

Emergency Response: A Systemic Approach to Diaper Rash, Chest Pain, and Medicaid in the ED

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INTRODUCTION

IN an effort to rein in health care costs, states have focused on non-emergent use of the Emergency Department (ED)² by people with Medicaid coverage. This focus has some merit. Although non-emergent ED use is by no means just a Medicaid issue,³ it imposes added costs and undermines care continuity. It is better for all patients to receive routine medical care in a primary care setting. And as more people gain insurance coverage by virtue of Affordable Care Act (ACA)⁴ provisions, it will be particularly important to provide the right care in the right location. Any attempt to address non-emergent ED use should be guided by two principles. First, as is reinforced by federal and state law, people should not be dissuaded from seeking needed emergency care. Second, as a matter of system sustainability, solutions should target the root causes of the problem.

These principles support a system-based approach that views ED overutilization as less a reflection of poor judgment on the part of patients and more a consequence of poor access to primary care and poor systems for managing the complex non-medical problems of high utilizers.⁵ A systemic

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² Recent medical and legal literature seems to favor the term “emergency department” or “ED,” though articles in the general media seem to favor “emergency room” or “ER” for the same entity. In this Article, I use ED unless quoting from a source that uses the other terminology. See Arthur L. Kellermann et al., *Emergency Care: Then, Now, and Next*, 32 HEALTH AFF. 2069 (2013) (discussing evolution of hospital-based emergency care and current challenges facing EDs).

³ See discussion *infra* notes 18–19 (comparing non-emergent ED use by patients on Medicaid with such use by patients with private insurance).

⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029 (2010). For a summary of key ACA provisions, see THE HENRY J. KAISER FAMILY FOUND., SUMMARY OF THE AFFORDABLE CARE ACT (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

⁵ See, e.g., Arthur L. Kellermann & Robin W. Weinick, *Emergency Departments, Medicaid Costs, and Access to Primary Care—Understanding the Link*, 366 NEW ENG. J. MED. 2141, 2142–43

approach of this sort is the seven “best practices” program,⁶ adopted in mid-2012 in Washington State in cooperation with the state’s Health Care Authority (HCA), all the state’s hospitals, its medical association, and its emergency physicians’ association. The “best practices” target several root causes of ED overuse: chronic medical conditions, substance abuse issues, and lack of primary care connections. They include recommended systemic elements: care plans for repeat patients, utilization of a state-wide prescription database, limits on narcotics prescribing, procedures to connect patients with primary care services following discharge, and educational outreach.

This system-based approach is in contrast to the misguided individualistic approach of proposed state policies that would restrict payment based on the urgency of the discharge diagnosis. A proposed payment-denial policy⁷ based on a long list of discharge diagnoses in fact predated—and prompted—the “best practices” program. Its fractured course highlights the problems with this approach, as does a 2013 study, which concluded that non-emergent conditions often present with emergent symptoms.⁸

This Article begins by setting out the context of non-emergent ED use. This is an issue among all payor groups, and among the varied causes two disparate ones stand out: lack of timely access elsewhere and repeat visits by people with complicating non-medical circumstances. This Article points out that a classic methodology for categorizing ED use is designed to assess the functioning of health systems and not to judge the decisions of individual patients to seek emergency care.⁹ The Article then proceeds in two distinct parts. First, because an individualistic, Medicaid payment-restriction approach seems to still have traction, Section III explains why it is misguided. Relying on a short list of diagnoses for payment restriction is unlikely to achieve real cost saving, and using a long list runs the serious, unacceptable risk of discouraging people from seeking needed emergency care while shifting costs to physicians and hospitals. The legal, ethical, and practical problems of this approach are compounded by the fact that it does not target the root causes of ED overuse and does not support transition to a health care system that does.

(2012) (urging consideration of the issue as one of “poor access” rather than “poor judgment”).

6 *ER Is for Emergencies*, WASH. ST. HOSP. ASS’N, <http://www.wsha.org/ERemergencies.cfm> (last visited Nov. 16, 2013). The website includes background and implementation information from several conferences, work group meetings, and webinars.

7 See discussion *infra* Part III.A.

8 Maria Raven et al., *Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying “Nonemergency” Emergency Department Visits*, 309 JAMA 1145, 1145 (2013) (listing states considering payment-restriction and co-pay proposals).

9 See, e.g., John Billings et al., Issue Brief, *Emergency Department Use: The New York Story*, COMMONWEALTH FUND 434 (2000), http://www.commonwealthfund.org/usr_doc/billings_nystory.pdf [hereinafter Billings et al., *Issue Brief 434*].

Section IV argues that states should instead adopt a systemic approach to non-emergent ED use by Medicaid patients. This section highlights the elements of Washington State's seven "best practices" program, and notes their potential benefit to all patients and to the health care system as a whole. This program relies upon, but does not itself include, more extensive and available primary care. Ultimately, though, having EDs that focus on emergencies requires a robust primary care system. It also requires systems for dealing with the complex, non-medical problems of high utilizers. Therefore, this section argues that sustainably reducing non-emergent ED use—by those with Medicaid and those with private insurance—will require effective implementation of primary care supports found in the ACA and in other initiatives, public and private. Finally the last section brings the analysis full circle by arguing that any use of co-pays as part of a systemic approach must not deter patients from seeking needed emergency care.

