,546	16.1
13 to 24	880	0.8	14,408	6.4
25 to 52	192	0.2	6,349	2.8
53 or More	43	<0.1	3,917	1.7
Total	**106,126**	**100.0%**	**226,619**	**100.0%**

Individuals who qualify for Medical Assistance because of age or disability could be expected to use emergency departments with greater frequency than the general population, and 68.9 percent of the 5,875 recipients who made six or more visits were eligible for Medical Assistance because they were elderly, blind, or disabled. Because most were 60 or younger, they qualified for Medical Assistance because of a disability rather than age.

We analyzed the diagnoses for the 43 fee-for-service recipients who made 53 or more emergency department visits in FY 2001-02. As shown in Table 10, these recipients were most commonly treated for symptoms related to sickle cell anemia, a disease that may require emergency care because it can produce extreme pain. All 43 individuals were either elderly, blind, or disabled.

Table 10

Top Five Diagnoses for Fee-for-Service Recipients with 53 or More Emergency Department Visits
FY 2001-02

Diagnosis	Number of Diagnoses	Percentage of Total
Sickle Cell Anemia	1,194	30.6%
Unspecified Procedures and Follow-up	366	9.3
Migraine	205	5.2
Respiratory and Chest Symptoms	164	4.2
Neurotic Disorders	153	3.9
Subtotal	2,082	53.2
Total for Those Making 53 or More Visits	**3,917**	**100.0%**

Use of Emergency Departments by Managed Care Recipients

Because HMOs do not submit reimbursement claims for each service they provide, and proprietary information on their payments to hospitals for emergency department services is not available, limited data are available regarding the use of emergency departments by Medical Assistance recipients who are served by HMOs. Since January 1, 2000, HMOs have submitted complete information on emergency department usage to DHFS, but because data for FY 2002-03 were not available during the course of our review, our analysis was limited to FYs 2000-01 and 2001-02.

As shown in Table 11, emergency department visits by Medical Assistance recipients enrolled in HMOs increased from a total of 155,734 in FY 2000-01 to 200,427 in FY 2001-02, or by 28.7 percent over two years. Reasons for the increase include a 13.7 percent increase in enrollment over that period, as well as a 23.9 percent increase in the number of recipients visiting emergency departments at least once.

Table 11

Managed Care Recipients' Use of Emergency Departments

Fiscal Year	Number of Recipients	Number Who Visited an Emergency Department	Percentage of Total Recipients	Total Number of Visits
2000-01	363,613	89,344	24.6%	155,734
2001-02	413,506	110,669	26.8	200,427
Percentage Change	13.7%	23.9%	—	28.7%

As shown in Table 12, 63.0 percent of the HMO recipients who visited emergency departments at least once in FY 2001-02 were female and 45.8 percent were age 10 or younger. This is not surprising, given that HMOs typically serve recipients who qualify for Medical Assistance because they are children or the parents of dependent children, and that only 2.3 percent of Medical Assistance recipients served by HMOs in FY 2001-02 were elderly or disabled. Overall, the demographic characteristics of managed care recipients who visited emergency departments were similar to those of all Medical Assistance recipients served by HMOs.

Table 12

Managed Care Medical Assistance Recipients Visiting Emergency Departments
FY 2001-02

	Managed Care Recipients	Percentage of Total	Managed Care Recipients Visiting Emergency Departments	Percentage of Total
Gender				
Female	244,357	59.1%	69,667	63.0%
Male	169,149	40.9	40,991	37.0
Total	**413,506**	**100.0%**	**110,658**[1]	**100.0%**
Number of Individuals By Age				
Infant - Age 10	185,985	44.9%	50,739	45.8%
Age 11 - Age 20	91,488	22.1	21,132	19.1
Age 21 - Age 30	58,037	14.0	19,757	17.9
Age 31 - Age 40	43,789	10.6	12,349	11.2
Age 41 - Age 50	20,507	5.0	5,065	4.6
Age 51 to Age 60	5,064	1.2	1,101	1.0
Age 61 to Age 70	2,802	0.7	352	0.3
Age 71 to Age 80	2,761	0.7	128	0.1
Age 81 to Age 89	2,302	0.6	31	<0.1
Age 90 and Above	771	0.2	4	<0.1
Total	**413,506**	**100.0%**	**110,658**[2]	**100.0%**
Enrollment Type				
Family and Other Types of Medical Assistance	309,443	74.9%	88,530	80.0%
SSI and SSI-Related	6,759	1.6	2,577	2.3
BadgerCare	97,304	23.5	19,562	17.7
Total	**413,506**	**100.0%**	**110,669**	**100.0%**

[1] Gender was not recorded for 11 recipients.
[2] Age was not recorded for 11 recipients.

As with fee-for-service recipients, emergency department diagnoses for managed care recipients varied widely. As shown in Table 13, five diagnosis categories accounted for 21.4 percent of all

diagnoses, and no single category accounted for more than 5.7 percent of the total. Upper-respiratory infections and ear infections were diagnosed most frequently.

Table 13

Top Five Primary Diagnoses for Managed Care Emergency Department Visits
FY 2001-02

	Count	Percentage of Visits
Acute Upper-Respiratory Infection	11,456	5.7%
Ear Infection	11,443	5.7
Symptoms of Abdomen and Pelvis	7,335	3.7
General Symptoms	7,091	3.5
Respiratory Abnormalities	5,596	2.8
Subtotal	42,921	21.4
Other	157,506	78.6
Total Emergency Department Visits	**200,427**	**100.0%**

As shown in Table 14, 60.5 percent of managed care recipients who used emergency department services in FY 2001-02 did so once. In contrast, slightly more than 2.8 percent made six or more visits each and accounted for 13.5 percent of all visits. Among this group were ten recipients who visited emergency departments more than an average of once per week in FY 2001-02, and one had a total of 121 emergency department visits.

Medical professionals with whom we spoke indicated that patients may visit emergency departments for minor illnesses and injuries for a variety of reasons, including because doctors' offices and urgent care centers are closed for the evening. However, emergency department usage data do not include information on the time of the visit, so it is not possible to determine if another care setting might have been available during the time a patient visited the emergency department.

Table 14

Frequency of Managed Care Recipients' Visits to Emergency Departments
FY 2001-02

Frequency of Visits	Number of Individuals	Percentage	Number of Visits	Percentage of Total
1	66,988	60.5%	66,988	33.3%
2	24,113	21.8	48,226	24.1
3	9,641	8.7	28,923	14.4
4	4,535	4.1	18,140	9.1
5	2,232	2.0	11,160	5.6
6 to 12	2,878	2.6	21,174	10.6
13 to 24	227	0.2	3,624	1.8
25 to 52	45	<0.1	1,448	0.7
53 or More	10	<0.1	744	0.4
Total	**110,669**	**100.0%**	**200,427**	**100.0%**

As shown in Table 15, the most common single diagnosis for managed care recipients with 53 or more emergency department visits during FY 2001-02 was related to back pain.

Table 15

Top Five Diagnoses for Managed Care Recipients with 53 or More Emergency Department Visits
FY 2001-02

Diagnosis	Count	Percentage
Back Disorders	82	11.0%
Symptoms of Abdomen and Pelvis	50	6.7
Migraine	47	6.3
Respiratory and Chest Symptoms	43	5.8
Disease of the Pancreas	40	5.4
Subtotal	262	35.2
Total of 53 or More Emergency Department Visits[1]	**744**	**100.0%**

[1] In FY 2001-02, a total of 103 different primary diagnoses were made for managed care enrollees who made 53 or more emergency department visits.

