Defining the Role of Emergency Care in a Broken Health System

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Learning Objectives

Discuss the impact of reimbursement regulations and health reform in the ED.

Link developments in Washington state to national Health reform and reimbursement.

Provide a platform for participant interaction and promote sharing of ideas and strategies.

CME/CEU Disclosure Statement

All speakers and planners completed financial disclosure declarations. 
Upon disclosure, none of the speakers or planners had any relevant financial relationships to report.
Washington State Stirs Prudent Layperson

For years, payers erected barriers to care in ERs:
Denying reimbursement for care not authorized
(including unscheduled emergencies!)

Denying payment for claims based solely on diagnosis

Denying payment for care provided out-of-network.
Incremental then Comprehensive Solution

Maryland legislature adopts prudent layperson standard, ACEP then adopted a definition:

*Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled care is required.*
From Maryland across the Nation

Since 1993, 32 states and the District of Columbia have enacted the prudent layperson standard.

Congress takes up the cause with introduction of the Access to Emergency Medical Services Act in successive Congresses.

1997 Balanced Budget Act incorporated the prudent layperson standard for Medicaid* effective October 1997

Same standard extended to Medicare in 1998.
Clinton & Patients’ Bill of Rights

Issues executive order in 1998 extending standard to all federal health plans

HHS issues regulation in 1999 extending patient protections to children in the CHIP program.

Democratic and Republic bills now include ACEP language
PP-- ACA

Managers amendment to Affordable Care Act included Cardin prudent layperson

Affordable Care Act is . . .

Patient Protection and Affordable Care Act

Questions- Implementation and Compliance
The Washington Experience

May 2011 Washington State enacted a 3 visit rule for “non-emergent conditions” that would deny payment and reimbursement

Plan to start denials of coverage October 1, 2012
Rule #1: Build a Team
Mandate to Collaborate

Legislature instructed HCA to “collaborate” with WSMA, WSMA, and WA ACEP

On Diagnosis List for non-emergent conditions

72 million dollars in savings over the 2 year budget

235 million per year in ED costs
“Collaborative” Negotiations

535 list from Billings study presented by HCA

Collaborative reduction to 216 diagnoses

HCA rejected list in August, published their own 718 list

Refused to reduce outside of five small diagnoses
“Non-Emergent Conditions”

Retrospective Denials For:

- Chest pain
- Shortness of breath
- Hemorrhage in pregnancy
- Visual problems
- Gallstones
- Diverticulitis
- Cholecystitis
- Asthma
- COPD
- Sprains/Strains/Burns
Go Public

September launched our first media campaign
   Tacoma News Tribune
   Seattle Times
   Kiro / Komo / King
   Local radio

General response was that people did not get it
Lawsuit Filed

September 30, 2011
S suit in Thurston County Superior Court

Allegations:
Failure to collaborate
Improper rulemaking
Violation of prudent layperson
EPDST violation
Unjust taking
Privileges and Immunities Public Policy
The Bill

Costly to fund

Developed our action fund
Victory!

November 10, 2011

Stay granted by Superior Court Judge for Failure to Follow Proper Rulemaking

HCA halted implementation.

Prior denials halted

No lost payment
Return to the Table

November 22nd, 2011

Returned to negotiate

One visit agreeable

EPA process

215 collaborative list

Everyone agreed to plan at table, moving forward to help the state
Christmas Gifts

December 22nd, 2011
Notice of conference call
23rd
“New plan,” no more 3 visits

December 23rd, 2011
Utilization Management
Zero Visits
515 diagnoses
NO exemptions
No negotiations
Legislative Approach

Meetings with everyone

2-3 trips per week to Olympia

Republicans, Democrats

Healthcare Committee, Power Players, Leaders

Representative Cody
Chairwoman of Healthcare Committee
Brokered talks with Senate and House

Accepted our alternative proposal

Eileen Cody, D-West Seattle
Legislative Morass

House Passed Alternative in their budget March 8

Republicans took over Senate Budget
Special session resulted
Not included in their budget
Rallying the Troops

New Media Campaign
February 2012

WSHA / WSMA / WAACEP

Bulletins to members

Grand Rounds at hospitals

Letter writing campaign
What Happened?

- CMS
- Legislative
- Congress
- Regulatory
- Media
- Lay Public
- Patient Advocates
- Legal

HCA Policy
We Won!