I. THE CHALLENGES OF ED "USE, MISUSE AND OVERUSE"¹⁰

Non-emergent use of the ED is higher in the United States than in other wealthy countries,¹¹ and reducing that usage could potentially reduce costs. A May 2013 special report by the Centers for Disease Control and Prevention (CDC) found that in 2010 in the United States 42% of the ED visits by adults under age 65 were triaged as "semiurgent" or "nonurgent," and 56% of visits by children were triaged with those designations.¹² By one estimate, the cost of an ED visit for a non-emergent condition is two to five times greater than the cost of receiving care in a primary care or urgent care setting for the same condition.¹³ A 2010 *Health Affairs* study concluded that treatment of non-emergent visits in appropriate alternate sites could save \$4.4 billion annually.¹⁴

¹⁰ James G. Adams, Editorial, *Emergency Department Overuse: Perceptions and Solutions*, 309 JAMA 1173 (2013).

¹¹ Karen Davis et al., *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*, Commonwealth Fund Pub No. 1400, 12–13 (2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf (concluding that Germany, the Netherlands, Australia, the United Kingdom, Australia and New Zealand reported lower rates than the United States; the other country included in this comparison, Canada, had slightly higher usage rates).

¹² NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, UNITED STATES, 2012 WITH SPECIAL FEATURE ON EMERGENCY CARE, 24 (2013), [hereinafter HEALTH 2012] available at <http://www.cdc.gov/nchs/data/hus/hus12.pdf> (the other triage designations in this classification are "emergent" and "urgent").

¹³ *A Matter of Urgency: Reducing Emergency Department Overuse*, NEW ENG. HEALTHCARE INST. 6 (Mar. 1, 2010), http://www.nehi.net/publications/55/a_matter_of_urgency_reducing_emergency_department_overuse.

¹⁴ Robin M. Weinick et al., *Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics*, 29 HEALTH AFF. 1630, 1634 (2010). A "retail clinic" is sometimes referred to as a "minute clinic." MinuteClinic is the name of a division of CVS Caremark Corporation, and has about 650 locations in pharmacies in half the states. MINUTE CLINIC, <http://>

In the grand scheme of national health care spending, this is not a lot—less than 1% of recent yearly totals.¹⁵

This cost difference is enough, though, to be a tempting budgetary target for strained Medicaid programs and other payors. And it reflects a care-coordination problem that likely adds costs.¹⁶ In addition, to the extent that appropriate primary care treatment (e.g. for diabetes, asthma, and cardiac disease) reduces ED visits, improved access at that level should reduce overall costs.¹⁷ Indeed, this sort of reduced ED usage is one of the goals of the ACA's support for broader insurance coverage and improved primary care.

Overall, ED use for conditions that are diagnosed as non-emergent is higher among those covered by Medicaid than by those covered by private insurance, but not by a large amount. For example, the May 2013 CDC report includes a table categorizing ED visits by primary payors. It found that 6% of ED visits by privately insured adults under age 65 were triaged as “nonurgent;” the comparable Medicaid figure was 9%.¹⁸ As to privately insured children, 9% of the visits were nonurgent; Medicaid use was slightly higher at 11%.¹⁹

A. Categorizing ED Use

Overarching this policy challenge are the questions of how to categorize ED use and to what end. Categorization is, in significant part, a matter of definition and perspective. Is anxiety “non-emergent” because it can be managed in a primary care setting, or “emergent” because in a particular patient it presented as chest pain that could have been a heart attack? Are parents who bring their children with ear infections to EDs in the evening misusing the system or rationally responding to lack of timely access elsewhere?

What about a patient with a headache who has a life-threatening hypertensive crisis that could have been prevented had he known he had high blood pressure and medically managed the condition? And if a patient shows up at the ED complaining of a “severe headache” 172 times in one year,²⁰ is

www.minuteclinic.com/ (last visited June 10, 2013). The number of retail clinics and urgent care centers is growing, partly in response to the expected expansion of newly insured people. Liz Zamosky, *Walk-in Clinics Gaining Popularity*, L.A. TIMES, June 14, 2013, <http://articles.latimes.com/print/2013/jun/14/business/la-fi-healthcare-watch-20130616>.

¹⁵ Weinick et al., *supra* note 14, at 1634.

¹⁶ If the analysis is expanded to include people whose condition is emergent but might have been prevented by timely primary care, the U.S. numbers are much higher. By one estimate, of the 120 million ER visits in the United States in 2006, nearly half were potentially avoidable. See Bernard M. Rosof, Editorial, *The Busy Emergency Department*, 25 AM. J. MED. QUALITY 170 (2010) (citing studies by Pitts et al. and Weinick et al.).

¹⁷ *Id.* at 70–71.

¹⁸ HEALTH 2012, *supra* note 12, at 24.

¹⁹ *Id.*

²⁰ Carol M. Ostrom, *Doctors Sue State over Limits on ER Visits*, SEATTLE TIMES (Sept. 30, 2011, 1:54 PM), http://seattletimes.com/html/health/2016370460_emergencylimitsoim.html (“In

there a point at which those 172 visits become “non-emergent”? Ultimately, would attaching that designation and denying payment do anything to address the patient’s underlying social, mental, addiction, and/or behavioral issues?