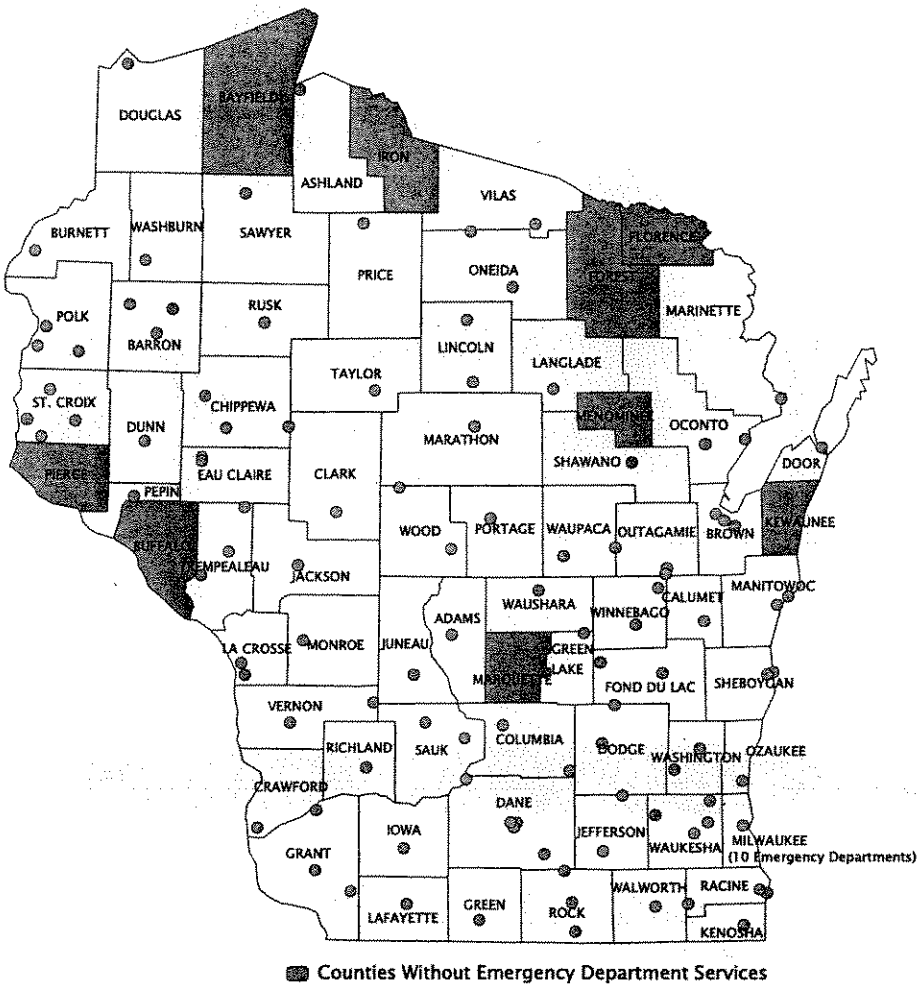
Some providers indicated that Medical Assistance recipients may also visit emergency departments for minor injuries and illnesses because they have difficulty finding a primary care provider who will accept them as patients because of reimbursement rates for services provided. We found that the number of physicians certified as Medical Assistance providers in Wisconsin decreased 5.1 percent over five years, or from 16,662 in FY 1997-98 to 15,808 in FY 2001-02. However, the percentage of physicians who were certified as Medical Assistance providers and submitted at least one reimbursement request increased from 73.3 percent to 87.2 percent during the same period.

Future Considerations

Some are concerned that use of emergency departments by uninsured patients could force emergency care facilities to close. Hospitals and medical professionals contend that reimbursement rates are not sufficient to cover the actual cost of treatment provided, and therefore costs for those without insurance or those enrolled in programs such as Medicare or Medical Assistance must be absorbed by providers. However, it does not appear that reimbursement rates have affected the number of facilities with emergency departments in Wisconsin. The number of Wisconsin hospitals with emergency departments actually increased from 115 in 1998 to 116 in 2002. Figure 1 shows the location of the 116 hospitals with emergency departments in Wisconsin during FY 2001-02. Appendix 1 provides a detailed listing of these facilities.

Figure 1

Location of Hospital Emergency Departments
FY 2001-02



Nationally, some hospitals have begun to address emergency department usage in various ways. For example:

- Some facilities discourage the use of emergency departments for minor illnesses and injuries by either instituting fees or refusing treatment. Locally, St. Joseph Regional Medical Center in Milwaukee recently began charging uninsured patients a $150 fee for emergency care in an effort to reduce the number of patients seeking treatment for minor ailments, such as colds. Such actions may reduce the number of patients seeking care at particular facilities, but it is possible they will only divert patients without private insurance to other providers, who will then bear the financial burden of providing care. In addition, under the terms of a special federal waiver, use of co-payments for emergency room services provided to Medical Assistance recipients is limited to $10 per visit.

- Some facilities have dedicated a small portion of their emergency departments to the treatment of minor injuries and illnesses. After an initial assessment, patients with minor medical conditions are diverted to these facilities, which are generally staffed by physician assistants who treat conditions such as small lacerations, ear infections, and sore throats. These "minor ERs" generally operate only during peak emergency department hours and are intended to decrease waiting times for those patients with minor injuries or illnesses, as well as to reserve space in the emergency department for those with more serious health needs.

As noted, a very small number of Medical Assistance recipients account for a significant percentage of total emergency department visits. Consequently, it may be beneficial for DHFS to analyze this population more closely to determine whether efforts could be made to improve health care delivery to them and potentially reduce costs through better management of these patients' medical conditions.

****

Appendix 1

Hospital Emergency Departments
FY 2001-02

County[1]	City	Facility Name
Adams	Friendship	Adams County Memorial Hospital
Ashland	Ashland	Memorial Medical Center
Barron	Barron	Barron Memorial Medical Center - Mayo Health System
Barron	Cumberland	Cumberland Memorial Hospital, Inc.
Barron	Rice Lake	Lakeview Medical Center
Brown	Green Bay	Aurora BayCare Medical Center
Brown	Green Bay	St. Mary's Hospital Medical Center
Brown	Green Bay	St. Vincent Hospital
Burnett	Grantsburg	Burnett Medical Center
Calumet	Chilton	Calumet Medical Center
Chippewa	Bloomer	Bloomer Medical Center - Mayo Health System
Chippewa	Chippewa Falls	St. Joseph's Hospital
Clark	Neillsville	Memorial Medical Center
Clark	Stanley	Our Lady of Victory Hospital
Columbia	Columbus	Columbus Community Hospital
Columbia	Portage	Divine Savior Healthcare
Crawford	Prairie du Chien	Prairie du Chien Memorial Hospital
Dane	Madison	Meriter Hospital, Inc.
Dane	Madison	St. Marys Hospital Medical Center
Dane	Madison	University Hospital & Clinics
Dane	Stoughton	Stoughton Hospital
Dodge	Beaver Dam	Beaver Dam Community Hospital
Dodge	Watertown	Watertown Area Health Services
Dodge	Waupun	Waupun Memorial Hospital
Door	Sturgeon Bay	Door County Memorial Hospital - Ministry Health Care
Douglas	Superior	St. Mary's Hospital of Superior
Dunn	Menomonie	Myrtle Werth Hospital
Eau Claire	Eau Claire	Luther Hospital - Mayo Health System
Eau Claire	Eau Claire	Sacred Heart Hospital
Fond du Lac	Fond du Lac	St. Agnes Hospital
Fond du Lac	Ripon	Ripon Medical Center
Grant	Boscobel	Boscobel Area Health Care
Grant	Lancaster	Grant Regional Health Center

