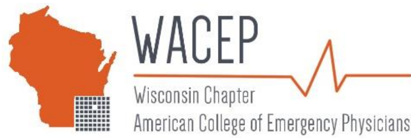

May 17, 2017

VIA EMAIL
Mr. Michael Heifetz, Medicaid Director
Wisconsin Department of Health Services
Division of Medicaid Services
1 West Wilson Street, Room 350, P.O. Box 309
Madison, WI 53707-0309
Email: michael.heifetz@dhs.wi.gov

RE: Wisconsin's Proposed Amendment to the 1115 Medicaid Waiver

Dear Director Heifetz:

On behalf of the Wisconsin Chapter of the American College of Emergency Physicians (WACEP), its parent organization, the American College of Emergency Physicians (ACEP), and the Emergency Department Practice Management Association (EDPMA), we appreciate the opportunity to voice our concerns with the proposed amendment to Wisconsin's Section 1115 Medicaid waiver application relating to emergency department use and copays.

Emergency physicians and the organizations that support the practice of emergency medicine appreciate the insight of the Wisconsin Department of Health Services in proposing an amendment to Wisconsin's Section 1115 Medicaid waiver that aims to not only ensure that we continue to have a sustainable health care safety net, but also encourages members to utilize appropriate health care services.

We have concerns, however, with the implications of the proposed increased copayments for childless adults who visit the emergency department. We must continue to balance financial mechanisms to create greater enrollee accountability without discouraging appropriate use and access to emergency care for all Medicaid beneficiaries.

We are writing to urge you to incorporate and reiterate the well-established prudent layperson standard in the amendment and ensure that no proposed policy could negatively impact it. The Prudent Layperson Standard, reiterated in the Balance Budget Act of 1997, requires Medicare and Medicaid plans to reimburse for emergency care when a prudent layperson believes he or she may be experiencing an emergency, including when he or she is experiencing severe pain. Plans may not require preauthorization in these circumstances.

The proposed amendment currently increases copayments for visits to the emergency department. It is unclear what level of financial obligation will deter patients from using the emergency department, even for symptoms that could represent true emergencies. If we find that a $25 copayment for second and subsequent use of the emergency department has such an effect, Wisconsin's proposed policies would lack sufficient insurance coverage for access to emergency care when an enrollee "possessing an average knowledge of medicine and health, to believe that his or her condition...is of such a nature that failure to obtain immediate medical care could place the health of such person or others in serious

jeopardy." We believe that anyone who seeks emergency care suffering from symptoms that appear to be an emergency, such as chest pain, should not be denied coverage for emergency services if the final diagnosis does not turn out to be an emergency medical condition. Beneficiaries with multiple chronic conditions or behavioral health disorders may be disproportionately affected.[1,2] CMS has concluded that ED use is driven by beneficiaries in need of emergency services which could have been prevented by better access to care and care management in other settings. Improving access to primary care in community settings is the most cost-effective method for reducing ED use by Medicaid beneficiaries.[3]

An analysis of increased emergency department copayments in Indiana by the Lewin Group's preliminary report shows that there was a resultant decreased use of the emergency department for non-emergent conditions. However, this analysis was based on the Billings Algorithm rather than on the patient's presenting medical complaint. Therefore, it is inconsistent with the legally mandated methods of determining a non-emergency under Healthy Indiana 2.0 which uses the prudent layperson standard. Subsequent applications for extension of Indiana's waiver did not discuss the analyses of the effect of their increased emergency department copayment on admission rate for ambulatory care sensitive conditions, which was the health outcome designated by CMS as the measure of any barrier to care created by the ED copay. It would also be important to track the frequency at which enrollees attempt to access the healthcare system in an ambulatory care setting, yet are redirected to an emergency department as a more appropriate setting for evaluation and treatment.

Because Wisconsin's Department of Health Services does not have a clear precedent to base these emergency department copayment policies on, we urge you to not approve the increased copayment for emergency visits until proper analysis of other states' similar copayments on health outcomes and access to care is complete.

As potential increased copayments for emergency department visits may be implemented, it is paramount that the logistics of implementing and collecting such copays be regulated carefully. We ask that you look to other state Medicaid waiver programs for examples of what may help the success of Wisconsin's program.