A prominent ED-use study—and one that is subject to misapplication—was published in 2000.²¹ The study by John Billings and colleagues classifies New York City ED visits into one of four categories based on the statistical probability that a given discharge diagnosis meets the category’s criteria.²² The four categories are: emergent/not preventable or avoidable (e.g. trauma, appendicitis, heart attack); emergent/ED care required but preventable or avoidable (e.g. flare-ups of asthma, diabetes, or congestive heart disease); emergent/primary care treatable (“treatment was required within 12 hours, but could have been provided in a primary care setting,” which would include minor lacerations); and non-emergent (“medical care was not required within 12 hours,” which would be true for many stable chronic conditions).²³

The authors found that New York City EDs were frequently used for conditions that did not require an ED setting and observed that this usage pattern “may actually be a reasonable response to an underdeveloped primary care system that is failing to meet patients’ needs.”²⁴ “For a parent of a child with high fever or abdominal pain, obtaining immediate access to care in an ED may make good sense if telephone consultation is unavailable, the wait in the local clinic is three hours, or the clinic is closed at night.”²⁵ They note that low-income patients in particular had limited options for timely routine care in the city’s areas with high ED usage.²⁶

As Arthur Kellermann and Robin Weinick stress in a 2012 *New England Journal of Medicine* article, this widely used algorithm (known as the “Billings” or “New York” algorithm) serves to highlight “the performance of primary care systems” and was not designed to “judge individual decisions to seek care.”²⁷ The study did not, for example, consider the symptoms that brought patients to the ED. It did not consider whether a lower-acuity setting was actually available within a reasonable time for a “primary care treatable” condition. It is a diagnosis-based study that has been widely used to assess and compare the functioning of health systems and considered valuable for that purpose.

2005, the top Medicaid ER user [in Washington State], a 27-year-old woman, visited ERs 172 times, mostly with migraine and headache complaints, according to [the state’s Medicaid agency]).

21 Billings et al., *Issue Brief 434*, *supra* note 9. See also John Billings et al., *Issue Brief, Emergency Department Use in New York City: A Substitute for Primary Care*, COMMONWEALTH FUND 433 (2000), http://www.commonwealthfund.org/usr_doc/billings_eduse_433.pdf [hereinafter Billings et al., *Issue Brief 433*].

22 Billings et al., *Issue Brief 434*, *supra* note 9, at 2. See also Raven et al., *supra* note 8, at 1146 (describing development of the algorithm and its use in various policy settings).

23 Billings et al., *Issue Brief 434*, *supra* note 9, at 2–4.

24 Billings et al., *Issue Brief 433*, *supra* note 21, at 3.

25 *Id.* at 4.

26 *Id.* at 3–4.

27 Kellermann & Weinick, *supra* note 5, at 2141.

A study published in the *Journal of the American Medical Association* (JAMA) in the spring of 2013 highlights problems with using the Billings algorithm to judge individual decisions to seek ED care. The study concluded that presenting complaints associated with emergent diagnoses are often the same as those associated with diagnoses that did not require ED services.²⁸

Drawing on the Billings algorithm, the study “identified ED visits with a discharge diagnosis that had a 100% probability of being either emergent, primary care treatable or non-emergent.”²⁹ There were 192 such diagnoses, with “unspecified disorder of the teeth and gums” being the most common.³⁰ Of the chief complaints associated with these 192 diagnoses the most common was “toothache.”³¹ Other common ones were skin rash and abdominal pain, cramps or spasms.³² Overall, the presenting complaints associated with these 192 diagnoses were also the presenting complaints for most of the ED visits.³³ Indeed, “among ED visits with the same presenting chief complaints as those ultimately given a primary care-treatable diagnosis, a substantial proportion required immediate emergency care or hospital admission.”³⁴

²⁸ Raven et al., *supra* note 8, at 1149.

²⁹ *Id.* at 1147.

³⁰ *Id.* at 1150. Altogether, these 192 diagnoses represented 6.3% of ED visits. *Id.* at 1151.

³¹ In considering low-income coverage and access issues, it is telling that “toothache” was the most common chief complaint associated with a non-emergent diagnosis. Child dental is a required element of Medicaid coverage; adult dental is an optional element and in tight budget times is often cut. See, e.g., VERNON SMITH ET AL., KAISER COMM’N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., MEDICAID TODAY; PREPARING FOR TOMORROW: A LOOK AT STATE MEDICAID PROGRAM SPENDING, ENROLLMENT AND POLICY TRENDS 8 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8380.pdf> [hereinafter SMITH, MEDICAID TODAY] (describing recent dental benefit cuts); *Dental Care*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html> (last visited Nov. 17, 2013). Child dental coverage is one of the ten essential health benefits to be included on the state health insurance exchanges. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302, 10104(b), 124 Stat. 119, 163-68, 896 (2010) (codified as amended at 42 U.S.C. § 18022 (2011)). Even where Medicaid dental coverage is available, it can be a challenge to find a dentist who will take a Medicaid patient on a timely basis. This is tragically illustrated by the case of twelve-year-old Deamonte Driver, whose delayed treatment for an infected tooth led to brain surgery and ultimately his death. Mary Otto, *For Want of a Dentist*, WASH. POST, (Feb. 28, 2007), http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116_3.html (“Twelve-year-old Deamonte Driver died of a toothache Sunday. A routine, \$80 tooth extraction might have saved him. If his mother had been insured. If his family had not lost its Medicaid. If Medicaid dentists weren’t so hard to find.”).

³² Raven et al., *supra* note 8, at 1150.

³³ *Id.* at 1149. The JAMA study is quite focused and does not address a number of potentially related questions. For instance, what percentage of patients actually do not, at the outset of an ED visit, think that their condition is emergent? Do many patients (high utilizers and others) deliberately describe their problem in a way that makes it seem emergent? Does knowledge of available alternative care sites and their convenience impact presenting complaints or discharge diagnoses?

³⁴ *Id.* at 1152.