County[1]	City	Facility Name
Grant	Platteville	Southwest Health Center
Green	Monroe	The Monroe Clinic
Green Lake	Berlin	Berlin Memorial Hospital
Iowa	Dodgeville	Upland Hills Health
Jackson	Black River Falls	Black River Memorial Hospital
Jefferson	Fort Atkinson	Fort Atkinson Memorial Health Services
Juneau	Mauston	Hess Memorial Hospital
Kenosha	Kenosha	Aurora Medical Center
La Crosse	La Crosse	Franciscan Skemp Medical Center - Mayo Health System
La Crosse	La Crosse	Gundersen Lutheran
Lafayette	Darlington	Memorial Hospital of Lafayette Co.
Langlade	Antigo	Langlade Memorial Hospital
Lincoln	Merrill	Good Samaritan Health Center
Lincoln	Tomahawk	Sacred Heart Hospital
Manitowoc	Manitowoc	Holy Family Memorial
Manitowoc	Two Rivers	Aurora Medical Center
Marathon	Wausau	Wausau Hospital
Marinette	Marinette	Bay Area Medical Center
Milwaukee	Milwaukee	Aurora Sinai Medical Center
Milwaukee	Milwaukee	Children's Hospital of Wisconsin
Milwaukee	Milwaukee	Columbia Hospital
Milwaukee	Milwaukee	Froedtert Hospital
Milwaukee	Milwaukee	St. Francis Hospital
Milwaukee	Milwaukee	St. Joseph Regional Medical Center
Milwaukee	Milwaukee	St. Luke's Medical Center
Milwaukee	Milwaukee	St. Mary's Hospital of Milwaukee
Milwaukee	Milwaukee	St. Michael Hospital
Milwaukee	West Allis	West Allis Memorial Hospital
Monroe	Sparta	Franciscan Skemp Healthcare
Oconto	Oconto Falls	Community Memorial Hospital
Oconto	Oconto	Oconto Memorial Hospital, Inc.
Oneida	Rhinelander	St. Mary's Hospital
Oneida	Woodruff	Howard Young Medical Center
Outagamie	Appleton	Appleton Medical Center
Outagamie	Appleton	St. Elizabeth Hospital
Outagamie	New London	New London Family Medical Center
Ozaukee	Mequon	St. Mary's Hospital Ozaukee
Pepin	Durand	Chippewa Valley Hospital
Polk	Amery	Amery Regional Medical Center

County[1]	City	Facility Name
Polk	Osceola	Osceola Medical Center
Polk	St. Croix Falls	St. Croix Regional Medical Center
Portage	Stevens Point	Saint Michael's Hospital
Price	Park Falls	Flambeau Hospital
Racine	Burlington	Memorial Hospital of Burlington
Racine	Racine	All Saints Medical Center - St. Luke's Campus
Racine	Racine	All Saints Medical Center - St. Mary's Campus
Richland	Richland Center	The Richland Hospital, Inc.
Rock	Beloit	Beloit Memorial Hospital
Rock	Edgerton	Memorial Community Hospital
Rock	Janesville	Mercy Hospital
Rusk	Ladysmith	Rusk County Memorial Hospital
Sauk	Baraboo	St. Clare Hospital & Health Services
Sauk	Prairie du Sac	Sauk Prairie Memorial Hospital
Sauk	Reedsburg	Reedsburg Area Medical Center
Sawyer	Hayward	Hayward Area Memorial Hospital
Shawano	Shawano	Shawano Medical Center
Sheboygan	Sheboygan	Aurora Sheboygan Memorial Medical Center
Sheboygan	Sheboygan	St. Nicholas Hospital
St. Croix	Baldwin	Baldwin Area Medical Center
St. Croix	Hudson	Hudson Hospital
St. Croix	New Richmond	Holy Family Hospital
St. Croix	River Falls	River Falls Area Hospital
Taylor	Medford	Memorial Health Center
Trempealeau	Arcadia	Franciscan Skemp - Mayo Health System
Trempealeau	Osseo	Osseo Area Hospital
Trempealeau	Whitehall	Tri-County Memorial Hospital
Vernon	Hillsboro	St. Joseph's Community Health Services
Vernon	Viroqua	Vernon Memorial Hospital
Vilas	Eagle River	Eagle River Memorial Hospital
Walworth	Elkhorn	Aurora Lakeland Medical Center
Washburn	Shell Lake	Indianhead Medical Center
Washington	Hartford	Aurora Medical Center
Washington	West Bend	St. Joseph's Community Hospital
Waukesha	Brookfield	Elmbrook Memorial Hospital
Waukesha	Menomonee Falls	Community Memorial Hospital
Waukesha	Oconomowoc	Oconomowoc Memorial Hospital
Waukesha	Waukesha	Waukesha Memorial Hospital
Waupaca	Waupaca	Riverside Medical Center

County[1]	City	Facility Name
Waushara	Wild Rose	Wild Rose Community Memorial Hospital
Winnebago	Neenah	Theda Clark Medical Center
Winnebago	Oshkosh	Mercy Medical Center
Wood	Marshfield	Saint Joseph's Hospital
Wood	Wisconsin Rapids	Riverview Hospital Association

[1] The following counties do not have hospitals with emergency departments: Bayfield, Buffalo, Florence, Forest, Iron, Kewaunee, Marquette, Menominee, and Pierce.

Asbjornson, Karen

From: Matthews, Pam
Sent: Wednesday, February 04, 2004 12:09 PM
To: Chrisman, James
Cc: Asbjornson, Karen
Subject: FW: Milwaukee Immediate Care Center

MICC Business Journal article....

Hi Joe,

We were contacted by this guy and he wanted us to have this information in the hopes of getting Sue to help him in some way. Do you have any advice on how to respond? I don't believe Sue is interested in solving the healthcare crisis in Milwaukee...

Pam

-----Original Message-----
From: Perry Margoles [mailto:perrymargoles@yahoo.com]
Sent: Tuesday, February 03, 2004 10:45 PM
To: pam.matthews@legis.state.wi.us
Subject: Milwaukee Immediate Care Center

Milwaukee, Wisconsin
February 3, 2004 10:30 p.m.

Dear Pam,

Thank you for the courtesy you extended in taking my call this morning regarding the above-headlined feature in Saturday's Milwaukee Journal Sentinel.

It would be my pleasure to discuss with Rep. Jeskewitz Milwaukee Immediate Care Center, a prototype inner city urgent care medical clinic, which for 18 years has been addressing the problem of inappropriate use of emergency rooms. Last year, this non-profit clinic served 15,000 people and saved the state millions of dollars. We have ideas that can do even more in this area. Unfortunately, the clinic is at serious risk because of diversion of state and federal monies (BadgerCare/Medicaid) by an H.M.O., which were designated for healthcare for the poor.

Spencer Coggs has been supportive of our clinic's efforts.

Attached is a feature on Milwaukee Immediate Care

Center which appeared in the mid-1990's in the Business Journal.

Hoping that this might be of interest to Ms. Jeskewitz and to hear from her, I am,

Very truly yours,

Perry Margoles

COMMENT

Central city clinic provides model for easing health care crisis

It's 9:30 tonight, and one of your employees needs a doctor. His wife's fever, for which she's taken medication throughout the day, has taken a turn for the worse. Or the employee has cut his arm at home and needs stitches.

Similarly, dozens of other Milwaukeeans will need medical care this evening. Some will be among many thousands locally without health insurance, or whose policies won't cover their treatment. Some of these and other patients will be among more than 150,000 residents of the city's predominantly minority near north side, where they face even fewer options — as much of this enormous area has become a virtual medical wasteland.

The expense of obtaining such medical care increasingly plagues the health of the nation's businesses.

ON CENTRAL CITY HEALTH CARE

Michael White
and Robert Doucette

At the same time, access to health care has become the most widespread and costliest of the various problems affecting the central city. It impacts on the young, seniors, workers, the unemployed and the underemployed. More frequently and more seriously than others on average, they suffer conditions such as hypertension, cardiovascular disease, diabetes and asthma.

In fact, the fastest-growing "at risk" segment of the black population in terms of accessing affordable health care are tens of thousands of lower- to upper-middle-income workers and their families. What too often is overlooked regarding race relations in Milwaukee is the diversity of the black community, and that a majority is *not* on welfare.

Unfortunately, gone and going are ever-increasing numbers of jobs which in recent decades lifted many out of poverty through comfortable salaries and benefits such as health insurance. Where such employment remains, more of these benefits are being constricted.

The effects are rippling throughout the general population, but are having disproportionate impact on the central city labor force. Mounting cases of avoidable illnesses, disabilities and related deaths are compelling evidence that new ideas are needed.

Equally apparent to employers is that it is unsustainable to be grappling with health care cost curves that now equal $1 out of every $7 produced in our entire economy — and are projected to reach 20 percent of the U.S. gross domestic product within the next decade.

Out of this shared concern rises a necessity to implement meaningful change even as the brakes have been put on sweeping national health care reform.

Whatever solutions are developed must take into account new economic realities to which the business world is adapting — notably, that simply throwing money at such problems no longer will suffice.

