Co-pays for Nonemergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis

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Executive Summary

State of Texas officials have become increasingly concerned about the costs and problems associated with Medicaid patients receiving primary or other nonemergency care at hospital emergency rooms (ERs). Prior to the passage of the federal Deficit Reduction Act of 2005, the Texas Medicaid program did not have the option to require co-payments for Medicaid recipients for use of the ER for a nonemergency condition unless the state obtained a special federal waiver. Because of changes in federal law, Texas now has the option of applying a co-payment when a Medicaid patient goes to the ER, if the problem is not a true medical emergency. Federal law sets parameters around exactly how much can be charged to different categories of Medicaid patients, and strictly limits the circumstances in which co-pays can be charged.

State and Federal Requirements

S.B.10, 80th Legislature, Regular Session, 2007, requires HHSC to adopt cost-sharing provisions for ER utilization within certain parameters, if determined to be feasible and cost effective. Per S.B. 10, Section 20, any cost sharing provisions would apply to a Medicaid recipient seeking care through an ER if:

- The hospital from which the recipient is seeking services performs an appropriate medical screen and determines that the recipient does not have a condition requiring emergency medical services.
- The hospital informs the recipient:
  - That the condition does not require emergency services.
  - That if the hospital provides nonemergency services, some form of cost-sharing payment may be required in advance.
  - Of the name and address of a nonemergency Medicaid provider who could provide the appropriate medical service with no required cost-sharing payment; and
- The hospital offers to provide a referral to the nonemergency Medicaid provider to facilitate the scheduling of the service.

If, after receiving this information and assistance from the hospital, the recipient chooses to receive nonemergency services from the hospital, a co-pay or other cost-sharing payment may be collected.[1]

HHSC contracted with Health Management Associates (HMA) to evaluate the cost effectiveness and feasibility of implementing a co-pay policy for Medicaid patients who use the ER for nonemergent care, as provided under the Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006, and S.B. 10.

The goal of the study was to determine if ER co-payments could be feasible and cost effective to the state, given the constraints imposed by federal and state law, as well as the structure and demographics of Texas Medicaid. The approach taken compared the necessary administrative

[1] Provisions indicated from S.B. 10 mirror those from the Deficit Reduction Act of 2005.

costs to develop and implement co-pays compared with the potential savings from shifting inappropriate use of ERs to less expensive alternatives.

Under federal law, to allow Medicaid co-pays for nonemergency services in an ER, the following process must be followed:

- An appropriate medical screening must occur.
- Determination of a nonemergency medical condition.
- The patient must be informed of state-specified, cost-sharing provisions.
- The patient must be provided an alternate provider that is available and accessible contemporaneously.
- The alternative provider must take Medicaid without cost sharing.
- The patient must be provided a referral to coordinate scheduling of treatment.

Federal law also prescribes specific populations and amounts of co-pay that can be charged to each population. Primary of these federal restrictions is a prohibition of requiring payment of co-pays to patients with incomes less than or equal to 100 percent of the federal poverty level (FPL). For those with income above 100 percent of FPL, co-pay amounts are largely limited to $3 and $6. In addition, S.B. 10 prohibits the state from reducing the hospital's reimbursement relative to the co-pay policy.

In Texas, 94.6 percent of all Medicaid recipients have incomes at or below 100 percent of FPL. Thus, 2.68 million of the total 2.84 million Medicaid recipients could not be required to contribute a co-payment for services under federal law. Children comprise the vast majority of Medicaid recipients (77 percent) with income under 100 percent of FPL. This income group also includes non-disabled adults under age 65 who have incomes less than approximately 14 percent of FPL, the Temporary Assistance for Needy Families eligibility level.

The remainder of Medicaid recipients, 5.4 percent, can have services withheld if the patient does not make the payment when notified by the ER staff that there is an alternative Medicaid provider available; however, federal rules limit the co-pay amount for a number of services for children and pregnant women.

Feasibility and Cost Effectiveness Analysis

In conducting an analysis of the feasibility and cost effectiveness of implementing a co-payment program for nonemergency use of the ER, the following elements were considered:

- Number of those recipients who could be required (mandated) to pay a co-payment.
- Of those who could be asked but not required (voluntary), number of those who can reasonably be expected to pay.
- Availability of alternative Medicaid providers at different times of the day and week.
- Impact of co-pays on diverting patients out of the ER.
- Impact of co-pays on patients choosing the community alternative provider, thus avoiding the ER.
- Costs of required assessment screenings in the ER.

- Savings/Cost of providing services in alternative settings compared to the ER.
- Administrative costs for establishing and operating the program.

The analysis built upon information about the current Texas health-care system, Medicaid patient utilization and cost experience, and the various administrative changes that would be needed to implement the policy within federal requirements. Where specific data was not available, assumptions based on knowledge of the health-care system and Texas Medicaid were used.

Two scenarios with different administrative responsibilities were developed to analyze possible cost effectiveness. The difference between the two was that, in Scenario 1, the hospitals would develop their own alternative provider referral networks, without Medicaid funding. In Scenario 2, the state would be responsible for certifying alternative providers for hospitals to call for referrals to divert patients. Using data and assumptions based on knowledge of the program, the analysis indicated that neither scenario would be cost effective, even when the cost of setting up the alternative Medicaid provider referral network was borne by the hospitals.

Cost/(Savings) from Co-payment Implementation
Two Years

Cost Category	**Scenario 1**			**Scenario 2**		
	Year 1	Year 2	Total	Year 1	Year 2	Total
Diversion Cost/(Savings)	($22,960)	($22,960)	($45,920)	($76,532)	($76,532)	($153,064)
Avoidance Cost/(Savings)	0	(17,164)	(17,164)	0	(17,164)	(17,164)
HMO Factor	10,332	18,056	28,388	34,440	42,163	76,603
Administrative Cost/(Savings)	881,972	65,857	947,829	2,580,607	295,483	2,876,090
Total State Cost/(Savings)	**$869,344**	**$43,789**	**$913,134**	**$2,538,515**	**$243,950**	**$2,782,464**

Note: Medicaid Medical Costs are matched at 59.53% federal funds for FFY 2009.
Medicaid Administrative Costs are match at 50% federal funds for FFY 2009.

Because of the federal requirement that an alternative provider must be available to see the Medicaid patient in order to charge a co-pay or withhold ER services, the issue of access to such providers is key to the feasibility and effectiveness of the policy. In many locales in Texas there are shortages of providers who will take Medicaid, generally resulting in long wait times to get an appointment with primary care providers and/or clinics. The probability that such an alternative can be identified, particularly on evenings and weekends, is low at this time. Thus, the proportion of Medicaid patients who would be diverted from the ER, or who would avoid going to the ER in the first place, would be relatively small.

In addition, the administrative burden on hospital staff to enforce the co-pay policy (particularly the multi-step, time-consuming process they would have to follow to identify and call the patient's primary care provider and/or other possible providers) combined with the lack of

financial incentive/penalty and the federal provision that discretion to enforce is left to the provider, contribute to the likelihood that the policy will not be imposed often or consistently.

Based on an extensive analysis of all applicable laws and available data, implementation of a Medicaid co-payment policy for nonemergency use of the ER would not be feasible or cost effective in Texas. This conclusion is based on four key factors:

- Complex federal law requirements, which make implementation very challenging, especially for the hospital staff that would have the primary responsibility for applying the policy.
- The very high percentage of Texas Medicaid patients with incomes below poverty who could not be required to pay co-pays.
- The lack of available alternative and accessible Medicaid providers, which reduces the number of times co-pays can be applied.
- Administrative costs resulting from the federal requirements, which raises the amount of savings needed to achieve cost effectiveness.

Introduction

There is wide consensus that a hospital ER is not the best place for individuals to seek care for health problems that are not emergency conditions. The over use of ERs by Medicaid clients has long been an issue of concern, not only in terms of costs but also quality, efficiency, and appropriateness of care.

National studies have found Medicaid recipients use the ER at almost three times the rate of privately insured and uninsured individuals. However, the difference in usage decreases by approximately half when health status is taken into account. Medicaid recipients report their health condition as fair or poor at a much higher rate (40 percent) than the uninsured (25 percent) and the private insured (13 percent). Also, more than 25 percent of Medicaid recipients report multiple chronic conditions, compared to less than 10 percent for the uninsured and privately insured. However, even when health status and other individual characteristics are considered, Medicaid recipients use the ER more than the uninsured and privately insured.[2]

In studies of the general population, a visit to a hospital ER has been found to be two to three times more expensive than to a clinic or doctor's office[3]. It is widely thought this is due to higher fixed overhead costs at an ER and the likelihood that more high-cost procedures and diagnostic tests would be done to ensure the problem is not an emergency.