This study highlights the difficulty of determining from a long list of “non-emergent” and “emergent, primary care-treatable” diagnoses whether an individual patient prudently sought emergency care. Patients arrive at the ED with symptoms and complaints, not diagnoses; this study highlights the frequency with which the same presenting complaint can be associated with conditions of varying urgency. The study’s authors suggest that a more limited set of diagnoses—more limited than the list of 192 they considered—might identify nonemergency visits, particularly if vital signs and other measures were included.³⁵

B. Reasons for “Unnecessary” ED Use

Why do people in the United States go to the ED with conditions that do not require ED-level services? For a variety of reasons: “A complex interplay of community, patient, and health system factors influence ED use.”³⁶ Some believe their symptoms actually suggest an emergency. Other patients seek narcotics. Some face long wait times for clinic appointments, or limited after-hours access.³⁷

Medicaid patients are more likely to have difficulty finding a physician who takes their insurance and can treat them in a timely fashion.³⁸ Many who show up at the ED do not have health insurance or financial reserves and know they will receive some level of treatment there nonetheless.³⁹ Children are over-represented in the group of those whose conditions are diagnosed in the ED as non-emergent.⁴⁰ This probably reflects difficulty in parental diagnosis,

³⁵ *Id.* at 1151–52.

³⁶ *Id.* at 1152 (citing studies published between 2006 and 2012 on reasons for non-emergent ED use). See also HEALTH 2012, *supra* note 12, at 23; Weinick et al., *supra* note 14, at 1630 (citing studies focusing on ED use by children and adults for non-emergent reasons).

³⁷ Weinick et al., *supra* note 14, at 1630. See also Ann S. O’Malley, *After-Hours Access to Primary Care Practices Linked with Lower Emergency Department Use and Less Unmet Medical Need*, 32 HEALTH AFF. 175, 175, 181 (2013) (finding that 30.4% of patients with after-hours access to their primary care provider reported ED use compared to 37.7% of those lacking after-hours access).

³⁸ See, e.g., Joseph Fastiggi, *New York Medicaid: Never Can Say Goodbye*, 16 CORNELL J.L. & PUB. POL’Y 581, 587–91 (2007); Alexandra Sternberg, *The Overuse of America’s Emergency Rooms*, ANNALS HEALTH L. ADVANCE DIRECTIVE, Spring 2011, at 70, 70–73.

³⁹ Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012) (establishing that hospitals that have an ED and accept Medicare must provide to all who seek treatment at least an initial screening and stabilize any emergency conditions).

⁴⁰ DELMARVA FOUND., CAL. DEPT. HEALTH CARE SERVS. MEDI-CAL MANAGED CARE DIV., STATEWIDE AVOIDABLE EMERGENCY ROOM VISITS 6 (2008), http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/ER%20Collaborative%202008%20FINAL.pdf. See also Anne Berry et al., *Why do Parents Bring Children to the Emergency Department for Nonurgent Conditions? A Qualitative Study*, 8 AMBULATORY PEDIATRICS 360, 362–64 (2008) (describing parents’ and caregivers’ reasons for bringing a child to the ED as relayed in the interviews conducted for the study).

especially as to young children, as well as scheduling challenges for work-hours clinic visits.⁴¹

The ED may be simply more convenient—a view reinforced when EDs advertise ready access and short wait times.⁴² There may be no financial or other disincentive to the patient in choosing the ED over another appropriate option. And there may be a lack of incentives for clinics to provide after-hours care and for hospitals and physicians to push for reduced ED usage.⁴³ Of course, health care professionals direct many people to the ED, based on patients' reported symptoms, clinic resource limits, or both.⁴⁴

In addition, many patients are not connected to a physician or clinic, and thus look to the ED as the place for episodic care. High utilizers, particularly those with extremely high utilization over several years, often have poorly managed mental health and substance abuse disorders in addition to chronic physical illnesses and social service needs.⁴⁵ Substance abuse, poorly managed mental health conditions, and some consequences of homelessness land people in the ED, but the ED cannot provide treatment to truly stabilize those circumstances.

41 See, e.g., Berry et al., *supra* note 40, at 360 (“Although parents report that education on the urgency of pediatric conditions would be helpful, substantial reduction of pediatric nonurgent ED use may require improvements in families’ PCP office access, efficiency, experiences, and appointment scheduling.”).

42 A Google images search for “emergency wait times sign” yields numerous pictures of billboards advertising low ED wait times; some of the billboards include close-to-real-time minute displays. *Emergency wait times sign – Google Search*, GOOGLE, <http://goo.gl/i2mqt4> (last visited Nov. 17 2013).

43 DELMARVA FOUND., *supra* note 40, at 12–13.

44 RENEE M. GINDI ET AL., CTNS. FOR DISEASE CONTROL AND PREVENTION, EMERGENCY ROOM USE AMONG ADULTS AGED 18–64: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–JUNE 2011 I (2012), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf (finding in a study of adults under age 65 who visited the ED in 2011 that 20% reported being directed to the ED by a health care provider and were not admitted to the hospital during that visit); see also Kellermann et al., *supra* note 2, at 2071 (discussing reasons why physicians increasingly direct patients with urgent problems to the ED).

45 See John V. Jacobi, *High Utilizers of ED Services: Lessons for System Reform*, 21 ANNALS HEALTH L. 35, 40–41, 44 (2012) (describing challenges of frequent ED utilizers and a non-profit health coalition project to connect frequent utilizers with community based services and, more broadly, to make the economic case for intensive case management of these patients). See also John Billings & Maria C. Raven, *Dispelling an Urban Legend: Frequent Emergency Department Users Have Substantial Burden of Disease*, 32 HEALTH AFF. 2099 (2013) (concluding that frequent ED users often suffer from a substantial burden of illness that can require emergency care).