This is particularly challenging concerning Milwaukee's central city health care crisis. After millions of dollars have been spent on this problem on the near north side, the limited results would not be deemed satisfactory in the business sector.

Where several decades ago there were dozens of doctors' offices in this area, the number now is less than 10. Most of the half-dozen community clinics in this area have closed. Those remaining require substantial, ongoing subsidies to survive.

A creative response to this problem can be seen in the innovative approach of Milwaukee Immediate Care Center, at 1971 W. Capitol Drive. Milwaukee Immediate Care Center was established in 1986, as a prototype central city urgent care clinic.

This model was developed after a year-and-a-half of research which identified factors that could enable a central city clinic to be viable while providing area residents and businesses with quality and cost-effective medical care.

Among the factors are:

• **Location.** While inner city, Milwaukee Immediate Care Center's location is not inner core. It is at a key transportation and business hub on one of the city's main thoroughfares. There, the clinic can draw patients from a broader geographic and economic base, allowing a more diversified mix of private-pay and private insurance to offset some lower levels of Medicaid reimbursement.

• **Primary and urgent care.** Milwaukee Immediate Care Center combines both *primary* care (patients regarding physicians as their family doctors for on- (one-time episodic treatment for patients who may or may not have their own primary care doctors). The higher levels of staffing, equipment, and protocol necessary for urgent care have made Milwaukee Immediate Care Center considerably more expensive to develop and operate compared to a conventional doctor's office or clinic.

But this mixed model, when properly implemented, can be financially self-sustaining in a central city setting. In large part, this is possible through reimbursements for minor injuries and health maintenance organization-enrolled urgent care patients.

While there are more than a dozen urgent care clinics in the metropolitan area, Milwaukee Immediate Care Center is the only such facility on the near north side. From morning through evening, seven days a week, patients are seen with or without appointments. Priority is given, first, to those who are injured or seriously ill, then to those with appointments or who are HMO urgent care referrals, and then to walk-in patients.

On an average day, one may hear the hurried footsteps of a parent bringing into the clinic a child suffering the onset of an asthmatic attack. Or see a worker with a minor injury.

Such cases exemplify how Milwaukee Immediate Care Center is trying to address one of the grossest misallocations of health care resources. Tens of millions of dollars are wasted each year in Milwaukee because up to 90 percent of the patients who end up at local emergency rooms reportedly do not have emergency conditions.

The ER utilization rate spirals nearly fivefold among some central city residents. Milwaukee Immediate Care Center has been saving millions of dollars by treating many such patients, at anywhere from one-third to one-eighth of the cost of the same care in an emergency room.

• **Patient-oriented treatment.** Milwaukee Immediate Care Center is intended to be a proactive bridge between communities at a time when Milwaukee ranks at or near the top nationally of a variety of racial disparities. Staffing, design and protocol are patient-oriented. This ranges from an emphasis on staff promptly greeting patients, to free blood pressure checks offered at all times the care center is open.

Milwaukee Immediate Care Center's fee for a basic office visit — $30 — is

care facilities. That more and more M waukeeans are having difficulty findi affordable health care is reflected in marked increase during the past year patients across a broad income spectru (both minority and non-minority) comi to Milwaukee Immediate Care Cent from throughout the county.

The clinic is organized to attempt minimize various "hassle factors" whi otherwise deter good doctors from pra ticing in the central city. No financial i vestment is required of staff physician who are paid an hourly fee. They are e couraged to focus on what they have be trained to do: practice medicine.

Nonmedical administrative matters a the responsibility of the board of directo of the nonprofit corporation that owns t

Whatever solutions are developed must take into account new economic realities.

clinic, in consultation with the medical d rector. The board consists of a divers group of business, professional, civic, an community representatives.

Milwaukee Immediate Care Center approaching operational self-sufficienc and will not require ongoing financial a sistance. Originally, it was to have bee sponsored partially by several downtow hospitals. Unfortunately, they subse quently closed, and Milwaukee Immed ate Care Center has been left carrying a indebtedness it must retire to remai open.

Consequently, we have joined othe businessmen — and seek and invite oth ers — in supporting this model, because provides an unusual opportunity to mak a genuine difference in an area where suc cess has become too rare.

Michael White is president of Rite Hite Corp., Brown Deer, and chairman o Milwaukee Immediate Care Corp. Robe Doucette is chairman of Milwaukee Insur

SURVIVAL COALITION OF WISCONSIN DISABILITY ORGANIZATIONS
16 North Carroll Street, Suite 400, Madison WI 53703 608/267-0214 voice/TTY 608/267-0368 fax

February 12, 2004

Senator Roessler, Co-Chair Joint Audit Committee
Room 8 South
State Capitol
P.O. Box 7882
Madison 53707-7882

FEB 16 2004

Dear Senator Roessler,
Janice Mueller, State Auditor
Senator Roessler
Representative Jeskewicz
Senator Lazich
Senator Jauch
Senator Liebham

Thank you for your ongoing interest and support of Wisconsin Medicaid recipients and the providers who serve them. Medicaid Prior Authorization (PA) has been an issue for many years for recipients, families and providers. In July of 2001, the WI Legislative Audit Bureau completed an audit of the Department of Health and Family Services application of Medicaid PA for therapy services. Since that important audit was produced, consumers and providers have continued to work to implement several important changes.

While I believe that problems and challenges with the process persist, I wanted to share some important news regarding progress made since that audit. In doing so, I also wanted to acknowledge the roles of the Legislative Audit Committee (previous and present), the Legislative Audit Bureau and Mark Moody, Administrator of DHFC for their support of these important changes.

Please review the following letter to Secretary Nelson and its related attachments regarding these important initiatives. I am hopeful that the Department will fully implement these changes with the spirit in which they were intended. That spirit is to better serve WI Medicaid recipients and their families and preserve the scarce Medicaid dollars for services rather than administrative processes.

Once again, thank you for your important role in elevating the importance of these issues and oversight in making sure those substantive changes actually happen. We may need your support again in the future on these and related Medicaid issues.

Sincerely,

Lynn Steffes, PT
Survival Coalition Medicaid Project Leader

Cc Helene Nelson, DHFS
Mark Moody, DHCF
Sinikka Santala, DDES
Gerry Born, WCDD
Lynn Breedlove, Survival Co-Chair
Michael Blumenfeld, Survival Co-Chair
Jennifer Ondrejka, Survival Co-Chair

wisconsin Medicaid and BadgerCare update

Draft

January 2004 • No. 2004-XX

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Occupational Therapists
Physical Therapists
Rehabilitation Agencies
Speech and Hearing Clinics
Speech-Language Pathologists
Therapy Groups
HMOs and Other Managed Care Programs

Wisconsin Medicaid addresses flexibility, duration, and coordination of therapy services

This *Wisconsin Medicaid and BadgerCare Update* includes information about the following:

- The flexible use of approved, medically necessary therapy sessions so a provider may meet a recipient's needs.
- The duration of approved therapy services on prior authorization (PA) requests.
- The request for coordination of therapy services for the same recipient for multiple therapy services.

Flexibility of approved, medically necessary therapy services

Wisconsin Medicaid allows flexible use of approved, medically necessary therapy sessions so a provider may meet a recipient's needs.

Wisconsin Medicaid may approve a specific number of therapy sessions that can be used flexibly. For example, rather than being restricted to providing therapy services once a week for 10 weeks as approved on a prior authorization (PA) request, a provider and recipient may change the frequency of the sessions over the ten-week period. For example, therapy services could be provided once a week for the first four weeks and twice a week *every other* week for the next six weeks.

The number of therapy sessions used may not exceed the approved quantity and must be used between the PA grant and expiration dates.

Plan of care must reflect flexibility of approved therapy services

Wisconsin Medicaid requires that the frequency and duration of therapy services be written in the therapist's plan of care under HFS 107.16, 107.17, and 107.18, Wis. Admin. Code. In order to use the sessions flexibly, the therapist must have a physician's prescription that allows therapy services to be used flexibly.