Although costs are a significant issue to be considered when the ER is utilized for inappropriate (e.g., nonemergency) care, there are also important quality of care issues raised. In many of the larger, urban ERs, hospitals report overcrowding has reached significant levels, often leading to long periods of 'drive-by diversion', during which a hospital ER is closed to additional patients, regardless of the critical nature of the patient's condition.[4] Furthermore, services provided in the ER are often isolated, without continuity of care and follow up, which can reduce the efficacy of

[2] Medicaid/SCHIP Cuts and Hospital Emergency Department Use, Peter Cunningham, Health Affairs, January/February 2006.
[3] Excess Cost of Emergency Department Visits For Nonurgent Care; Baker & Baker, Health Affairs, Winter 1994, p.p. 166, 169].
[4] Code Red: The Report, pp 127-128

the treatment and undermine the concept of a medical home where the patient is known and complete medical records are kept.

In many cases, commercial health insurers have addressed the use of the ER with significant cost-sharing requirements for recipients. In the commercial market, standard co-pays[5] are charged for using the ER, regardless of whether an emergency or nonemergency condition exists. For example, when an individual with private health insurance coverage determines it is necessary to take a child to the ER because of a high temperature, a co-payment of $50 to $150 or more may be charged. The high co-pay is intended to discourage unnecessary use of the ER and becomes part of the decision-making process as the parent decides how, when, and where to seek medical care for the child.

Prior to the federal Deficit Reduction Act of 2005, Texas Medicaid did not have the option to require co-payments for Medicaid recipients for use of the ER for a nonemergency condition unless the state obtained a special federal waiver. Because of changes in federal law, Texas now has the option of applying a co-payment when a Medicaid recipient goes to the ER **if** the problem is not a true medical emergency. This option varies significantly from how co-pays are used in the commercial health insurance market. Federal law sets parameters around exactly how much can be charged and to which Medicaid patients, and only permits co-pays under very specific circumstances. Given these requirements, S.B. 10 directs HHSC to study this policy option to determine if ER co-payments for nonemergency conditions can be implemented in a feasible and cost-effective manner in the Medicaid program.

HHSC engaged HMA to conduct an analysis of the cost effectiveness and feasibility of implementing co-payments to Medicaid recipients who use the ER for nonemergency conditions.

Specifically, for Texas Medicaid, the following information was analyzed:

- Federal requirements.
- State requirements.
- Service delivery models (Capitated Managed Care and Primary Care Case Management)
- Who uses the ER.
- Where high ER utilization occurs.
- Most frequent nonemergent diagnoses of recipients in the ER.
- Cost of specific diagnosis by treatment setting (e.g., ER, clinic, or physician's office)
- Availability of alternative Medicaid providers.

In addition, relevant lessons from other states were reviewed and an extensive literature review of studies was conducted regarding use of the ER in Medicaid, other public programs, in the commercial market and among the uninsured. An analysis of approaches allowed by federal law and how they applied to Texas Medicaid was done using available Texas program data, along with other information gathered from related studies, to determine the cost effectiveness of each approach.

[5] The term "co-pay" is used throughout this report since it is the form of cost sharing being considered for this analysis.

Finally, other qualitative information was gathered from professionals who work in the system to discuss the feasibility of applying co-pays as an effective means for getting Medicaid patients in to the most appropriate care settings.

Issue Identification

One of the primary reforms of Texas Medicaid over the past ten years has been an emphasis on establishing a medical home for the Medicaid patient. Whether through a Health Maintenance Organization (HMO), Primary Care Case Management (PCCM), or Integrated Care Management (ICM), matching each patient to a primary care provider who will manage their health-care needs is essential to ensuring early access to preventive care, avoiding more costly problems left unattended, and reducing inappropriate use of ERs.

Unfortunately, even with the medical home model in place for approximately half of Texas Medicaid recipients in 2005, almost half of all visits to the ER turned out to be for nonemergent care. That is, 47 percent[6] of the visits by Medicaid recipients were not for health conditions defined as true emergencies, such as those threatening life or limb.[7] Of the approximately $307 million spent on ER services in state fiscal year 2005, $121 million was for nonemergency services.[8]

Table 1: Examples of Emergency and Nonemergency Conditions

Emergency	Nonemergency
Chest pains	Common cold
Broken bone	Sore throat
Excessive bleeding	Stomach ailment
Poison or drug overdose	Vomiting
Severe allergic reaction or animal bite	Headache

In addition, these patients often contribute to overcrowding in the large urban safety net hospitals, which are typically major trauma centers for their communities and are often the provider of last resort for patients with no health insurance.

There are many reasons a Medicaid patient seeks care in hospital ERs, some of which have implications for the larger health-care system, and some of which may reflect deficiencies in

[6] HHSC Statistics and Data Analysis.

[7] 'Emergency Services' are defined in the Social Security Act as: "after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in –
(i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or
(iii) serious dysfunction of any bodily organ or part."

[8] If should be noted that examination of the data indicated numerous instances where a patients' services in one day included both nonemergent and emergent classifications; thus, these numbers may overstate the actual proportion and costs of 'nonemergent' care.

Texas Medicaid itself. These will be discussed in the analysis that follows and must be considered when deciding how best to address this problem.

Federal and State Medicaid Emergency Room Co-Payment Provisions

Unlike private insurance, which typically places a co-pay on use of the ER regardless of the severity of the episode, federal Medicaid law prohibits co-pays for true emergency care and sets stringent requirements around co-pays for nonemergent care. Although recent changes in federal law and the passage of S.B. 10 by the Texas Legislature altered a number of historical barriers to Medicaid co-pays, there are still significant requirements to be followed in the design and implementation of a co-payment program.

Federal Requirements for Co-payments

The original design of the federal Medicaid law prohibited any form of cost sharing for Medicaid recipients. However, as the program expanded over time to cover higher-income individuals, some limited cost sharing has been allowed under special federal waivers, although persons under 100 percent of FPL, $17,170 per year for a family of three, were specifically excluded. For recipients with incomes higher than 100 percent of FPL, co-pays could be requested at the time of service but could not be enforced (mandatory). That is, care would be provided even when the patient could not pay the co-pay.

In 2005, the federal Deficit Reduction Act (DRA) (Public Law No. 109-71) provided new options for Medicaid state plan amendments (which are easier to secure than waivers) to use cost sharing as a means to encourage patients to use less expensive care, when available and appropriate, for items such as prescription drugs and nonemergency use of the ER.

This analysis assumes that the state would seek state plan amendments as allowed by the DRA and not seek a waiver for the co-pay policies. States can pursue Medicaid policy changes through 1115 waivers, which is the approach used by other states pursuing major reform efforts in recent years. Texas could request changes in any of the DRA federal rules on co-pays that are examined in this analysis as part of the larger 1115 waiver reforms being developed. However, certain policies are very difficult to get federal approval for or have never been allowed, such as mandating co-pays for persons with incomes below 100 percent of FPL.

In the case of the ER, the principle DRA change was to allow states to require and enforce cost sharing as a prerequisite for receiving nonemergency services in an ER under certain specific circumstances. In 2006, Congress passed technical amendments in the Tax Relief and Health Care Act (TRHCA) (P.L. 109-432), which further clarified the DRA provisions on cost sharing. Taken together, the federal parameters for imposing cost sharing are important when considering whether the implementation of such a program would be cost effective and/or feasible to operate.

Table 2: Federal Requirements for Co-payments in the Emergency Room

Appropriate medical screening must occur.
Determination of a nonemergency medical condition must occur.
Patient must be informed of state-specified cost-sharing provisions.
Patient must be provided an alternate provider name and location for service provision.
Alternate provider must be available and accessible.
Alternate provider must take Medicaid without cost-sharing requirements.
Patient must be provided a referral to coordinate scheduling of treatment.

These requirements are significant in scope and it is important to understand the detailed steps required in order to analyze cost effectiveness and feasibility.

An ***appropriate screening*** must be done as directed by the federal Emergency Medical Treatment and Active Labor Act (EMTALA; section 1867 of the Social Security Act), which requires a medical screening and stabilization of patients, and also regulates transfers of patients between hospitals. Under any circumstance Medicaid must pay for this screening and any diagnostic tests performed during the screening, even if the patient goes elsewhere to be treated.

A nonemergency medical condition is defined as care or services furnished in an ER of a hospital that do not constitute an appropriate medical screening examination, stabilization and treatment required to be provided by the hospital under EMTALA .

Determining that a co-pay applies, informing the patient, and verifying the amount owed would be a new responsibility for the hospital staff at the ER, and would add new expenses for the hospital in staff time. As this report explains in greater detail later, there are multiple considerations for hospital staff to take into account.

Alternative Medicaid nonemergency services provider must be available and accessible. The nonemergency services provider is defined for these purposes to include providers such as a physician's office, health-care clinic, community health center, hospital outpatient department, or similar health-care provider that:

- Are actually available (open) and accessible (proximate to hospital in terms of distance and time to get there and patient has a way to get there).
- Can provide clinically appropriate services for the diagnosis or treatment of a condition ***contemporaneously*** with the provision of the nonemergency services that would be provided in an ER of a hospital for the diagnosis or treatment of a condition.
- Is participating in the Medicaid program.

"***Contemporaneously"*** is not further defined in the federal law, regulations, or other federal guidance; however, the dictionary defines it as "existing or happening at the same time." "***Actually available and accessible"*** is defined in federal law as it is applied by the Secretary under SSA section 1916(b)(3), which states, "…and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services."