Governor Suspended Zero Tolerance Policy April 1st, 2012

Moved forward with alternative plan in budget proviso on April 10th, 2012

June 15th deadline for implementation
Seven Point Checklist

A – Implement EDIE Complete System
B – Discharge instructions on utilization available in ED
C – PRC Client list, use and develop care plans
D – Establish system for 72 hour follow up
E – Narcotic Guidelines with WA ACEP Material
F – PMP Program – 75% of EDP by July 1
G – Feedback Reports – Program to utilize
Building a System

EDIE Information Exchange

Address frequent flyers (>5 visits per year)

Need 75% of Medicaid patients
Improving Care

Care Plan Development in all hospitals
  Address PRC Clients
  PRC = Zero Narcotics

PRC access
  72 hour follow up
  Case management
Decreasing Drugs

Opioid Policy
WA ACEP Guidelines
‘Oxyfree’ EDs
Feedback reports

Prescription Monitoring Policy

Right time, right place, right patient discharge instructions
Reducing Outliers

Feedback reports to physicians

Narcotics
Imaging
Utilization
Educating Patients

Discharge instructions on right place, right time, right provider

Follow up arrangements for frequent flyers
If unsuccessful in signing up, if hospitals representing at least 75% of Medicaid ER visits do not sign up, the state will revert to the no-payment policy.
Proven Success

10% decline over the last year
  All payor mixes
  Statewide

Dramatic reduction in our low acuity
  (blue / grey)

Static to improving patient satisfaction scores
Conclusion

Teamwork

Sound medical judgment for policy

Protect the safety net

We must have a plan
ACEP’s response to WA Events

Wrote to CMS Administrator in September 2011

Put the CMS leadership on notice
Received quick commitment to review
Met with Acting Administrator Tavenner
Met with Medicaid Director Cindy Mann

Feds express concerns tying hands of cash-strapped states
Congress reluctant to get involved
Medicaid and CHIP Payment and Access Commission (MACPAC)

Created in 2009, and expanded under the Affordable Care Act

Modeled after MedPAC

17 members with mix of relevant expertise; majority must be non-providers

Make annual recommendations to the Congress, the HHS Secretary and the states in March report on Medicaid and CHIP issues.
Other Rules Affecting Medicaid

In June 2011, CMS issued proposed regulations for measuring changes in Medicaid patient access.

ACEP supported the draft rule
No word on time table to finalize this rule
Factors at work may be
No deadline for final rule

Supreme Court decision on provider access case (Douglas v. Independent Living Care of Southern California), which puts decisions back in lower courts

General desire to avoid controversy in run-up to November election
ED Use Higher Among Children with Medicaid or CHIP Coverage

Source: MACPAC, Report to the Congress on Medicaid and CHIP, March 2012
Medicaid and State Budgets

State budgets generally improving but pressure to limit Medicaid ongoing
  On average, in 2010, 16% of state general funds were spent on Medicaid, second only to K-12 education

When federal contributions are included, Medicaid accounts for 22% of state budgets, ranging from 7% (WY) to 30% or more (FL, MO, PA)

Inverse proportion to Medicaid enrollment and spending to state revenue

Extra federal matching funds were provided under stimulus bill (ARRA) expired in June 2011; big jump in state contributions for 2012 budgets (29% on average)

Current federal law prohibits eligibility reductions, so to meet budget goals states have tightened payment rates and benefits

Further cuts expected in many states for 2013 budget years (beginning July 1 in most states)
State Policy Changes Affecting ED visits

For 2011 and 2012 budgets, many states imposed new co-payments for ED use or increased existing ones

AZ, OR, IL, IA, NE, NC, TX

Some states are also limiting coverage of ED care

WA, TN, NH limits on non-emergency use of ED

TX, IA payment reductions for non-emergency care
Dual Eligibles Subject of Federal and State Activity

9 million individuals account for disproportionate share of spending in both programs

21% of Medicare beneficiaries and 36% of spending

15% of Medicaid beneficiaries and 39% of spending

New federal demonstration aims to better coordinate care for these complex, high cost beneficiaries. States are submitting proposals in spring 2012, some may be implemented as soon as January 2013.

Most states will test model under which capitation payment covers full range of Medicare and Medicaid benefits for duals.

Savings will be built into capitation rates.

Dual eligible beneficiaries will be passively enrolled into certified managed care plans but may opt out for their Medicare services.
2014 Medicaid Expansion

ACA includes largest coverage expansion since inception -1965

CMS estimates 26 million additional enrollees by 2020

2014 expansion includes individuals with incomes up to 133% of poverty level

Expansion population differs from existing Medicaid population of children and parents of dependent children

13% of uninsured childless adults <133% of poverty are ages 55-64
Expansion’s Effects on EDs

Medicaid enrollees highest ED users (CDC and MACPAC)

Primary care physician shortage

No guarantee specialists will take more Medicaid patients

Where will patients go for care?

ED/hospital capacity issues

Financial sustainability issues

Massachusetts experience post-reform
  Overall decrease in ED use as uninsured declines, but patients with usual source of care at safety-net provider twice as likely as other low-income adults to visit ED for non-emergency care
Concluding Thoughts

Big Unknowns

Supreme Court decision

Outcome of the general elections

Repeal of Affordable Care Act

Sluggish economic recovery/growth

Ongoing delivery system reform experimentation, quality metrics, value based purchasing, bundled payments, electronic health records