Note: Flexibility applies to PAs for maintenance therapy, extension of therapy services, and spell of illness (SOI). Refer to the July 2000 *Wisconsin Medicaid and BadgerCare Update* (2000-24), titled "Prior authorization for maintenance therapy" and the July 2003 *Update* (2003-79), titled "Changes to spell of illness prior authorization," for more information about maintenance therapy and SOI, respectively.

Duration of approved therapy services on prior authorization requests

Prior authorization requests for therapy services must meet the criteria of medically necessary under HFS 101.03(96m), Wis. Admin. Code. Refer to the May 2002 *Update* (2002-32), titled "How 'medically necessary' is applied when

evaluating prior authorization requests for therapy services," for the definition of medically necessary.

The duration and frequency on a PA request should accurately reflect the plan of care. Wisconsin Medicaid may allow the following duration and number of sessions for therapy provided to individuals with ongoing therapy needs:

- Up to three sessions per week, for a maximum duration of 26 weeks (up to 78 sessions).
- One or less than one therapy session per week, for a maximum duration of 52 weeks (up to 52 sessions).

Note: Duration applies to PAs for maintenance therapy and extension of therapy services. Refer to *Update* 2000-24 for information about maintenance therapy.

Coordinating multiple prior authorizations

Wisconsin Medicaid allows providers to request coordination of grant and expiration dates for the same recipient from different therapy types. Providers should request the same grant and expiration dates on each Prior Authorization Request Form (PA/RF) and note that it is for coordination of care purposes.

Information regarding Medicaid HMOs

Draft

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid*.

PHC 1250

WISCONSIN COUNCIL ON DEVELOPMENTAL DISABILITIES

WCDD

Promoting Independence and Equality

February 12, 2004

Helene Nelson, Secretary
Department of Health and Family Services
1 W. Wilson Street
Madison, WI 53702

RE: Medicaid Prior Authorization Update

Dear Secretary Nelson,

The WCDD and members of the advocacy community were very pleased with the Department of Health and Family Services recent changes to the Medicaid prior authorization (PA) process. I have attached the Medicaid Prior Authorization DRAFT Update # 2004-XX along with a document entitled "Recent Modifications to Wisconsin Medicaid Therapy Services" which was distributed by DHFS at the January Therapy Associations' Meeting and a Draft of an optional "Family Participation Form". The changes reflected in the Update, the DHFS document, and the form if implemented fully, should create an opportunity to streamline and therefore reduce the over-use of the costly PA process. These solutions make sense for Wisconsin Medicaid recipients and the providers that serve them.

In a survey conducted in the fall of 2002 among Wisconsin families with children enrolled in Medicaid, many families reported that the frequency of the prior authorization process and its lack of coordination of services were among some of their primary concerns. Survey families' thoughtful suggestions included:

- "One suggestion might be to extend PAs to six months or one year so that families and providers are not fighting these battles every other month…"
- "Approve PAs for longer periods."

With the proper application of this update, prior authorization on services, already deemed medically necessary by the process, can now be done annually or semi-annually. Fewer PAs result when approval periods are lengthened. This should reduce Departmental costs as well as recipient and provider concerns.

Highlights of this Update include:

Flexibility: This Draft includes clarification on the use of approved physical, occupational and speech therapy sessions to best meet the needs of the recipient. The total number of sessions, a start and end date for the PA are authorized. However, families and providers can modify the number of sessions provided per week to optimize the use of sessions for children and families. This new change will allow families with special circumstances to maximize the total number of visits authorized to meet their child's needs.

600 Williamson Street, PO Box 7851, Madison, Wisconsin 53707-7851
Voice 608/266-7826 • FAX 608/267-3906 • TTY/TDD 608/266-6660
Email wiswcdd@dhfs.state.wi.us • Web http://www.wcdd.org

Highlights of this Update continued:

Duration: This Draft reinforces maximum available durations on PAs including:

2-3-therapy sessions/week for up to 26 weeks (52-78 sessions)

1 or less therapy sessions/week for up to 52 weeks (52 sessions)

This new change will reduce the burden on families and providers to resubmit repetitive prior authorization information several times/year.

Families surveyed also made the following important suggestion:

- "Provide an opportunity for multi-disciplinary prior authorizations, to encourage coordination and collaboration of providers…"

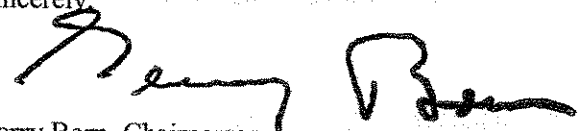
This Medicaid Update creates an opportunity for coordination of services and PAs for therapy services:

Submission of Coordinated PAs: DHFS has offered language enabling families and providers to coordinate the PA process when multiple services are involved. This creates an opportunity for the consumer, family and providers to develop a team plan and will lead to better coordination of care for the recipient and family and less redundant paperwork for providers.

Family Participation Form:
Acknowledges the role of the family and gives them a "voice" in planning, goal-setting and implementation of the PA process for therapy services.

It is our hope that with full implementation of these PA improvements that Medicaid recipients and their families and the providers who serve them could focus their energy on optimizing the important Medicaid resources made available to them, not in meeting the repetitive and costly prior authorization process. We are also confident that even with these changes, PA will continue in its compliance and "sentinel" roles.

Sincerely,



Gerry Born, Chairperson
Wisconsin Council on Developmental Disabilities

Cc Diane Welch, Executive Assistant
Sinikka McCabe, DDES Administrator
Mark Moody, DHCF Administrator
Janice Mueller, State Auditor
Joan Sanzen, Constituent Relations
Jennifer Ondrejka, WCDD Executive Director
Lynn Steffes, Survival Coalition Medicaid Consultant

Recent Modifications to Wisconsin Medicaid Therapy Services

I. Recent Changes in the Prior Authorization (PA) process.

A. Revision of the Prior Authorization Therapy Attachment (PA/TA) – January 2002.

1. Developed in cooperative effort with Wisconsin Medicaid and state-therapy associations.
2. Based on standards of practice and Wisconsin Administrative Code and meant to better assist providers when requesting Therapy PAs.

B. Modification to Birth-to-3 (B-3) PA process and Reimbursement Rate. – July 2002.

1. Eliminates the need for renewal of PA requests for therapy services provided to children as part of the B-3 program.
2. Allows providers to submit a prior PA request *only once* per child, per therapy type up to the recipient's third birthday.
3. DHFS also enabled therapy providers to receive an enhanced reimbursement ($21.50 per child, per date of service, per type of therapy) in addition to standard reimbursement when therapy services are provided to children in the B-3 program in the child's natural environment.

C. MA no longer requires providers to submit a copy of the physician's prescription when requesting PA or spell of illness (SOI) - July 2002.

1. Providers will still be required to maintain the physician's prescription in the recipient's record with a current plan of care.
2. Reduces documentation and administrative requirements for providers.

D. Modification in Spell of Illness Prior Authorization (SOI/PA) process - July, 2003

1. Eliminates the need for providers to submit detailed documentation of the recipient's diagnosis or condition when requesting a new SOI.
2. Instead, providers are required to provide the appropriate primary ICD-9 diagnosis code and answer "yes" or "no" to seven statements about the recipient's diagnosis or condition.
3. The answers to these statements are used to determine if the SOI request will be approved and will determine the maximum allowable treatment days for the SOI
4. Is expected to significantly reduce PA requests and administrative burden on providers and DHFS

E. Flexibility, duration and coordination of therapy services in Prior Authorization requests. – November 2003.

1. Increases PA duration, up to 6 months, if PA request for continuing therapy meets, if all criteria of departmental review and all standards for medical necessity are met.

2. Approved therapy sessions may be used flexibly by the treating therapist to meet the medically necessary treatment needs of the recipient. For example, if the recipient is hospitalized and requires additional therapy sessions post discharge, those therapy sessions not used during the hospital stay may be used after discharge to provide additional medically necessary services.
3. Provides information regarding requesting coordination of therapy services for the same recipient for multiple therapy services.
4. Systems modifications implemented in November 2003, with a published update expected for February 2004.