Alternate provider must take Medicaid without cost-sharing requirements. The alternative must be a Medicaid provider; however, since there are no other co-pays in Texas Medicaid, the issue of the alternative providing the service without imposing other cost sharing does not apply.

Patient must be provided a referral to coordinate scheduling of treatment. Under this requirement, there must be a responsible person available in the ER to assist in scheduling a referral. It is likely this would be a hospital staff person, although it could also be state staff or a contractor of the state available in the ER or by phone.

Only after all of these conditions are met will the patient either go to the referred alternative Medicaid provider, and thus not pay a co-pay, or choose to stay for treatment and pay a co-pay, which is based on their income and the type of service needed.

Finally, the federal law provides that the hospital physician can waive the co-pay at his or her discretion, on a case-by-case basis. (Social Security Act, section 1916A(d)(2)). In addition to these process requirements, there are specific federal limits on whom and what to be included under co-pays.

Federal Requirements and Texas Populations Covered under Co-pays

Once a state has met these federal requirements, copayments may be charged if the patient decides to stay for treatment at the ER for a nonemergent condition. However, charge of the co-payment is not universally applied to all Medicaid recipients. The limitations on whether a state can mandate payment of a co-pay and the amount allowed are also defined by federal law and regulation.

Recipients with incomes less than 100 percent of FPL ($17,170/year for a family of 3) can be requested, but not mandated, to pay a nominal co-pay ($.50- $3). Services must be provided in the ER even if the patient does not pay the co-pay. Also, the standard Medicaid Scope, Amount, and Duration provisions apply to co-pays. Thus, any co-pay policy must be applied consistently across all recipients below poverty and can not be targeted to particular sub-groups of that population (e.g., TANF Adults, SSI, etc.).

In Texas, 94.6 percent of all Medicaid recipients have incomes below 100 percent of FPL. Therefore, 2.68 million of the total 2.84 million Medicaid recipients could not be required to contribute a co-payment for services. Children comprise the vast majority of Medicaid recipients (77 percent) under 100 percent of FPL. This income group also includes nondisabled adults under 65 years of age who have incomes less than approximately 14 percent of FPL, the TANF eligibility level[9].

Recipients with incomes between 101 – 150 percent of FPL ($17,171 - $25,755/year for a family of 3) can be required to pay a co-pay up to two times the nominal amount, or $1 - $6. Services can be withheld if the person does not make the payment when notified by the ER staff that there is an alternative Medicaid provider available.

In Texas, there are approximately 136,721 recipients with incomes in this category; however, because of federal rules regarding other exemptions discussed later in this section, not all services and/or recipients could be charged at two times the nominal amount, rather only the nominal amount.

Recipients with incomes over 150 percent of FPL ($25,755+ /year for a family of 3) can be required to pay a co-pay if an alternative Medicaid provider is available. The amount is set by the state (not limited in federal law), and services can be withheld if payment is not made. For example, $50 is the amount charged in the Children's Health Insurance Program (CHIP) for nonemergent ER use.

In Texas there are approximately 15,605 Medicaid recipients in this income group who could be charged the state-set co-pay. Again, not all services and/or recipients could be charged this $50 rate because of federal rules regarding other exemptions discussed below.

Note: For detailed breakouts of each eligibility group by income categories, see Tables A-1, A-2, and A-3 in Appendix A.

Additional Federal Restrictions

In addition to federal requirements for specified income levels, the federal government also sets out restrictions on co-payment amounts based on specific services and specific recipients, regardless of the recipients' income. States are not allowed to charge more than a nominal (no more than $3 per visit) co-payment for any services, including nonemergency services provided in the ER, for the following groups and services:

- Children ages 0 -18 under 100 percent of FPL.
- Foster or adopted children.
- Breast/cervical cancer patients.
- Persons in hospice, hospitals, nursing homes or ICF-MRs.
- Preventive services for children (well baby, well child, immunizations).
- Family planning services and supplies.

[9] See Appendix A for a table with maximum income levels for states with pre-DRA co-pays and for the Texas Medicaid population.

- Services for certain disabled children.
- Pregnancy related services for pregnant women.

Family Cap

In addition, the federal regulations establish a limit on the maximum co-payment a family may be charged based on its total income. States may not require a family to pay more than 5 percent of family income, as applied on a monthly or quarterly basis, as a co-payment for services. However, the state can seek a waiver of federal regulations to waive this requirement. To summarize, Table 3 illustrates the various requirements as they apply to the Texas Medicaid population.

Table 3: Federally Allowed Medicaid Co-Pays for Nonemergency Services in the ER by Texas Medicaid Eligibility Category

Eligibility Group	Under 100% FPL	101%-150% FPL	Over 150% FPL
Co-pay Amount	Nominal $0.50 - $3 (voluntary)	Twice Nominal - $6 (mandatory)	No Limit (mandatory)
Aged, Blind & Disabled	641,050	3,405	1,413
TANF Adult	43,982		
TANF Child	199,205		
Foster Care/Adoption	32,893		
Pregnant Women[1]	102,600	16,385	6,116
Newborns under 1 year[1]	158,495	6,207	424
Expansion Children 1 – 5 years[1]	627,721	110,724	7,652
Mandatory Children 6 – 18 years[1]	835,459		
Medically Needy	43,247		
TOTAL	**2,684,652**	**136,721**	**15,605**

Note:
1. Shading indicates that co-pays are limited to no more than $3 for certain services typically used by these populations: preventive services for children, pregnancy-related services and family planning services.
Source: HHSC Eligibility and Enrollment Data, April 2007.

State Requirements for Co-payments

The 80th Legislature established provisions for the collection of co-payments for nonemergency use of the ER through S.B 10. The law allows the implementation of co-payments in line with the federal DRA, with two additional conditions:

- The state may not reduce the hospital's reimbursement for the services rendered by the hospital, regardless of whether the co-payment is collected.
- The implementation of a co-payment must be cost effective to the Texas Medicaid budget.

These federal and state provisions, particularly in relation to Texas Medicaid, play a significant role in the ability to collect revenue through a co-payment program, the administrative costs required to operate the program, and the policy options available to Texas.

Experience from Other States

Prior to the DRA, 36 states charged some form of cost sharing (co-pay or co-insurance percentage of charges) for nonemergent services in ERs. However, co-pays could not be mandatory for the traditional Medicaid population (i.e., A Medicaid patient's failure to pay would not keep them from receiving care).

As with all Medicaid policy, there is a wide range of approaches and special requirements employed by the states, including which eligibility groups were affected and limits on number of visits covered. Most states used either a $3 co-pay for nonemergency services in ERs (11 states) or a general hospital outpatient co-pay of $3 (9 states). Nine other states charged more than $3 for using the ER for nonemergencies since they covered higher income populations, and two states had policies to not pay at all for nonemergent services provided in ERs (Vermont and New Jersey).

There are very few studies of the impact on use of any services, ER or otherwise, from the imposition of Medicaid co-pays. Regarding Medicaid ER co-pays specifically, we did not find any evaluations or studies regarding the impact of co-pays on diversion from or avoidance of ERs, or any documented behavior change resulting from imposition of co-pays. Nor did we find any studies or data on the rate of co-pay voluntary or mandatory payment by Medicaid patients.

Since the passage of the DRA and TRHCA, only Kentucky has sought federal approval to apply cost sharing, although not a co-pay, under the new ER option. The charge is a co-insurance of 5 percent of the service cost, up to $225/year per family or 5 percent of family income in a quarter. The charge is not applied to those under 100 percent of FPL.

Interviews with Kentucky staff indicate that the co-insurance is made after the service has been provided and determined to be nonemergent. Thus, unlike a co-pay, which is applied at the point of service, Kentucky's co-insurance is billed to the patient after the fact. There does not seem to be a strong enforcement effort to ensure that the cost sharing is paid.

In addition to these complex federal parameters, implementation of any co-pay policy must be considered in the context of how Texas Medicaid is structured.

Note: See Table A-4, Appendix A for a breakout of states with co-payments for nonemergency ER services.

Impact of HMO and PCCM Service Delivery Models

Texas operates two distinct managed care service delivery models for the majority of all Medicaid clients: Health Management Organizations (HMO) and Primary Care Case Management (PCCM). As of 2007, approximately 1.3 million recipients were in HMOs,

700,000 in PCCM and 850,000 in fee-for-service (FFS). HMO and PCCM models in Texas have historically operated in the urban and surrounding counties. Starting in September 2005, the state moved towards a clear geographical distinction between the two models. The HMO model generally operates in the major metropolitan areas and the surrounding counties while the PCCM model operates in the remaining, mostly rural areas. The different service delivery models have important implications for a potential co-pay policy.

HMOs are at full financial risk for medical costs. The HMO is paid a monthly capitation rate based on a number of factors, including average costs, historical utilization and projected medical cost trends. This rate is established on an annual rate cycle. If the health plan can contain or reduce costs below the capitation payment, the health plan is allowed to retain some of that savings as profit. Thus, there are significant financial incentives in place in HMOs for finding ways to decrease the use of high cost services, such as the ER or hospital inpatient care.