II. PROBLEMS WITH MEDICAID PAYMENT–RESTRICTION POLICIES

Faced with “unrelenting pressure to control the pace of spending,”⁴⁶ policymakers in some states have focused on Medicaid ED use. The counter-cyclical nature of Medicaid enrollment means that the recent economic recession has both severely strained state budgets and also increased the Medicaid rolls.⁴⁷ Medicaid is among any state’s highest budget items, typically second after education.⁴⁸ Among the many policy changes directed at holding down Medicaid costs, several states in 2011 and 2012 considered adopting policies that deny or restrict payment for ED Medicaid visits.⁴⁹ For example, New Hampshire enacted a rule limiting payment for nonemergency visits to EDs to four per year.⁵⁰ Florida announced its intent to seek federal approval to limit the number of covered ED visits per year to six for all but pregnant women.⁵¹ Mississippi adopted and then revoked a six-visit payment limit for adults.⁵² The starkest examples of ED payment–restriction policies were those considered and then abandoned in Washington State, as described in the next section.

Because a payment–restriction approach seems to have some traction, it is important to point out its practical, legal, and ethical problems before turning to analysis of a better approach. As the experience in Washington State demonstrates, relying on a short list of conditions (diaper rash and the like) for which ED payment will be withheld probably will not save much money. Relying on a long list of conditions (unspecified chest pain, severe headache and the like) might save real money, but doing so unacceptably risks

46 VERNON K. SMITH ET AL., KAISER COMM’N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., MOVING AHEAD AMID FISCAL CHALLENGES: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS 44, 75 (2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8248.pdf> [hereinafter SMITH, MOVING AHEAD].

47 *Id.* at 75 (“[In 2010] Medicaid experienced increases in total spending that averaged 7.3%. More significant for states, the state cost of Medicaid grew by 10.8%, adding to state fiscal stress as enhanced ARRA federal Medicaid matching rates began to phase down and state revenues recovered slowly but remained well below actual levels of three years earlier.”).

48 See Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 411 (2007) (describing pressures on state budgets during difficult economic times and Medicaid’s varied roles in supporting crucial state health programs).

49 See Raven et al., *supra* note 8, at 1145–46. As described in Section III of this paper, states are actively considering the imposition of co-pays for nonemergency Medicaid ED use, and proposed federal rules would allow such a co-pay subject to several restrictions. See *infra* Section III.C.

50 Service Limits, N.H. CODE ADMIN. R. ANN. HE-W 530.03 (2013).

51 *States Cutting Medicaid: 13 States Cut Medicaid to Balance Budgets*, KAISER HEALTH NEWS (July 24, 2012), <http://www.kaiserhealthnews.org/Stories/2012/July/25/Medicaid-Cuts-Chart>.

52 See 23–202 MISS. CODE R. § 2.3 (West, Westlaw through Mississippi Administrative Rules of Filings dated November 2013); Medicaid Final Action on Rules (Sept. 30, 2012), 2012 MS REG TEXT 303589 (Netscan, Westlaw) (creating rule in Mississippi that limited coverage for adults to six non-emergency ED department visits per year); Medicaid Final Action on Rules (Nov. 30, 2012), 2012 MS REG TEXT 308589 (Netscan, Westlaw) (removing the six visit limit).

dissuading people from seeking needed emergency care. Restricting payment for an ED visit based on the discharge diagnosis raises serious concerns. This is true whether the covered population has Medicaid coverage or not, though the concerns are more acute with a low-income population. Those with Medicaid are somewhat more likely to be diagnosed in the ED with a non-emergent condition.⁵³ And they are less likely to have financial reserves to readily cover significant costs.

A. One State's Experience

In 2010 the Washington State legislature, facing a serious budget shortfall, estimated that the Medicaid program overall could save more than \$30 million a year by limiting coverage for non-emergency visits to three per Medicaid beneficiary per year, and directed HCA to collaborate with the hospital and medical associations to identify the diagnostic codes and review procedures for payment denial.⁵⁴ Collaboration faltered, with significant differences on the list of codes and review procedures. In September 2011, HCA announced that “[b]eginning October 1, 2011, Medicaid will only pay for three non-emergency visits to the Emergency Room per client per year. Subsequently, Medicaid will not cover the fourth non-emergency visit, and clients may be billed for those services.”⁵⁵

Non-emergency was defined by reference to a list of 704 diagnoses.⁵⁶ This

⁵³ HEALTH 2012, *supra* note 12, at 24.

⁵⁴ 2011–2013 Operating Budget, ch. 50, § 213(49), 2011 Wash. Sess. Laws 3988.

⁵⁵ Press Release, Wash. Health Care Auth., Washington State Medicaid to Limit Non-Emergency Use of Emergency Rooms, Effective October 1 (Sept. 22, 2011) [hereinafter Washington Medicaid Press Release] (on file with author). As a legal and practical matter, the ability to bill in this type of situation would be limited. Medicaid patients may be billed for non-covered services only if the patient has provided specific written authorization before receiving the service. In Washington State, this written authorization, DSHS Form 13-879, is to include, among other information, the type of treatment, treatment alternatives, and the cost to the patient. WASH. ADMIN. CODE § 182-502-0160 (2013); *see also* WASH. STATE HEALTH CARE AUTH., AGREEMENT TO PAY FOR HEALTHCARE SERVICES (Aug. 2012), *available at* http://www.hca.wa.gov/medicaid/forms/documents/13_879.pdf. Under EMTALA, the screening (and, if necessary, stabilizing treatment) may not be delayed or otherwise hindered in order to establish payment arrangements. *See* 42 C.F.R. § 489.24 (2012). Thus, to implement this sort of billing, the ER would need to carefully manage the timing of non-covered service discussion and form presentation, and also clarify the potential billed amount. *See* discussion *infra* Section III.C. (regarding proposed federal rule as to copayments).