II. Other Areas

A. Training Guide for Wisconsin Medicaid Therapy Providers – November 2002.

1. Provides a comprehensive guide for providers of occupational therapy, physical therapy, and speech and language therapy provided through the Wisconsin Medicaid fee-for-service benefit.
2. Includes information on:
    a. Wisconsin Medicaid and BadgerCare
    b. Overview Wisconsin Medicaid Certification.
    c. Prior Authorization.
    d. Claims.
    e. Resources (Internet and resources included in this training guide).

B. Publication of new Speech Language Pathology (SLP) Handbook – July 2003.

1. Provides up-to-date information regarding MA policies and SLP services.
2. Developed in cooperative effort with Wisconsin Medicaid, Wisconsin Speech and Hearing Association (WSHA) and providers.

C. Occupational Therapy (OT) and Physical Agent Modalities (PAMs) – October 2003.

1. Expands scope of service for OT's to provide services for PAMs.
2. Complements revision in scope-of-practice in Administrative Code for OT's.
3. Developed in cooperative effort with Wisconsin Medicaid, Wisconsin Occupational Therapy Association (WOTA) and providers.

D. HIPAA Modifications and Revision of Procedure Codes for Therapy Services. - October 2003

1. DHFS systems and codes are compliant with federal HIPAA standards.
2. Modify certain codes to reflect changes implemented nationally by the federal government.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11039 (Rev. 06/03)

WISCONSIN MEDICAID

FAMILY PARTICIPATION FORM FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH AND LANGUAGE PATHOLOGY SERVICES

The completion of this form is voluntary. If the recipient is unable to complete this form, a caregiver or family member can do so on the recipient's behalf.

SECTION I — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial) :

SECTION II — DOCUMENTATION

What do you want the therapist to address (e.g., cannot get out of bed, cannot feed self)?

How will this therapy service help you or your child in daily life?

DRAFT

What changes do you expect to see?

How will you or your child practice these new skills?

Does the recipient receive other therapy or home-care services? ☐ Yes ☐ No
If yes, what are these services and why are these additional therapy services needed?

Have you read the completed prior authorization request?	☐ Yes	☐ No
Do you agree with the goals of the therapy being requested?	☐ Yes	☐ No

Name (please print)	Relationship to the Recipient
Signature	Date Signed

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement.

Wisconsin Chapter
American College of
Emergency Physicians

MAR 31 2004

March 18, 2004

The Honorable Carol A. Roessler
The Honorable Suzanne Jeskewitz
Co-chairs
Joint Legislative Audit Committee
State Capitol
Madison, WI 53702

Re: Legislative Audit Bureau Report
Use of Emergency Department Services
by Medical Assistance Recipients

Dear Senator Rossler and Representative Jeskewitz:

The Wisconsin Chapter - American College of Emergency Physicians (WACEP) is the professional organization representing more than 370 doctors providing care in emergency departments throughout the State of Wisconsin. We reviewed with great interest the recent report by the Legislative Audit Bureau dated January 30, 2004, concerning the use of emergency department services by Medical Assistance recipients.

We believe this report reveals an urgent need for policy makers to address the underlying factors that contribute to the demand for emergency department services. While the statistics presented in the report clearly are of great interest, the numbers tell only part of the story and may well raise more questions than they answer. **Accordingly, we respectfully request that your committee schedule a hearing to examine the issues we believe are raised by this study.**

The report does an excellent job of gathering statistics regarding the use of emergency departments. Indeed, WACEP has long expressed concerns about utilization trends and potentially overcrowded conditions in emergency rooms. Our organization has been actively engaged in discussions with Administration officials and legislators to consider ways of improving access and availability of patient care, especially for non-urgent emergency department visitors.

We have become increasingly worried about the fragile state of our emergency care system. It can be rightly stated that the state's emergency departments and the physicians, nurses and others who staff them provide the *health care safety net* for our citizens. Wisconsin's emergency departments quite literally are the place of last resort for some people. As other problems ripple through the health care system – including growing numbers of uninsured and underinsured, drug and alcohol abuse, threats of terrorism, and access issues to primary care physicians – many end up on the doorstep of the emergency room. The federal EMTALA law mandates that emergency departments provide care regardless of a patient's ability to pay, and that is as it should be.

Administrative Office: 10 W. Phillip Rd., Suite 120, Vernon Hills, IL 60061-1730
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The report does recognize that increased emergency department utilization seems to parallel an increase in medical assistance caseloads. However, it does *not* draw any conclusions regarding the specific reasons *why* patients rely on emergency department services for periodic visits or for non-urgent care. In fact, the report's authors acknowledge they did not have enough information to evaluate the suitability for the patient visit. However, the data does suggest that increased utilization of emergency department services is directly proportional to a decline in physicians available to patients in the medical assistance program.

Emergency physicians and staff provide quality treatment to each and every patient who comes through the door. It is important to note that while care in a different setting might be *more appropriate,* if a patient has no other place to go, then their utilization of the emergency department *is* proper.

Many policymakers focus on the high charges associated with emergency care, but they tend to overlook the inadequacy of reimbursement for emergency physicians providing the services. The report identifies a serious problem regarding payment rates for emergency physicians. For example, Tables 3 & 4 show that over a five-year period, 85% of payments made for emergency care went to hospitals and only 15% went to the medical professionals. The average payment to hospitals increased by 14.1% while payments to the doctor was *flat* over the same five-year period. We can only speculate what impact these trends may have, if allowed to continue, on the viability and capacity of our emergency care system and the number of physicians able to provide care.

Wisconsin's emergency physicians are eager to participate in these discussions and want to be proactive in helping policymakers to take actions which result in improvements to our health care delivery system. That is why we respectfully ask that your committee hold a hearing on the Audit Report. We feel confident that testimony resulting from this hearing will assist the legislature – and others – to better understand the problem and also prompt solutions.

We look forward to working with you and the committee on this matter of vital importance to the citizens of Wisconsin. Thank you for your consideration. Please feel free to contact me if you have any questions or if there is any additional information I can provide.

Sincerely yours,

Richard H. Paul
Executive Director

cc: Janice Mueller, *State Auditor*
Helene Nelson, *Secretary, Department of Health and Family Services*
Members, Joint Legislative Audit Committee

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

June 2, 2004

Mr. Richard H. Paul, Executive Director
Wisconsin Chapter—American College of Emergency Physicians
10 West Phillip Road, Suite 120
Vernon Hills, Illinois 60061-1730

Dear Mr. Paul:

The Joint Legislative Audit Committee has scheduled a public hearing to examine issues raised in the Legislative Audit Bureau's recent report on emergency room use by Medical Assistance recipients. This hearing will be held on Thursday, June 24, 2004 at 10:00 a.m. in room 411 South of the State Capitol.

This hearing will be open for public testimony and we hope that a representative from your organization will be available to testify before the Committee. Please contact Ms. Pam Matthews in the office of Representative Jeskewitz at (608) 266-3796 to confirm your organization's participation in the hearing.

Thank you for your interest.

Sincerely,

Senator Carol A. Roessler, Co-chair
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz, Co-Chair
Joint Legislative Audit Committee

cc: Janice Mueller
State Auditor

SENATOR ROESSLER
P.O. Box 7882 • Madison, WI 53707-7882
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REPRESENTATIVE JESKEWITZ
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State Senator
Carol Roessler

Memorandum

TO: Carol
FROM: Jennifer
DATE: June 17, 2004
SUBJECT: Meeting with Bill Bazan, WI. Hospital Association

Bill is the Vice President of the Metropolitan Milwaukee office of the WI. Hospital Association. He stopped in to let you know that he will be testifying next week at the Audit Hearing. More specifically, he will discuss ER use by MA recipients and the uninsured.