In addition, the state requires the HMOs to report performance on other indicators related to ER usage. The state sets performance targets, and HMOs who do not meet the required performance levels can be penalized.

In the PCCM financial model, primary care providers are paid a $5 per member per month fee to "manage" their Medicaid patients. Under PCCM, these primary care providers are required to have 24-hour coverage, for which many primary care providers use an answering service and must return the call within a prescribed period of time. However, primary care providers are not at risk for member costs and have less incentive to be proactive in managing recipients to prevent nonemergency care in the ERs.

Use of the Emergency Room in the Texas Medicaid Program

To understand the potential cost effectiveness and feasibility of a co-payment program for nonemergency use of the ER in the Medicaid program, it is important to understand the different types of ERs, who is using the ERs and for what health conditions.

Differences in Types and Sizes of ERs across Texas

Texas has 227 hospital ERs, which vary widely in size, scope, and utilization. There are 13 level I ERs, which are the highest level for full service; 9 level II ERs, which are slightly less well staffed; 40 level III ERSs; and 165 level IV ERs, which are mostly in rural areas and intended for stabilizing and transferring high-need cases.[10] In many of the smaller, quieter level III or level IV ERs outside the large urban centers, nonemergent visits are part of their anticipated revenue stream; many of these smaller ERs serve more as urgent care clinics in practice.

It is not widely understood that in the Texas Medicaid PCCM delivery model, which is the primary service model in these less urban areas, and in Medicaid FFS, payments to the ER physician are already reduced by 40 percent if the care is determined to be nonemergent, bringing the cost much closer to what it costs in a nonhospital clinic or even doctor's office, if extensive diagnostic testing is not done in the ER. In some communities, allowing patients to be

[10] Code Red: The Critical Condition of Health in Texas, p. G-5.

treated in these settings could be the most efficient, if not cost-effective method, both in maximizing limited resources and time for all parties.

Common Nonemergency Health Conditions

In 2005, Medicaid recipients made 1,851,676 visits for medical treatment in hospital ERs. Although the medical conditions vary considerably, analysis of the data shows that 874,289, or 47.2 percent, of the total Medicaid visits were classified as nonemergent episodes.

The ten most common nonemergent conditions were:

- Common cold
- Sore throat
- Stomach problems
- Pregnancy-related conditions
- Vomiting
- Acute bronchitis
- Head or neck bruising
- Headache
- Urinary tract infection
- Viral infections

Which Medicaid Patients Use the ER for Nonemergency Conditions?

Data is kept differently for HMO vs. PCCM/FFS recipients. HMA looked at Texas Medicaid PCCM/FFS data from 2006 to assess which types of Medicaid patients went to the ER for any of the ten most common nonemergent conditions. The data shows that for the top ten nonemergent conditions, 63 percent of the visits were for children; 12 percent were by pregnant women; 10 percent by aged or disabled patients on SSI; and 10.4 percent were by TANF-type recipients.

In terms of charging a co-pay, as the general data on Medicaid eligibility shown earlier indicated, relatively small numbers of these population groups have incomes above 100 percent of FPL, and fewer still above 150 percent of FPL.

Reasons for ER Usage for Nonemergency Conditions

Nonemergency conditions are not always a clear cut decision for most individuals. Many people can think of an instance when they choose to use the ER for something that turned out to be nonemergent: a first born toddler with a high fever or vomiting, or an unexplained pain in the stomach that might be appendicitis.

However, for the Medicaid population in Texas, there may be other reasons why a person would choose to go the ER as a regular source of care. For example, appointments, or timely appointments, with a regular doctor or clinic may not be not available.

ER Usage During the Day, Evenings, and Weekends

Data on times of day that Texas Medicaid patients go to the ER, or particularly for nonemergent care, are not available. While it is clear that there is a need for care after normal doctor's office or clinic hours (after 5 p.m. on weekdays and on weekends), it is also true that patients use the ER during regular office hours as well. A recent study of ER visits (all patients) to the Hermann System hospitals in Houston over the past five years showed that utilization is lowest around 5 a.m. and rises sharply to a steady level between 11 a.m. and 5 p.m., and then rises to the highest level around 8 p.m. It stays relatively high until around 10 p.m. and tapers off through the night. The study also found that utilization was fairly consistent throughout the week, with Monday being slightly busier and Friday, the least busy.[11]

Thus, in designing a co-pay policy, the availability of alternative Medicaid providers during normal business hours, after hours and on weekends must be taken into consideration.

Policy Options and Considerations

Who to Include Under Co-Pay Policy

For the cost effectiveness analysis, all Medicaid recipients were included except for two groups: institutionalized patients and those who are dually eligible for both Medicare and Medicaid. Institutionalized patients, including those in hospitals, state schools, community Intermediate Care Facilities for Persons with Mental Retardation, and hospice, generally do not decide when to go to the ER, since their medical care is managed by the institution's staff. In addition, they have extremely limited personal care allowances and very low incomes. For dually eligible recipients, Medicare is the primary coverage for in- and out-patient hospital care, and the state Medicaid program is responsible for covering any cost sharing for their Medicare services. For both institutional and dually eligible groups, the absence of incentive to the patient for behavior change did not merit their inclusion.

The analysis assumes pregnant women would be subject to co-pays, although distinguishing what constitutes a "pregnancy-related" or "non pregnancy-related" condition is subject to various interpretations. It would be difficult to apply different co-pay amounts based on whether the condition is pregnancy related, since the federal law states that only nominal co-pays ($3) can be charged for pregnancy-related services, regardless of the woman's income. The same type of issue arises regarding preventive services for children, among others.

The analysis does include Medicaid patients with incomes below 100 percent of FPL, for whom co-pays cannot be mandatory because they comprise the vast majority (94.6 percent) of Medicaid recipients in Texas and most of those who use the ER. This, however, is a policy decision the state must make, and there are pros and cons to including this voluntary co-pay population.

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[11] *Emergency Department Use Study, January 1, 2005 through December 31, 2005, FINAL REPORT, Memorial Hermann Health care System Hospitals;* Charles Begley, Patrick Courtney, Keith Burau; The University of Texas School of Public Health, Houston, p.p. 17- 18

HMA did not find any documentation or studies of the impact of Medicaid voluntary co-pay on behavior.

In support for including those under poverty, asking for a co-pay provides an opportunity to educate or remind patients that there are more appropriate places to get basic care for themselves or their children and perhaps influencing them in the future to go elsewhere. In addition, including the voluntary co-pay population is in keeping with the idea of treating Medicaid patients more like the privately insured population.

The primary argument against charging a voluntary co-pay is that once the patients understand they can not be mandated to make the co-pay or that services can not be withheld for failure to pay, it becomes an exercise that is highly unlikely to change their behavior. Furthermore, it also would add a new and significant burden on the hospital staff's workload, and would conceivably require additional staff in some of the busier ERs. The combined effect could be that staff, particularly in very busy ERs, would be reticent to go through the exercise of determining whether and how much co-pay to request and take time to identify a referral for an alternative Medicaid provider. Kentucky, the only other state to set up cost sharing since the DRA allowed application of voluntary co-pays on the population below poverty, chose not to include them in their co-insurance policy.

If the voluntary (under 100 percent of FPL) population is not included, then the entire policy would cover a maximum of 150,000 Medicaid recipients. The actual number of patients it would affect would depend on the frequency with which they use the ER. The average number of visits per year for the Texas Medicaid population is 0.55, or once every two years. HMO data indicates that a very small percentage of Medicaid members go to the ER more than once a year.

Complexity of the Federal Requirements

Beyond the state administrative costs reflected in the cost analysis, there are feasibility and cost issues that affect providers in the ER and alternative settings, as well as recipients. These can not be assigned a financial cost but merit consideration.

The complexity of the federal requirements significantly impact administrative resources and patient compliance. While the intention of imposing co-pays is to discourage unnecessary use of the ER and redirect patients to more appropriate care, the Medicaid rules do not parallel the way co-pays are used in the private insurance market. Imposing a co-pay only on 'nonemergency" services requires a medical assessment, which in the ER can be extensive because of liability concerns. The patient, therefore, receives medical attention before the co-pay is determined. The state will be charged for this assessment regardless of the severity of the patient's condition—nonemergency or emergency.

Because of the circumstantial variation in which Medicaid patients can be charged and the co-pay amount dependent upon which services are needed, the state would need to establish precise policies and procedures that the hospital would have to apply. For example:

- How many alternatives must be contacted to find a referral?
- Should the primary care provider be contacted first, regardless of time of day the patient is in the ER?
- Does the patient have transportation to the alternate Medicaid provider, or is transportation available? How far away is the alternate?
- Is an alternate Medicaid provider available "contemporaneously?" Within what timeframe must an alternate Medicaid provider be available to see the patient?
- Will the state ID card, which will show the basic co-pay amount applicable to that patient, also show the "nominal" amount for children's preventive services or a pregnant woman's pregnancy-related services?