⁵⁶ Washington Medicaid Press Release, *supra* note 55; *see also* Ostrom, *Doctors Sue State over Limits on ER Visits*, *supra* note 20 (stating that there were to be a number of exceptions to this policy, including visits for mental health diagnosis, patients brought in by police or ambulance, and patients whose ED visit resulted in hospital admission or emergency surgery). In a FAQ on the policy, HCA stated that there would be an “Exception to Rule” process that hospitals and physicians could use for reimbursement appeals and that “[t]he diagnosis code is merely a starting point for the analysis—not the end point, and the [ED] physician is in charge of the process.” WASH. STATE HEALTH CARE AUTH., 2011 FACT SHEET: FAQ, NON-EMERGENCY ER VISIT LIMIT 1 (Oct. 2011), http://www.hca.wa.gov/medicaid/provider/Documents/FAQ_ERVisit.pdf [hereinafter *Oct.*

list seems generally based on the Billings algorithm, including both the “non-emergent” and “emergent/primary care treatable” diagnosis categories. “Diaper or napkin rash” is on this list, as are “acne” and “ingrowing nail.”⁵⁷ As news reports⁵⁸ and the ensuing lawsuit⁵⁹ stressed, however, many of the diagnoses on this list are commonly associated with emergent symptoms. For example “chest pain (NOS) [not otherwise specified]”⁶⁰ would present in a patient as chest pain that might indicate a heart attack. Also, several of the diagnoses on the list relate to asthma.⁶¹ Asthma is a particular concern with children, for whom it is a very common reason for hospitalization.⁶² Somewhere between three and ten percent of the state’s Medicaid patients would have exceeded this limit in the prior year.⁶³ According to a press release, “[t]he small number who exceed that limit are responsible for scores of visits—and most of them are for chronic conditions and complaints of pain—visits that usually end with a narcotics script.”⁶⁴

The policy received a great deal of media attention. A casual reader or viewer could have been left with the impression that policy limited access *to the ED itself*. “Wash. to limit Medicaid emergency room visits,” read a headline in a Seattle paper;⁶⁵ “Medicaid cuts limit ER visits,” headlined an article out of Spokane.⁶⁶ The Washington Chapter of the American College of Emergency Physicians sued the state, alleging that the policy’s adoption was procedurally defective and that its substance violated federal and state Medicaid coverage

2011 *Fact Sheet*].

57 Petition for Declaratory Judgment and Injunctive Relief Pursuant to RCW 34.05, App. B, at 5, Wash. Chapter of the Am. Coll. of Emergency Physicians v. Wash. Health Care Auth., No. 11-2-02109-0, 2011 WL 4577381 (Wash. Super. Ct. Sept. 30, 2011) [hereinafter Petition for Declaratory Judgment and Injunctive Relief] (listing billing codes for 704 conditions).

58 See, e.g., Ostrom, *Doctors Sue State over Limits on ER Visits*, *supra* note 20.

59 See Petition for Declaratory Judgment and Injunctive Relief, *supra* note 57, App. A (copy of letter); see also Declaration of George A. Woodward, M.D. at 3–7, Wash. Chapter of the Am. Coll. of Emergency Physicians v. Wash. Health Care Auth., No. 11-2-02109-0 (Wash. Super. Ct. Sept. 30, 2011); Declaration of Nathaniel Schlicher, M.D., J.D. in Support of Plaintiff’s Motion for Stay Pursuant to RCW 34.05 at 8, 10, Wash. Chapter of the Am. Coll. of Emergency Physicians v. Wash. Health Care Auth., No. 11-2-02109-0 (Wash. Super. Ct. Sept. 30, 2011).

60 Petition for Declaratory Judgment and Injunctive Relief, *supra* note 57, App. B at 14 (list of billing codes for 704 conditions).

61 *Id.* at 11.

62 See Atul Gawande, *Now What?*, THE NEW YORKER (Apr. 5, 2010), http://www.newyorker.com/talk/comment/2010/04/05/100405taco_talk_gawande.

63 In its press release, HCA estimated that only about 3% of the state’s approximately 1.1 million Medicaid patients sought ED care beyond this limit in the prior year. See Washington Medicaid Press Release, *supra* note 55. In a subsequent FAQ, however, HCA stated that 11,000 people exceeded the limit in the prior year. Oct. 2011 *Fact Sheet*, *supra* note 56, at 1.

64 Press Release, Washington Medicaid Press Release, *supra* note 55, at 1.

65 *Wash. to Limit Medicaid Emergency Room Visits*, SEATTLE TIMES (Sept. 26, 2011), http://seattletimes.com/html/localnews/2016323768_apwamedicaidemergencyvisitsistldwritethru.html.

66 John Stucke, *Medicaid Cuts Limit ER Visits*, THE SPOKESMAN-REVIEW, Sept. 3, 2011, at A1.

rules.⁶⁷ In November, 2011 the court ruled that the state did not follow proper rulemaking procedures and suspended the policy.⁶⁸

In subsequent discussions as rulemaking proceeded, the physicians' group proposed a list of approximately 200 diagnoses that are most often not emergencies, but argued that even for those, exceptions should be made for patients with unstable vital signs and other circumstances.⁶⁹ Throughout the discussions HCA was constrained by the legislative directive to achieve specified cost savings by limiting non-emergent visits. Relying on a list to do so meant that the list could not be a short one.