- 15 months ago Bill/WHA started a coalition of five health systems and four Federally Qualified Health Centers (FQHC's) to develop a concept plan for Milwaukee and Medicaid recipients. They want to find somewhere for MA recipients and the uninsured to get primary care, other than the Emergency Room.
- This Coalition asked the federal government for $8.5 million to expand the primary care system in Milwaukee. This group is in the process of writing the grant application. Secretary Thompson is very supportive as well as the state Division of Health Care Financing and many state Legislators.
- The timeline for this process is as follows:
  *The grant should be written over the summer and completed by the deadline, which is October 31, 2004.
  *The Coalition should hear something by December 31, 2004.
  *If approved, the grant will be for three years. The first year dollars will be provided in spring, 2005.
- If the plan is approved and funding is provided, 32,000 new primary care slots would be created in Milwaukee.
- In addition to the grant funding the Coalition is trying to get, they are also working on two other initiatives:
  1. Develop a triage and referral system to identify the "frequent flyers" who are visiting the ER more than 10 times a year and are receiving MA or are uninsured. They would like to set up a system where they are treating the person and then directing them to a primary care physician as well as identifying potential needs for disease management. They would like to see DM used to steer people away from the ER. Example: Asthma patient who has been in the ER 10 times because he/she is not taking medication. Link him/her up with a primary care physician and get something in place to help that person properly take medication at the appropriate times etc.
  2. Target 18-30 year old males for public education strategies to encourage primary care usage. Low-income males often opt out of accepting health insurance for higher pay and then use the ER for primary care.

Voice: 608-266-5300
Fax: 608-266-0463

The primary goal of the Coalition is to identify MA recipients and the uninsured and develop medical screening but find them medical homes as well.

- The Coalition does have 2 concerns:

    1. What are the responsibilities of MA/Badger Care HMOs in terms of Care Management (i.e. Disease Management)? Less frequent users = more money for the HMOs. There is not a lot of evidence of HMOs practicing Care Management.

    2. One MA/Badger Care HMO pays $25.00 for an ER visit when the HMO classifies the visit as a primary care visit. ER doctors should be paid much for than this. The HMO should be directing the patients using the ER for primary care to the appropriate setting in which to receive primary care. Instead, the HMO just pays the $25 for the "primary care visit," which occurred in the ER.

       *I asked Bill if the WHA or the Coalition has had any communication with the WI Association of Health Plans about HMOs not following through with Care Management and potential ways to improve the situation. He said that they have not because there are only two HMOs serving Milwaukee and only one is the problem…Managed Health Services.

The Coalition is **very** opposed to imposing any kind of MA co-pay for ER use. This will just create bad debt. States that have this receive little benefit. The co-pay would be low and the state would likely require the hospital to re-coup a portion of the co-pay from the patients. Bill was very clear in stating that if a MA co-pay were created, this group would likely just give up on their efforts to reduce ER use.

The State Division of Health Care Financing is working with the Coalition to possibly help fund a demonstration project. This would help the group demonstrate whether or not their efforts actually reduce ER visits.

The Coalitions plan has the potential to be used as a national model.

If you have any questions for him or would like him to hit a particular topic to help support your views in any way, he asked that you (or staff) give him a call.

Use of Emergency Department Services by Medical Assistance Recipients

Legislative Audit Bureau
June 2004

1

Costs and Visits

- From FY 1997-98 through FY 2001-02, costs increased by 47.3 percent and averaged $20.1 million annually
- Number of visits to emergency departments increased:
  - 30.2 percent increase in fee-for-service visits
  - 28.7 percent increase in managed care visits

2

Increased Visits are the Result of Increased Enrollment

- Overall program enrollment increased 31.5 percent from FY 1997-98 through FY 2001-02
- Majority of the increase was the result of the introduction of BadgerCare in July 1999
- Percentage of recipients visiting emergency departments held steady at about 20.0 percent per year

3

Frequent Users – Fee-for-Service

- Among fee-for-service recipients, 58.3 percent visited emergency departments only once in FY 2001-02
- In contrast, 5.5 percent of those who visited went six or more times during that year

4

Frequent Users – Managed Care

- Among managed care recipients, 60.5 percent of those who visited emergency departments did so only once in FY 2001-02
- In contrast, 2.8 percent of those who visited emergency departments did so six or more times

5

Addressing High Use

- Some facilities have instituted fees
- Some facilities dedicate a section of their emergency departments for minor illnesses and injuries

6

Future Considerations

- DHFS could target efforts to frequent users in order to:
  - provide health care in a more appropriate setting
  - reduce emergency department costs

7

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin
Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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TESTIMONY FOR JOINT LEGISLATIVE AUDIT COMMITTEE HEARING REGARDING THE LEGISLATIVE AUDIT BUREAU (LAB) AUDIT OF EMERGENCY ROOM (ER) UTILIZATION AMONG MEDICAID RECIPIENTS

Mark B. Moody, Administrator
Division of Health Care Financing
June 24, 2004
Capitol, 411 South

Good morning, Chairpersons and Members of the Joint Audit Committee.

Thank you for the opportunity to testify regarding the LAB audit of Medicaid fee-for-service emergency room utilization. I would like to take this opportunity to commend the Audit Bureau for the professionalism with which they conducted their audit. I would also like to recognize the professionalism and integrity of the men and women working within the Division of Health Care Financing and our fiscal agent for working diligently and openly with the LAB staff in preparation of this audit report.

Let me begin by saying that Secretary Nelson and I recognize the importance of emergency rooms in the overall health care delivery system, particularly in Milwaukee. We also recognize that they play a unique and vital role as safety net providers for folks who are uninsured and have no established relationship with the health care system.

We also recognize that certain hospital emergency departments are under great stress in Wisconsin. This is also true of the doctors who see patients in the emergency room. As the LAB audit points out, the average amount paid to emergency room doctors has remained unchanged at $30 per visit since 1997-98. Secretary Nelson and I are very concerned about the viability of these safety net and front line providers. Secretary Nelson met with representatives of emergency room physicians very early in her tenure. She also spent an entire afternoon at Columbia Saint Mary's emergency department to observe first hand what life in the emergency room is like.

I have visited the emergency department at Aurora Sinai and met with emergency room physicians there on two occasions.

As a recent study by the Wisconsin Primary Care Association and the Wisconsin Hospital Association indicates the crisis facing hospital emergency departments is far from just a Medicaid problem. Their survey shows that emergency room use among the uninsured is an even bigger problem.

The problems facing hospital emergency departments are highly complex and will defy easy solutions. All concerned parties (hospitals, community providers including primary care doctors, specialists, FQHCs, county mental health providers, as well as managed care organizations and Medicaid) have a role to play in the solution. MA cannot be the principal solution to the problems facing hospital emergency departments around the state.

I would like to make a few remarks with respect to the audit findings, and then I would like to discuss our ongoing analysis of emergency room utilization.

Remarks about Audit Findings

The challenges related to emergency room utilization are not unique to Wisconsin or to Medicaid. A recent Centers for Disease Control and Prevention survey of emergency room use reported a 20% increase in emergency room utilization and a 15% decline in the number of emergency rooms across the United States between 1992 and 2001.

At first glance, the total spending for emergency room services when the visit did not result in an inpatient stay appears striking. But when we adjust for the increase in Medicaid and BadgerCare enrollment over the same time period, we see that ER utilization was steady over the 5-year period of the study. The percentage of recipients using the ER is up slightly from 21.6% to 22.4%, and the number of visits per person visiting the emergency room remained virtually unchanged. Perceptions about increasing emergency room use by Medicaid and BadgerCare recipients are driven by increased caseload, not by increased utilization.

The findings in the LAB report that we found most disturbing were the small number of very high utilizers. As Secretary Nelson committed in her letter to the Committee dated January 30, 2004, we have investigated those cases further since the LAB issued its report.

Department of Health and Family Services (DHFS) Initiatives on ER Use

Current Efforts

Over the past months, the Department and Division have done a number of things to investigate and begin to address the problem of high ER use. Our goal is to collaborate with doctors, hospitals and HMOs to facilitate Medicaid participants getting the right care in the right place at the right time. While this is the case for the vast majority of persons on Medicaid--in both fee-for-service and HMOs-- we do have opportunities for improvement.

- Independent of the LAB audit, the Division convened a stakeholder workgroup comprised of HMOs participating in Medicaid and BadgerCare, hospital emergency departments, ER clinicians and others to develop strategies to decrease inappropriate ER use by Medicaid and BadgerCare HMO enrollees.

- We initiated a more in-depth review of the small subset of fee-for-service recipients who use the emergency room more than 52 times in a year that were identified in the LAB

report. One of our Chief Medical Officers has reviewed medical records of these users of emergency care in the Milwaukee area.