A study of co-pays in Utah (for all types of services) concluded, *"A tiered system that used different co-payments for different beneficiary categories and for different services resulted in considerable provider confusion and increased burden on physician's office staff members. The state found that additional orientation programs and outreach to physicians' offices were needed to clarify the co-payment requirements."*[12]

The same would be true, perhaps even more so, for ER staff in Texas. Whatever the decision is on applying the requirement for "contemporaneously," the policy will have to be approved by the U.S. Secretary of Health and Human Services.

Provider Discretion

Even when all of the federal and state steps are followed, federal law gives the final discretion to the hospital medical staff on when or when not to apply the co-pay, and under S.B. 10, the hospital reimbursement cannot be reduced to reflect any co-pay. This would likely result in an uneven application of the co-pay policy. If the hospital staff has to make several calls or wait on hold to get the referral, it reduces the probability that they would impose the co-pay policy. Rather, they would be more inclined to say there was no alternative available and proceed to serve the patient.

Additionally, the hospital has little financial incentive to enforce the policy. The hospital's rates are not reduced and the revenue received from treating the patient significantly outweighs both alternative outcomes: the small co-payment that might be collected; or the cost of staff time to find alternatives. Finally, if a diagnosis is made during the assessment the question for the hospital staff could become "why not go ahead and treat the patient?" if the treatment is simple and easily available, such as a prescription.

Availability of Alternative Medicaid Providers

Perhaps the most important variable in the cost effectiveness and feasibility of establishing a co-pay system is whether there is another place the ER patient can go to get the appropriate care. Its importance is due to the fact that it triggers the application of the co-pay policy—whether mandatory or voluntary. Federal requirements set the bar very high for states to be able to charge co-pays, requiring that they can be imposed only when an alternative Medicaid provider

[12] Impact on Providers: Cost Sharing Practices in Medicaid: Lessons Learned. Dr. Shenkman, Institute for Child Health Policy, University of Florida, March 30, 2007.

is actually available and accessible contemporaneously. This greatly complicates the ability to divert Medicaid patients from ERs. The factors in play include:

- The alternative Medicaid providers' hours of operation.
- The distance and time it would take to get to the alternative Medicaid provider.
- The patient's ability or means to get there.
- The capacity for the patient to be seen in a timely manner at the alternative site.

In an attempt to understand the general proximity of providers (not including primary care providers), particularly those that might be open for extended hours, paid provider types were reviewed from the 19 counties with the highest number of Medicaid recipients. For a sample of geographically dispersed hospitals with ERs where Medicaid patients go, HMA looked at clinic providers (federally qualified health clinics and rural health clinics—both freestanding and hospital-based) within a 10-mile radius. The data indicated that the number of clinics that take Medicaid and might meet the federal requirements for "actually available and accessible" varies significantly among the different areas of the state.

Discussions with health-care providers who work with Medicaid patients reflected a widespread consensus that currently there are very few true alternatives for after hours (5 p.m. – 8 a.m. M-F and all weekend). For those providers who take Medicaid and are open during regular hours, there are often long waiting periods (multiple weeks) to get an appointment.

During regular office hours of the primary care provider or clinic the issue would be whether the patient can be worked in to be seen in a reasonable period of time. During after-hours or weekends, the issue would be finding providers who are open, relatively close by, and who can see the patient within the state set time limits. The state is now creating a database of information about the hours of operation of the Medicaid providers who self report.

This information could form the starting point for developing a referral system of designated alternative providers who take Medicaid for the various times of the regular weekday as well as after hours and weekends. There would likely need to be agreements in place between the hospital and the alternative Medicaid provider. In areas with HMOs, agreements would have to include the alternative clinics in their provider network. These agreements may have to be mandated in hospital and HMO Medicaid contracts with the state.

There is no way to estimate the other two factors – whether the patient has means to go to an alternative site or whether the provider could actually see them within a state-set timeframe.

Recent in-depth analysis by the Save Our ERs Coalition, on how to address the crisis in ER services in Harris County, found that over half (54.5 percent) of all ER visits—by insured, uninsured, and Medicaid patients—were inappropriate, and that about half of these were by 'safety net' population—uninsured and Medicaid. The study concluded that "*over half of current uninsured and Medicaid ER visits are inappropriate, but adequate community-based primary care and other capacity are unavailable.*" Based on the analysis, they concluded that "*strategies focused solely on redirecting inappropriate ER use are likely to fail due to lack of*

adequate alternative capacity". Furthermore, "*any adopted strategy must seek to better balance the health care system through building new capacity and improving coordination of care*."[13]

Diversion and Avoidance: Impact of Co-pays on Patient Behavior

HMA was not able to find any studies evaluating the impact on utilization related to Medicaid co-pays—voluntary or mandatory—specifically for ER use. The most cited study[14] of the general population in the commercial insurance market shows that persons with higher cost sharing made fewer physician visits than people who had either no or lower out of pocket expenses (such as the low co-pays allowed for Medicaid). The study also found that reductions in visits were for both appropriate and inappropriate care. In addition, the poorest people (who had no co-pay) had better outcomes, such as control of hypertension, and fewer "serious symptoms" (such as chest pains, bleeding not associated with accidents or injuries, shortness of breath with light exercise or work) when they were seen by a doctor.

However, trying to apply any of the various studies of the general population in the commercial market or other types of cost sharing in Medicaid to the particular policy of small Medicaid co-pays for ER use is highly problematic. Requiring a high-cost co-pay for any service which must be paid regardless of the condition or circumstances is quite different from the federal Medicaid co-pay rules. Of the Texas Medicaid population, 94.6 percent cannot be mandated to pay a co-pay, and, because of their low incomes, are not likely to voluntarily pay the co-pay or go elsewhere unless it is very close by and easy to get to, such as an on-site urgent care clinic. To the extent that such alternatives exist today, patients are possibly being sent there already by the ER. In addition, the co-pay amounts that can be mandated for the 5.4 percent of patients above 100 percent of FPL, if there is an alternative Medicaid provider available, are relatively low ($3 - $6 for 90 percent of those over poverty). Unless it is very easy to go elsewhere from the ER (or before going to the ER), the impact of co-pays on patient behavior is likely to be very small, if any.

Comparison of Service Savings/Cost of Non-ER Use vs. Use of ER as Main Service

To get a sense of what HHSC pays for treating nonemergent conditions in the two different provider settings, ERs and community-based physician offices, a one month "snapshot" (February 2006) of paid claims data was analyzed for a sampling of each provider type from across the state. This payment data reflects the actual Medicaid cost of a treatment 'episode' for patients with at least one of the top ten most frequently nonemergent conditions.[15] The ten primary conditions include:

[13] "Revisioning the Delivery of Health Care Services to Uninsured Patients in Harris County." The Lewin Group for the Save Our ERs Coalition, Harris County, Texas, p. 4.

[14] The RAND Corporation, Health Insurance Experiment, as summarized on their website: http://rand.org/pubs/research_briefs/RB9174/index1/html.]

[15] It is important to note the costs and utilization rates used in this section are based on the state's PCCM and FFS data and does not include actual HMO data. It is difficult to ensure comparability between HMO claims data and PCCM/FFS claims data due different data systems; therefore, we have used PCCM/FFS data as a proxy for all costs and utilization rates. This is a conservative approach which, if anything, may overstate savings.

- Common cold
- Sore throat
- Stomach problems
- Pregnancy-related symptoms
- Vomiting
- Bronchitis
- Bruising
- Headache
- Urinary tract infection
- Viral infection

This treatment episode cost includes all services paid to the hospital facility or community-based physician for that patient on that date of service, with the exception of certain costs. Those costs could not be compared across the three provider groups, because the state pays them differently. Excluded from all episodes in both provider types are pharmacy and dental costs. Each of the datasets was analyzed to develop an average cost for the top ten nonemergent conditions for each provider type—ER and primary care provider. Based on this data, the average of Medicaid payments for the top ten nonemergency visits is $279 for the hospital ER and $129 for the community-based physicians.[16]

The analysis did not include other community providers, such as federally qualified health clinics or other clinics that serve many Medicaid patients. If these providers have higher costs, the savings from diverting or avoiding the ER would be lower.

Collection of Co-pays

S.B. 10 prohibits the state from reducing the ER provider's reimbursement to reflect expected co-pay revenue from the patient. Thus, savings to the state would be from the ER referring the patient to a less expensive provider (called "diversion"), or from change of behavior so that patients do not go to the ER for minor problems (referred to as "avoidance"). In the following cost analysis it was assumed that the hospitals would keep the co-pays and not have to account for them to the state based on several considerations:

- Revenue collected could be used by the hospital to offset a portion of the additional costs incurred as a result of complying with the co-pay process requirements.
- Without retaining the revenue, the hospitals would likely argue that they should be compensated for this new administrative requirement.
- It would be burdensome and costly for the state to establish a new state system to account for and monitor hospital collections.