As discussed above, we are pleased to see Wisconsin does not attempt to determine if ED visits are emergent or non-emergent, as this classification raises many legal challenges as emergency physicians attempt to balance the prudent layperson standard and Emergency Medical Treatment and Labor Act (EMTALA). Requiring emergency physicians (EPs) to explain to patients that their federally mandated EMTALA "emergency medical screening" exam is complete, that they do not have an emergency and then the referral, treatment and co-pay options for "non-emergency" treatment as apparently required by Indiana's waiver make the EPs already difficult functions likely untenable in the context of busy trauma centers and community hospitals.

In addition, Wisconsin may consider applying an exemption to the increased copayment for certain individuals, as other states have done, such as anyone who is greater than 20 miles from a community health center or urgent care (Arizona) or enrollees who call a triage line run by a managed care

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[1] Berry JG et al. Impact of Chronic Conditions on Emergency Department Visits of Children Using Medicaid. J Pediatr. 2016 Dec 13. pii: S0022-3476(16)31360-9. doi:10.1016/j.jpeds.2016.11.054.

[2] Harris, LJ et al. Characteristics of Hospital and Emergency Care Super-utilizers with Multiple Chronic Conditions Journal of Emergency Medicine, Volume 50, Issue 4, e203 - e214.

[3] Lowe RA, McConnell KJ, Vogt ME, Smith JA. Impact of Medicaid cutbacks on emergency department use: the Oregon experience. Ann Emerg Med. 2008 Dec;52(6):626-634. doi:10.10.

organization before visiting the emergency department (Indiana). We believe these exemptions give exception to enrollees who are truly attempting to use the healthcare system appropriately.

Lastly, we encourage you to implement a system of collecting copayments retrospectively, as both Arizona and Michigan have successfully done in their recent waiver demonstrations. If the copayment is applied at the time of service, it is important that it be applied to the facility fee rather than the provider fee. Providers do not have the systems built in place to collect such copayments while evaluating and treating patients. Any application of the copayment to the provider fee at the time of service would be, in essence, partially defunding the care provided by emergency physicians as mandated by EMTALA, because physicians often cannot collect a significant portion of self-pay charges.

The most important first step in a physician-patient interaction in an emergency department is to establish trust. Once trust is established the patient sees the provider as their advocate, and is more open when the provider declines to prescribe antibiotics, narcotics, an unnecessary radiologic study or other study. The provider can teach them about other places to receive care. These are the steps that have been proven to add value and reduce costs. The request to pit provider against patient to collect a co-pay will break this bond, and decrease our ability to educate and influence our patients towards better health outcomes through appropriate use of the healthcare system.

We appreciate the opportunity to comment on the proposed addendum to Wisconsin's BadgerCare Reform Demonstration Project Waiver. Ultimately, emergency physicians in Wisconsin are proud to practice in a state where our Medicaid program is the only one in the nation to cover childless adults up to 100% of the federal poverty level even without increased federal funding under ACA Medicaid expansion. We look forward to working with you in continuing to provide improved healthcare value for the residents of Wisconsin.

Sincerely,

Lisa Maurer, MD, Treasurer and Legislative Chair
Wisconsin Chapter, American College of Emergency Physicians (WACEP)
563 Carter Court, Suite B; Kimberly WI 54136
Email: mcgi0021@gmail.com; WACEP@badgerbay.co

Rebecca B. Parker, MD, FACEP, President
American College of Emergency Physicians (ACEP)
4950 W. Royal Lane; Irving, TX 75063-2524
Email: rparker@acep.org; hmonroe@acep.org

Andrea M. Brault, MD, MMM, FACEP, Chair of the Board
Emergency Department Practice Management Association (EDPMA)
8400 Westpark Drive, 2nd Floor; McLean, VA 22102
Email: andrea@emergencygroupsoffice.com; emundinger@edpma.org

About our organizations:

Wisconsin Chapter of the American College of Emergency Physicians (WACEP) represents a diverse group of over 500 Wisconsin emergency physicians, residents and medical students in the state. WACEP is committed to protecting the interests of emergency physicians, the profession of emergency medicine, and especially patients needing emergency medical treatment. WACEP promotes policies that preserve the integrity of the profession and supports collaboration with other specialties, healthcare organizations, academic institutions and governmental agencies.

The American College of Emergency Physicians (ACEP) is the national medical specialty society representing emergency medicine. ACEP is committed to advancing emergency care through continuing education, research and public education. Headquartered in Dallas, Texas, ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia. A Government Services Chapter represents emergency physicians employed by military branches and other government agencies.

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, billing, coding and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.