What We Have Learned from Current Efforts

We have learned a great deal from our discussions and investigation. I would like to share some of the highlights of what we have learned so far:

- First, as the LAB audit found, 80% of the persons on Medicaid don't use the emergency room in any given year.

- Of those who do use the emergency room, most go only once or twice per year and many of them do for true emergencies.

- A much smaller number of persons on Medicaid seek emergency department care for minor illnesses and non-emergency conditions, such as earaches and colds, that can be treated by primary care doctors.

- Another very small group of persons, primarily in the fee-for-service Medicaid program, appropriately seek emergency care for chronic conditions such as acute asthma attacks or complications of diabetes. With better outpatient care and management, many, if not most, of these ER visits would not need to occur.

- Finally, there are a small number of individuals, primarily in the fee-for-service program, who appear to use the ER excessively. The LAB report identified a small group of 43 persons who use the ER more than 52 times in a year. While small in number and total ER costs to Medicaid, these individuals pose a particularly difficult challenge.

Here are some characteristics of these 43 high ER users based on our medical chart review and further statistical analysis:

- We have found that these high ER use individuals have high overall costs, not just high emergency room utilization.

- The average cost per person for the 43 high utilizers was $66,625 in 2002 and very similar in 2003. They incurred significant Medicaid expenditures for hospital-related costs when compared to the non-institutionalized fee-for-service population in general. Approximately 70% of Medicaid expenditures for high ER users went to hospitals, as opposed to 30% for the fee-for-service population. Most of these expenditures were for inpatient services. Their claims indicate that they were usually admitted from the ER even though they had many visits that did not result in admission. Only 13% of their total costs were for emergency room care. The charts attached to my testimony show the total costs for these clients.

- Several of the highest users have sickle cell disease who go to the emergency room to seek relief from acute pain. While Children's Hospital in Milwaukee has a sickle cell clinic, there is no adult equivalent for this disease that can be extremely debilitating and difficult to manage in advanced stages.

- Many of the high utilizers have a severe underlying mental illness or addiction. They incur numerous ER visits for nonspecific complaints and minor illness. In some cases, they have gone to multiple emergency rooms on the same day. Many of these individuals, because of their severe illness and behavioral problems, have great difficulty sustaining an effective therapeutic relationship with a doctor.

- Persons who visit the ER 53 or more times a year are often receiving a lot of other services. In many cases, these individuals are already connected to mental health providers, drug treatment services, medical doctors, home health services, day treatment and group homes.

- Certain high ER users are seeking drugs. They appear to be going to the emergency room to obtain narcotic medication. Some of these individuals have been enrolled in the Medicaid "lock-in" program, a program that assigns individuals determined to be abusing their Medicaid prescription drug coverage to a single doctor and pharmacy to help curb and manage their abuse.

As you can see, this small group of patients represent a very challenging set of problems that will not be easily solved and which may never be solved entirely.

Constraints on Implementing Strategies for Change

We are already looking at a number of strategies to address the problem of high users. I want to re-emphasize that there are no easy solutions or "quick fixes" and that Medicaid is part of an even larger problem for emergency rooms.

We also recognize the constraints hospital emergency departments are under with the Emergency Medical Treatment and Labor Act (EMTALA) and "prudent lay person" requirements. As most of you know, EMTALA requires hospital emergency departments to screen patients presenting at the emergency department to determine if an emergency medical condition is present. If such a condition is found, emergency departments are required to stabilize the patient - regardless of the patient's ability to pay.

Prudent lay person federal requirements dictate that all emergency services must be covered even if outside of an HMO's network, if the patient shows symptoms that a prudent lay person, possessing an average knowledge of health and medicine, could reasonably expect to result in serious impairment to his or her health.

These constraints make it difficult, but not impossible, for ER physicians, health care providers, hospitals and HMOs to implement strategies that prevent recipients from using an ER for non-emergency care.

Some of these people are unlikely to comply with case management plans and have great difficulty establishing or maintaining effective treatment relationships at this point in their lives.

Notwithstanding EMTALA and prudent lay person constraints, the Department, hospitals, and managed care providers are taking steps to study and reduce the number of visits to emergency departments for minor injuries and illnesses.

Additional Things That Can Be Done To Improve ER Use

There are a number of things we can do to help those providers who are seeing Medicaid emergency room patients. Most of the recommendations below were made by the HMO/ER Workgroup but could also apply to Medicaid fee-for-service, and in some cases, other groups as well. Most of these solutions require collaboration among all the participants in the delivery system. We are willing to be part of that collaboration. Examples of things that would help are:

- Educating Medicaid participants about the best places to get care and about the illnesses that really need emergency and urgent care and those that do not. For example, one HMO in Milwaukee that serves adults with disabilities now includes education on the appropriate use of ERs as part of their initial enrollee health needs assessment. A recent study of WIC families in California found significant reductions in hospital emergency room use for clients who had received education about managing minor health problems.

- Increasing the availability of primary care physicians and specialists for ER doctors to send people to; either for appropriate initial care or for follow-up care. We understand that ER doctors often spend a considerable amount of time finding providers - especially providers of some specialties - who will see Medicaid or fee-for-service patients for follow-up.

  The Wisconsin Primary Health Care Association and the Milwaukee-area Wisconsin Hospital Association have applied for federal funding to expand federally-qualified health care center hours and satellite facilities that would provide more primary care during evening hours.

  The Department is also working on an initiative to expand the use of managed care among the SSI population. We believe this will improve access to ambulatory care and better care management and coordination, and will have the effect of reducing unnecessary emergency room care. Our contractual conditions obligate the managed care organizations to provide care, and create financial incentives and appropriate safeguards to do so.

- Improving systems of communication so that ER doctors have information - important for assuring the best coordinated patient care - at their fingertips.

  The HMO/ER Workgroup recommended that the Department establish a central database of frequent ER users to identify Medicaid enrollees inappropriately seeking drugs or prescriptions.

  Collaboratively developing and communicating care management plans for persons who frequently use the ER. The HMO/ER Workgroup recommended developing a pilot

project in one or more areas of the state to provide intense case management to frequent ER users.

- Explore opportunities to expand and improve the impact and effectiveness of the Medicaid Recipient "Lock-in" program. The Lock-in program requires individuals found to be abusing prescription drug coverage to use one physician and one pharmacist as a condition for receiving Medicaid benefits.

- Continuing to meet with ER providers and HMOs to learn more about some of the successful strategies and best practices they have employed to reduce inappropriate utilization.

  Some hospitals have implemented rigorous triage systems that redirect non-emergencies to co-located general practitioners or other community physicians or resources

- Applying for grant money to help implement some of the recommendations in the HMO/ER Workgroup and LAB Reports.

Overall, our managed care programs have helped reduce emergency room utilization. They and the hospitals they work with can and should do much more. It is in both their interests to do so and they don't need to wait on the Department. Both would benefit directly from effective collaboration to further reduce unnecessary emergency room use. As private sector enterprises, they have both the motivation and the where-with-all to do so. Expanding managed care programs for the SSI population would further leverage their capabilities, especially with that portion of the population that does not have ongoing relationships with primary care doctors and where chronic conditions could be better managed.

I have attached a diagram that I believe illustrates the interdependence and the actions the various stakeholders need to take as part of comprehensive solutions to the problem.

The last myth that I wish to dispel is the idea that there is a great deal of money to be saved by rapidly eliminating unnecessary emergency room utilization. First, changing the utilization behavior of the vast majority of people is a gradual process involving education, behavior change and better access to community care. Second, the very highest utilizing group is a tremendous challenge and their emergency room costs, while high, are a very small proportion of the total.

Finally, we should bear in mind that the actual variable cost of treating a person without severe trauma or acute conditions is quite low. The facility is already staffed and equipped. If expensive interventions are not indicated and not ordered, the true cost, as distinguished from charges, may not be high at all. We should bear that in mind because for some people, particularly the uninsured, the emergency room is the only place where they can get any care at all.

Before I finish speaking about Department initiatives regarding ER use, I want to comment on strategies that are unlikely to reduce ER use among the very high utilizers: co-payments and limits on ER visits.