Frequent Users and Co-pay Cap

We could not factor into the analysis the probability that frequent ER users who are above poverty (with mandatory co-pays) are more likely to possibly reach the limit established by the family cap and thus not be subject to co-pays for some periods of time each quarter. However,

[16] For a detailed description of the methodology see Appendix B.

given the small number of Medicaid patients to whom this might apply, HMA assumes in its analysis that all anticipated co-pays are collected without consideration of the family cap. As mentioned previously, the state could seek a waiver for this provision under an 1115 waiver.

Cost Effectiveness Analysis

In conducting an analysis of the cost effectiveness of implementing a co-payment program for nonemergency use of the ER, the following elements were considered:

- Number of those recipients who could be required (mandated) to pay a co-payment.
- Of those who could be asked but not required (voluntary), how many can reasonably be expected to pay.
- Impact of co-pays on diverting patients out of the ER.
- Impact of co-pays on patients choosing the community alternative physician, thus avoiding the ER.
- Costs of required assessment screenings in the ER.
- Savings/Cost of providing services in alternative settings compared to the ER.
- Administrative costs for establishing and operating the program.

Factors that were not included in this analysis include the costs to the hospital for staff time needed for the referral process; in Scenario 1, the cost to hospitals of establishing their alternative provider networks; an estimate of revenue collected at the local level; or cost of monitoring or evaluating the application and impact of co-pays.

In the final analysis, the question to be answered is whether or not a co-payment for nonemergency services that meets all federal and state requirements can be implemented in a cost-effective and feasible manner. Would the administrative costs of setting up and administering the co-pay process be offset by the potential reduction of medical costs from patients being served in other settings?

Administrative Costs

A co-pay policy would create costs for the state and the hospitals with ERs. How those costs are distributed depends on how the administrative structure is designed. The analysis includes high-level estimates for the state eligibility system and the program contractors who administer parts of the program. These estimates would have to be significantly refined as more specific details of the policy are determined in implementation. Experience suggests they would most likely increase as the process is developed and thus should be viewed as potentially understating costs.

Establish and Maintain Alternative Provider Listing

For this cost effectiveness analysis, two different approaches for establishing and maintaining alternate provider listings were considered:

- Scenario 1—Hospital Responsibility: HHSC's contracted claims administrator and PCCM administrator, the Texas Medicaid & Healthcare Partnership (TMHP), would make available to hospitals a list of all Medicaid providers with information on location and hours of

operation. These providers may or may not be an available alternative provider, so each hospital would be required, as part of the Medicaid provider contract, to set up a referral system of agreements with the alternative providers. Thus the primary responsibility and cost would be at the local level for each individual hospital.

- Scenario 2—State Responsibility: TMHP would be responsible for designating and maintaining a system of available alternative Medicaid providers for the hospitals to use to make referrals and divert patients. TMHP would monitor and update the designated providers periodically.

All other administrative duties are the same in both scenarios.

Additional Information on the Medicaid ID Card

The state would have to modify systems to establish the correct co-pay amount each month based on all recipients' income and eligibility categories. The state's eligibility system would need to be configured to determine the co-pay information so that it can be included on each Medicaid ID card.

In addition, there would have to be a system for providing information when inquiries about co-pays are made.

On-going Tracking of Monthly Co-payment per Enrollee

For every Medicaid recipient who has a co-pay, the state (in this case, likely the state's contracted enrollment broker, MAXIMUS) would need a system to establish the 5 percent family cap threshold. The state would send a notice to the Medicaid family with a form for the family to track their co-pays. Once the cap is met, the family and health plan are notified that the co-pay does not apply for the remainder of that quarter. Even though it is unlikely that many Medicaid patients would have enough visits to get close to their family cap, the system would have to be set up for all potential co-payees. Alternately, the state could request a waiver to waive the cap provision, although federal approval of this request is unlikely.

There would also need to be a contact point (information line) for either the patient or the ER staff to check to see if a co-pay applies when a family does not have their Medicaid identification card. This would only be an issue if the patient has had several visits, so the volume would not be expected to be high and would depend on the patient raising the issue to trigger the call. However, a point of contact for up-to-date information on all recipients would have to be in place.

Medicaid Recipient and Provider Education

The state would have to require HMOs and the PCCM administrator (in this case, TMHP) to conduct patient and provider education for ER staff statewide who would be implementing co-payment policies and for the Medicaid patients. This is a key factor in the success of the policy and may be understated in these estimates.

Referral process

It was not possible for HMA to estimate the direct costs of the referral process for the hospitals. These would vary widely by hospital, depending on staffing capacity; how busy the ER is at the time; how quickly staff can get contact information and reach primary care providers or alternative Medicaid providers; how long it takes to explain the choice and co-pay to the patient; and so forth. Whether or not the retained co-pay amounts would be sufficient to cover those costs is questionable, especially on a hospital-by-hospital basis.

Although estimates of the hospitals' administrative costs have not been included, the new staff responsibilities may be seen as an unfunded burden. The greater the burden on hospitals in terms of complexity, time, and staff responsibilities for the co-payment program, particularly if it is unfunded, the less likely the co-pay policy would be diligently applied by the hospital staff. As a result, the degree to which patient behavior would be affected is reduced; therefore, HMA has incorporated this impact on its expectations for patient diversion.

Table 4: Estimated State and Federal Administrative Costs
Scenario 1 – Hospital Responsibility/Scenario 2 – State Responsibility

State Administrative Function	Scenario 1			Scenario 2		
	Cost Estimate Year 1	Cost Estimate Year 2	Total Cost Estimate Year 1-2	Cost Estimate Year 1	Cost Estimate Year 2	Total Cost Estimate Year 1-2
Additional information on the Medicaid ID Card one-time system modifications.	$561,895	$0	$561,895	$561,895	$0	$561,895
Establish alternative provider listing and provider education.	0	0	0	$2,834,270	0	$2,834,270
Maintain alternative provider listing and provider education.	0	0	0	563,000	459,252	1,022,252
One-time set up tracking monthly co-pay per enrollee and family cap; also recipient co-pay education.	1,070,336	0	1,070,336	1,070,336	0	1,070,336
Ongoing tracking of monthly co-pay per enrollee and family cap; also recipient co-pay education.	131,713	131,713	263,426	131,713	131,713	263,426
Total State and Federal Administrative Costs	**$1,763,944**	**$131,713**	**$1,895,657**	**$5,161,214**	**$590,965**	**$5,752,179**
Federal Costs	**$881,972**	**$65,857**	**$947,829**	**$2,580,607**	**$295,483**	**$2,876,090**
State Costs	**$881,972**	**$65,857**	**$947,829**	**$2,580,607**	**$295,483**	**$2,876,090**

Note: Medicaid administrative costs are matched with 50% federal funding.

Savings

The information used in analyzing cost effectiveness was derived, to the extent possible, from available data from both the state and national levels. For those factors without applicable data, the model included assumptions based on knowledge and experience with Medicaid programs across the country, as well as the health-care environment and Medicaid program in Texas today. Each assumption is explained below and may tie back to additional information discussed in the "Policy Options and Considerations" section of this report.

Scenario 1 – Hospital Responsibility, differs from Scenario 2 – State Responsibility, only on establishing the alternative provider referral network. The implications of the two different approaches, combined with all of the factors discussed above, were considered in developing estimates of the potential amount of Medicaid patient diversion from ERs and avoidance of the ER, which in turn would yield savings in medical costs.

The following estimates and assumptions apply to both scenarios except where noted otherwise:

Voluntary and Mandatory Populations

All Medicaid patients are included except dual Medicare-Medicaid or institutionalized patients. Some 94.6 percent are voluntary (cannot be required to pay or be denied service) while 5.4 percent are mandatory (must pay co-pays if an alternative is available) and ER treatment can be withheld if co-pay not paid. The mandatory population is 78 percent children ages 1-5, 11 percent pregnant women, 4 percent newborns and 3 percent aged/disabled.

Note: See Table A-5, Appendix A for the estimated number of enrollees who could be charged co-payments.

Hospital Assessment Amount

For the basic ER assessment, only the $25 fee for the basic EMTALA screen was included, although it is likely that, in many cases, the assessment would include additional charges for tests or lab work. If these costs were quantified, the state cost of implementation would increase compared to the estimates.

Alternative Medicaid provider and Contemporaneous Service Requirement Factor

Based on the lack of capacity in available alternative Medicaid providers, it was assumed Texas Medicaid generally would have limited opportunities to charge co-pays after normal business hours with the exception of a few situations where nearby hospital outpatient or other urgent care clinics operate. In addition, it is unlikely that the federal mandates for available and contemporaneous alternatives would be achievable in most places on a regular basis, during normal Monday - Friday business hours. For this study, it was assumed that 15 percent of recipients who could be charged a co-payment would also be offered a federally acceptable alternative Medicaid provider and contemporaneous service.

Patient Diversion from ER

This includes the estimated percentage of Medicaid patients who go to the ER but are diverted to an available alternative Medicaid provider rather than paying a co-pay and being served at the

ER. This assumes an insignificant number of voluntary patients would go elsewhere, because there is no enforceable co-pay or withholding of service at the ER. The vast majority is very poor and has limited transportation options, and in most cases, after diagnosis, it would be easier for the patient to get the care in the ER.