In late December 2011 the state announced an arguably more restrictive policy: Effective April 1, 2012, it would "stop paying for hospital Emergency Room visits when those visits are not medically necessary for that place of service" and referenced a list of 500 diagnoses.⁷⁰ "The ER cannot be the medical home of the 21st century,' [the chief medical officer for Washington State's Medicaid program] said. 'We will not pay for diaper rash treated in the emergency room.'" ⁷¹ On the revised list, some of the most hotly contested diagnoses, including "chest pain," were gone. Under this proposed policy, Medicaid patients could not be billed for non-covered ED visits. This non-payment approach might seem surprising given that only a few months prior a state court had found the three-visit payment limit policy procedurally defective based on a lack of formal rulemaking. Negotiations were actively proceeding, however, as to both the diagnoses on a list and any payment alternatives. More significantly, negotiations were proceeding as to a systemic rather than an individualistic, payment-restriction approach.

The 2013 JAMA study described above focused on a much smaller list—192 diagnoses—and concluded that even regarding that smaller group, the presenting symptoms were frequently associated with emergency diagnoses.⁷² "Patients present to the ED with chief complaints, symptoms, and signs, but not with discharge diagnoses."⁷³ The same complaint could be associated with need for emergency care within the hour, a primary care visit within the week, or some other intervention altogether. Abdominal pain could be appendicitis

67 Petition for Declaratory Judgment and Injunctive Relief, *supra* note 56.

68 Order Granting Petitioners' Motion for Stay, at 1, 3, Wash. Chapter of the Am. Coll. of Emergency Physicians v. Wash. Health Care Auth., No. 11-2-02109-0 (Wash. Super. Ct. Thurston Cnty. Nov. 18, 2011) (on file with author).

69 Carol M. Ostrom, *State Medicaid Program to Stop Paying for Unneeded ER Visits*, SEATTLE TIMES (Feb. 7, 2012), http://seattletimes.com/html/localnews/2017449883_emergency08m.html.

70 12-06 Wash. Reg. 036 (March 21, 2012) ("[E]ffective April 1, 2012, Health Care Authority (HCA) is directed to pay for only medically necessary emergency services performed in the emergency room"); WASH. STATE HEALTH CARE AUTH., 2011 FACT SHEET: FAQ, NON-EMERGENCY CARE IN THE ER I (Dec. 2011), http://www.hca.wa.gov/medicaid/provider/Documents/FAQ_ER_Visit.pdf.

71 Ostrom, *State Medicaid Program to Stop Paying for Unneeded ER Visits*, *supra* note 69.

72 Raven et al., *supra* note 8, at 1150.

73 *Id.* at 1151.

or indigestion. Cramps could be an ectopic pregnancy or mild stomach flu. This study, and the story of Washington State, highlights the problem with using a list of diagnoses to determine whether a patient wisely sought treatment in the ED.

B. The Prudent Lay–Person Standard and Its Ethical Underpinnings

As a legal matter, payment–restriction strategies risk violation of the “prudent layperson” insurance coverage standard for ED visits.⁷⁴ The development of this standard is directly related to previous payor attempts to restrict payment based on discharge diagnosis. This standard, in its various formulations, has an obvious connection to the federal Emergency Medical Treatment and Labor Act (EMTALA).⁷⁵ Congress enacted EMTALA in 1986 in response to problems with “patient dumping,” patients being turned away from EDs or turfed to county hospitals for economic reasons.⁷⁶ Where it applies, EMTALA requires as an initial matter that all individuals who seek ED treatment receive an appropriate screening to determine whether they are in an “emergency condition.”⁷⁷ If the patient is not in an emergency condition, EMTALA does not require that any further treatment be provided. For reasons of medical ethics, hospital missions, convenience, and certainly to some extent, the hope of payment, further treatment often is provided. And, as a practical matter, in many medical circumstances the line between screening and treatment can be an elusive one.⁷⁸

74 Another legal concern, from a different vantage, is the risk of triggering fraud and abuse laws. A factual statement by a hospital administrator that “Medicaid will not pay if the discharge diagnosis is one of those on this list” could too easily be interpreted as “avoid those discharge diagnoses if possible.” And that sort of message risks the submission of “false or fraudulent” claims triggering potential False Claims Act liability with its *qui tam* provisions, penalties, and treble damages. See False Claims Act, 31 U.S.C. §§ 3729, 3730 (2012); 31 U.S.C. § 3802 (2012). See also, e.g., WASH. REV. CODE §§ 74.66.010, 74.66.020 (2012) (showing analogous state law). If states proceed down this problematic payment–restriction route, hospital administrators and practitioners ought to be mindful of this risk.

75 Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012). See also Sara Rosenbaum, *The Enduring Role of the Emergency Medical Treatment and Active Labor Act*, 32 HEALTH AFF. 2075 (2013).

76 See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare–Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, and 489) (clarifying rules regarding payment inquiry and basis).

77 42 U.S.C. § 1395dd(a).

78 Letter from Andrew Sama, President, Am. Coll. of Emergency Physicians, to Marilyn Tavenner, Acting Adm’r, Ctrs. for Medicare and Medicaid Servs. (Feb. 19, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0124> (click “view attachment” to download PDF) (“The presumption by many policy–makers that there is a bright line during the course of an ED visit where the screening portion of the visit is over and the treatment (subject to a co–pay) begins, does not reflect the reality of care in an ED.”).