The estimated percentage of mandatory patients that would be diverted depends on:

- The general availability of primary care providers and alternative Medicaid providers within proximity of the hospital ER, which would vary by community, time and day of week, etc.
- The extent of the alternative Medicaid provider network for the hospital to contact for referrals.
- The ability of hospital staff to facilitate scheduling an appointment with an alternate Medicaid provider based on state rules regarding how many referral calls should be made before concluding there are none available; how busy the ER is and staffing available.
- Whether the patient has means to go to the other provider without additional cost.
- Whether the patient has the co-pay amount and chooses to stay at the ER.

Based on these factors, it was assumed that for the Hospital Responsibility (Scenario 1) the diversion rate would be very low (3 percent), and in the State Responsibility (Scenario 2) it would be 10 percent; it is assumed it would not change significantly from year to year.

Table 8: ER Diversion Annual Cost/(Savings)

Diversion	Scenario 1	Scenario 2
Total Number of Hospital Nonemergent Visits where an alternative is available[1]	131,143	131,143
Percent of the Population that is Mandatory out of those who Could be Charged Co-pays[2]	7%	7%
Total Number of Divertable Hospital Nonemergency Visits	9,180	9,180
Rate of Hospital Diversion due to Co-pays	3%	10%
Number of Visits Diverted to Physician Office	275	918
Cost/(Savings) per Visit Diverted to Physician Office	($231)	($231)
Hospital Assessment Charge per Visit Diverted	$25	$25
Total Cost/(Savings) for all Diverted Visits	**($56,733)**	**($189,109)**
Subtotal, Federal Cost/(Savings)	**($33,773)**	**($112,576)**
Subtotal, State Cost/(Savings)	**($22,960)**	**($76,532)**

Note: Medicaid Medical Costs are matched at 59.53% federal funds for FFY 2009.

1. Based on SFY 2005 data created by the Research Team, Center for Strategic Decision Support, Texas Health and Human Services Commission, November 12, 2007. The total number of nonemergent visits was 874,289, which has been reduced to 131,143 to reflect the 15% assumption of available alternatives.
2. Assumes all diversions would only occur for mandatory populations.

Patient Avoidance of ER

This includes the estimated percent of Medicaid patients who would have gone to the ER but choose not to go to the ER based on previous experience with being diverted, or an awareness of the co-pay policy. It assumes a negligible percent of voluntary patients, because co-pay is not enforceable, behavior is unlikely to change, and availability of timely access to primary care providers or alternative providers is scarce in most communities at this time. The estimated percentage of mandatory patients' behavior depends on the following:

- The majority of Medicaid patients only go to the ER one or less times in a year (rate is 0.55 percent visits per year for all Medicaid patients) and therefore the percentage of patients who return to the ER in a 12-month period is small.
- There is a lot of turnover in the mandatory populations of pregnant women as well as newborns and children aging out or otherwise losing their coverage, so that they are not on the program long enough to face the ER option again.
- The higher income, mandatory population are more likely to have work constraints that force them to use after hours services such as an ER and are more likely to be able to pay the $6 or even $50 in some cases to save the time or effort.
- In many cases, if a person has been to the ER it is likely they were not diverted because there were no available alternatives, and they did not learn the new behavior.

Based on these factors it was assumed that the avoidance rate for the mandatory co-pay patients would be 0 percent in the first year, primarily because few Medicaid patients go more than once a year and the turnover in the program is high. A 2 percent avoidance rate was assumed in the second year.

The factors used reflect there would likely be some, albeit small, change in behavior for some Medicaid recipients. This change will result from education about when to use the ER, establishing a connection with their primary care provider medical home, wanting to avoid the co-pay charge, and more avoidance in those areas where there are more after hours or other alternative Medicaid providers near the hospitals

Table 9: ER Avoidance Annual Cost/(Savings)

Diversion	Scenario 1	Scenario 2
Total Number of Hospital Nonemergent Visits where an alternative is available[1]	131,143	131,143
Percent of the Population that is Mandatory out of those who Could be Charged Co-pays[2]	7%	7%
Total Number of Avoidable Hospital Nonemergency Visits	9,180	9,180
Rate of Hospital Avoidance due to Co-pays	0%	2%
Number of Visits Diverted to Physician Office	0	184
Cost/(Savings) per Visit Diverted to Physician Office	($231)	($231)
Total Cost/(Savings) for All Avoided Hospital Visits	**0**	**($42,412)**
Subtotal, Federal Cost/(Savings)	**0**	**($25,248)**
Subtotal, State Cost/(Savings)	**0**	**($17,164)**

Note: Medicaid Medical Costs are matched at 59.53% federal funds for FFY 2009.

1. Based on SFY 2005 data created by the Research Team, Center for Strategic Decision Support, Texas Health and Human Services Commission, November 12, 2007. The total number of nonemergent visits was 874,289, which has been reduced to 131,143 to reflect the 15% assumption of available alternatives.
2. Assumes all avoidance would only occur for mandatory populations.

Comparative Costs of Services at ER and for Community-based Providers

As discussed in the "Policy Options and Considerations" section, a snapshot of average costs for the same services for each of three key provider types was developed. The average ER cost is $279, and the average community physician cost is $129. Other non-hospital providers, such as Federally Qualified Health Centers (FQHCs) or other community clinics, were not included in

the cost comparison. Because they have higher costs, the potential savings from patients choosing them instead of the ER would be smaller.

Retention of Co-Pays

It was assumed that the hospitals would retain the co-pays and not have to account for them to the state. Thus revenue collected could be used by the hospital to offset a portion of the additional costs to the hospital of the co-pay process requirements. It would be burdensome and costly for the state to establish a new state system to account for and monitor hospital collections.

Cost Effectiveness Estimates

From the assumptions and cost analysis performed above, estimates of costs or savings for Year 1 and Year 2 of operation were created for each of the two scenarios.

Year 1

Costs

In Scenario 1, a significant part of the administrative duties—for setting up the network of alternative Medicaid providers—is borne by the hospitals. The remaining state costs for the other administrative tasks are shown.

In Scenario 2, the state's administrative costs are significantly higher in Year 1 because of changes for existing information technology system and setting up new systems, which are needed to meet the federal requirements for a Medicaid co-payment program.

Savings

In Scenario 1, the first year diversion-related savings are assumed to be very low (1 percent for the Mandatory population), because hospitals would not build as extensive of a referral network as in Scenario 2, where TMHP would be funded to develop the network. Avoidance savings are assumed to be negligible in both scenarios. This is because Medicaid patients would not learn or understand the ER co-pay policy until they actually experienced it once, and the Voluntary patients would not pay or go elsewhere. Based on the average number of visits for the Medicaid population likely to pay co-pays of 0.55 per year (i.e., one visit every two years) the avoidance factor would not be seen for the Mandatory Medicaid patients until Year 2, at the earliest.

Year 2

Costs

The administrative costs in the second year are lower in both scenarios, because the systems are established and only ongoing functions are assumed.

Savings

In the second year of implementation, the savings from the estimated rate of avoidance (patients who choose an alternative rather than going to the ER) begin to accrue for the Mandatory population. Each scenario has the same rate of diversion as it did in Year 1, although there could be some interactive effect from the avoidance rate lowering the overall number of people entering the ER. If there were an interactive effect, the diversion rate would be lower.

Table 10: Cost/(Savings) from Co-payment Implementation
Two Years
Scenario 1 – Hospital Responsibility/ Scenario 2 – State Responsibility

Cost Category	**Scenario 1**			**Scenario 2**		
	Year 1	Year 2	Total	Year 1	Year 2	Total
Diversion Cost/(Savings)	($22,960)	($22,960)	($45,919)	($76,532)	($76,532)	($153,065)
Avoidance Cost/(Savings)	0	(17,164)	(17,164)	0	(17,164)	(17,164)
HMO Factor	10,332	18,056	28,388	34,440	42,163	76,603
Administrative Cost/(Savings)	881,972	65,857	947,829	2,580,607	295,483	2,876,090
Total State Cost/(Savings)	**$869,344**	**$43,789**	**$913,134**	**$2,538,515**	**$243,950**	**$2,782,464**

Note: Medicaid Medical Costs are matched at 59.53% federal funds for FFY 2009.
Medicaid Administrative Costs are match at 50% federal funds for FFY 2009.

In either Scenario, costs of the co-pay system are greater than probable savings from patients going to less expensive providers.

Feasibility Considerations

As discussed in detail throughout the report, the complexity of the federal requirements makes the use of co-pays for nonemergent ER conditions a complicated and difficult policy choice to implement. Additional issues affecting feasibility include:

- Lack of alternative Medicaid providers and overloading of existing alternative Medicaid providers who take Medicaid.
- Lack of alternative after hour clinics that take Medicaid in most areas.
- Questions whether voluntary co-pays (which are 94 percent of the Texas Medicaid program) would be a deterrent, or if the small, mandatory co-pay amounts would alter behavior.

Conclusion

From the analysis above, the implementation of a co-payment program for nonemergency use of the ER would not be cost effective or feasible in Texas.

This conclusion is based on four key factors:

- Complex federal law requirements, which make implementation very challenging, especially for the hospital staff that would have the primary responsibility for applying the policy.
- The very high percentage of Texas Medicaid patients with incomes below poverty who could not be required to pay co-pays.
- The lack of available alternative and accessible Medicaid providers, which reduces the number of times co-pays can be applied.
- Administrative costs resulting from the federal requirements, which raises the amount of savings needed to achieve cost effectiveness.

Appendix A

Table A-1: Number of Texas Medicaid Under 100% FPL

Allowable Co-payment Amount $0.50 - $3.00	Texas Recipients
Aged, Blind & Disabled	641,050
TANF Adult	43,982
TANF Child	199,205
Foster Care/Adoption	32,893
Pregnant Women	102,600
Newborns under 1 year	158,495
Expansion Children 1 – 5 years	627,721
Mandatory Children 6 – 18 years	835,459
Medically Needy	43,247
TOTAL	**2,684,652**

Source: HHSC Eligibility and Enrollment Data, April 2007.

Table A-2: Number of Texas Medicaid Between 101 - 150% FPL

Allowable Co-payment Amount $1.00 - $6.00	Texas Recipients
Aged, Blind & Disabled	3,405
TANF Adult	0
TANF Child	0
Foster Care/Adoption	0
Pregnant Women	16,385
Newborns under 1 year	6,207
Expansion Children 1 – 5 years	110,724
Mandatory Children 6 – 18 years	0
Medically Needy	0
TOTAL	**136,721**

Source: HHSC Eligibility and Enrollment Data, April 2007.

Table A-3: Number of Texas Medicaid Over 150% FPL

Allowable Co-payment Amount No Limit	Texas Recipients
Aged, Blind & Disabled	1,413
TANF Adult	0
TANF Child	0
Foster Care/Adoption	0
Pregnant Women	6,116
Newborns under 1 year	424
Expansion Children 1 – 5 years	7,652
Mandatory Children 6 – 18 years	0
Medically Needy	0
TOTAL	**15,605**

Source: HHSC Eligibility and Enrollment Data, April 2007.

Table A-4: Maximum Income Levels as a Percent of the Federal Poverty Levels for States with Pre-DRA Co-payments for Nonemergency ER Services

States with Co-payments for Nonemergency ER Services				Maximum Incomes for Medicaid Eligibility			
State	**$3 Co-pay**	**Greater than $3 Co-pay**	**Voluntary/ Mandatory**	**Children**	**Non-working Parents**	**Working Parents**	**Pregnant Women**
Alabama	X		Voluntary	133%	42%	65%	133%
Georgia	X		Voluntary	200%	31%	55%	200%
Indiana	X		Voluntary	150%	21%	27%	150%
Kansas	X		Voluntary	150%	29%	36%	150%
Maine	X		Voluntary	200%	200%	207%	200%
Massachusetts	X		Voluntary	200%	133%	133%	200%
Michigan	X		Voluntary	185%	38%	61%	185%
Mississippi	X		Voluntary	185%	27%	33%	185%
Rhode Island	X		Voluntary	250%	185%	192%	250%
South Carolina	X		Voluntary	185%	48%	97%	185%
Washington	X		Voluntary	200%	39%/200%	79%/200%	185%
Arizona		X	Voluntary	140%	200%	200%	133%
California		X	Voluntary	200%	100%	107%	200%/300%
Maryland		X	Voluntary	200%	31%	38%	250%
Minnesota		X	Voluntary	280%	275%	275%	275%
New Mexico		X	Voluntary	235%	28%/200%	65%/409%	185%
North Dakota		X	Voluntary	133%	38%	65%	133%
Tennessee		X	Voluntary	185%	70%	50%	185%
Utah		X	Voluntary	133%	42%/150%	49%/150%	133%
Wyoming		X	Voluntary	133%	43%	57%	133%
Texas				**185%**	**14%**	**29%**	**185%**

Sources:

1. Kaiser Family Foundation Medicaid Benefits Online Database, www.kff.org/medicaid/benefits, and
2. "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and SCHIP in 2006", Kaiser Commission for the Medicaid and Uninsured, January 2007.

Note: When two numbers are noted, the second number is eligibility criteria through a Medicaid waiver or state funded program, typically with fewer benefits and higher co-payments.

Table A-5: Estimated Number of Recipients Who Could be Charged Co-payments If Federal Mandates for Alternative Medicaid Providers Are Met

Eligibility Category	Total Recipients Mandatory	Total Recipients Voluntary	Total All Recipients
Aged/Disabled/Blind	1,204	302,692	303,896
TANF Adult	0	43,982	43,982
TANF Child	0	199,205	199,205
Foster Care/Adoption	0	32,893	32,893
Pregnant Women	22,501	102,600	125,101
Newborns under 1 year	6,631	158,495	165,126
Expansion Children 1 – 5 years	118,376	627,721	746,097
Mandatory Children 6 – 18 years	0	835,459	835,459
Medically Needy	0	43,247	43,247
TOTAL, Mandatory Recipients	147,508		
TOTAL, Voluntary Recipients		2,043,602	
Assumption of Appropriate Alternatives Offered	15%	15%	
Total Number of Recipients	**22,126**	**306,540**	**328,667**
Percent of Total	**7%**	**93%**	

Appendix B

Methodology and Results

February 2006 Medicaid Payments for Patient Treatment Episodes with at Least One Nonemergent Condition: Comparison of Hospital and Physician Office Settings

To get a sense of what HHSC pays for treating nonemergent conditions in the hospital ER compared to physician office settings, HMA asked HHSC for a one month "snapshot" sample of paid claims data for hospital ERs in the areas where diversion is most feasible. This payment data sample reflects actual Medicaid payments for a treatment "episode" for patients with at least one of the top ten nonemergent condition codes, based on utilization. This treatment episode cost includes all services paid to the hospital facility for that patient, for that date of service, except for hospital pharmacy codes, which were removed so that the ER episode cost could be compared adequately to episode costs for patients with the same "top ten" nonemergent diagnoses in physician office settings.

To get a sense for physician office costs, HMA reviewed similar sample data for episode costs for treatment at physician office settings to treat the same most common nonemergent conditions. Note that treatment in these settings could be provided by a physician, a physician's assistant, or a nurse practitioner.

HMA conducted identical analyses on the two distinct datasets based on paid claims data from the snapshot month (February 2006). For each unique combination of client patient care number (PCN) and date of service we aggregated the data into an "episode". Each "episode" reflected one of the top ten nonemergent conditions and included the total amount paid for all other codes for that patient for that date of service. HMA conducted univariate analyses on both datasets. They calculated basic statistics for the amount paid, for each of the ten nonemergent condition episodes, including the mean, minimum, maximum, and standard deviation.

In reviewing the data for individual patients, HMA observed that the presence of one of the top ten nonemergent codes did not necessarily mean that the *episode of care* (all the services paid for that date of service) or the patient's presenting condition was not urgent or even a serious emergency. More than one code can be billed for a given episode of care, so the nonemergent code could be just one of a number of codes billed by the provider for that date of service. For example, a patient with a code for congestive heart failure could also have a code for an upper respiratory infection (a nonemergent code). We believe this is an important observation when making statistical statements about how much care is emergent versus nonemergent.

Since a limited review of some of these high-cost cases suggested they reflected episodes of care that, while having a nonemergent condition code within the episode, also included other codes that suggested the episode may be more appropriately classified as "urgent" or even an emergency, HMA adjusted for this problem by removing high episode cost outliers. Their belief was that the removal of these outliers may better focus the data on nonemergent episodes, but their analysis of outliers was not definitive and only a small number of outliers were excluded from the calculations.

To remove these outlier cases from the data (e.g., episodes in which the care appeared to be emergent), HMA excluded all episode costs that were more than three standard deviations above the mean. By excluding these high-cost outliers, the underlying data may be more likely to reflect situations where the care truly met the nonemergent criteria. This was particularly true of the hospital data.

This data sample is merely a snapshot based on one month of 2006 and should be used with some caution, but it does reflect actual history for nonemergent care in that month and should result in a reasonable proxy for Medicaid payments for these episodes. HMA also reviewed a similar data run for the same month for Federally Qualified Health Clinics (FQHCs). However, this data run resulted in a very small number of data points or no data for a few codes, so they could not draw conclusions from the FQHC data sample with confidence. Additionally, the data evaluated does not include costs from Medicaid managed care areas, since that data was not available for this analysis.

As indicated in the "Policy Options and Considerations" section, the average of Medicaid payments for the top ten nonemergency visits is $279 for the hospital ER and $129 for the community-based physicians. The difference between physician and hospital average costs for each of the ten diagnoses ranged significantly. The smallest difference was for acute pharynangitis , which was 2.7 times more expensive in the hospital ER setting than in the physician's office, while the greatest variation was for contusions of the face, neck, and scalp, which was 12.6 times more expensive in the hospital ER setting.