The 1990s saw a rise in complaints from patients and hospitals about insurance companies denying coverage for ED visits where the diagnosis turned out to be a non-emergent one.⁷⁹ In response, many states enacted provisions, often as part of a “patient bill of rights,” which required coverage by state-regulated insurance plans for ED services if a prudent layperson would have thought the visit warranted.⁸⁰

The federal government enacted a “prudent layperson” regulatory provision with respect to Medicaid managed care as part of the Balanced Budget Amendments of 1997.⁸¹ The implementing regulations require coverage of services that are “[n]eeded to evaluate or stabilize an emergency medical condition.”⁸² In language that closely tracks EMTALA, these regulations define an emergency medical condition as:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) *that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:*

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.⁸³

This definition is common to other “prudent layperson” statutes.⁸⁴ Writing prior to the adoption of this federal regulation, law professor Diane Hoffmann raises an important concern about its application in relation to those with Medicaid coverage. By including the modifying phrase “*who possesses an average knowledge of health and medicine*” the standard might disadvantage the most vulnerable.

If interpreted [in a technical, empirical rather than general sense] . . . , the language may be particularly harmful to individuals from different cultural backgrounds who have very different ideas about the concepts of health and disease. In addition, the standard would seem to harm those who are not well educated and may be particularly harsh for Medicaid beneficiaries.⁸⁵

79 See generally Diane E. Hoffmann, *Emergency Care and Managed Care—A Dangerous Combination*, 72 WASH. L. REV. 315 (1997) (describing managed care prospective and retroactive limits on ED access, federal and state legislative responses, and evolution of prudent layperson standard).

80 *Id.* at 390–93 (analyzing prudent layperson standards).

81 Balanced Budget Act of 1997, Pub. L. No. 105–33, § 4704, 111 Stat. 251, 496 (prudent layperson standard applied to Medicaid managed care plans). See also § 1852, 111 Stat. at 290 (prudent layperson standard applied to Medicare managed care plans).

82 42 C.F.R. § 438.114 (2009).

83 *Id.* (emphasis added).

84 See Hoffmann, *supra* note 79, at 390–93.

85 *Id.* at 393.

The Medicaid managed care regulations go on to specify that payment may not be limited “on the basis of lists of diagnoses or symptoms,”⁸⁶ and that a beneficiary who has an emergency medical condition “may not be held liable for payment.”⁸⁷ The “prudent layperson” standard’s applicability throughout the country is further reinforced and extended by virtue of the “patient protection” provisions of the ACA.⁸⁸ The ACA now applies the same standard set forth above to most private health insurance plans,⁸⁹ including those not previously reached by state legislation.

Oddly, these state and federal statutory provisions might not clearly apply in the Medicaid fee for service (FFS) context, where care is not delivered through a managed care entity. The genesis of these statutory provisions tracks to private insurance and managed care. Although Medicaid is increasingly provided through managed care entities, there still are significant areas of FFS provision.⁹⁰ The focus on denying coverage or imposing cost-sharing in the FFS context is relatively new, and partly a result of flexibility granted to the states under the Deficit Reduction Act of 2005, and subsequent waivers granted by the Center for Medicare and Medicaid Services (CMS).⁹¹ Thus, this legal issue—the prudent layperson protections in Medicaid FFS—might not have been directly considered. To treat these similarly situated Medicaid patients differently—to leave only some low-income people out of protections that apply to others with Medicaid coverage and to virtually all other privately insured Americans—would be fundamentally unfair. It also raises a potential question of whether the prudent layperson standards are intended to protect providers as well as patients. Certainly advocacy by providers—hospitals and physicians—was central to the passage of these protections.

The ethical underpinnings of both EMTALA and also of “prudent layperson” insurance protections recognize that laypeople are often ill-suited to recognize a medical emergency. As an ethical matter, people should not be dissuaded from seeking ED treatment for conditions that might be emergent. Both legal standards reflect the ethic that in a well-functioning system, a significant number of people who arrive at EDs will not be in an emergency condition. If an ED rarely sees conditions that are non-emergent, something is wrong with its entrance criteria or its record-keeping.

⁸⁶ 42 C.F.R. § 438.114(d)(1)(i) (2009).

⁸⁷ *Id.* at § 438.114(d)(2).

⁸⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §10101(h), 124 Stat. 119, 888 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

⁸⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.). *See also* 45 C.F.R. § 147.138 (2012) (implementing regulations).

⁹⁰ *See* SMITH, MEDICAID TODAY, *supra* note 31, at 54.

⁹¹ Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6041, 120 Stat. 4, 81-85 (2006) (codified as amended at 42 U.S.C. § 1396o-1 (2012)); *see also* SMITH, MEDICAID TODAY, *supra* note 31, at 41-42.

Furthermore, from an ethical perspective, it is important to consider not just what a policy says but also how it is interpreted. A policy that “Medicaid will pay for only three non-emergency ED visits a year”—the Washington State plan in the fall of 2011—can too readily be understood as “those with Medicaid can go to the ED only three times a year.” I know of no studies on public perception of Washington’s proposed policy, but I had public health students, including those who had studied EMTALA, who described the policy as a “three visit limit.” A quick read of the headlines about the proposal reinforces this view.⁹² A perception that there is a limit to the number of times one can go to the ED risks delaying necessary treatment, with its resulting human and financial costs.

This is a particular concern with children, who make up the bulk of the Medicaid population. A California study found that among Medicaid age groups (excluding infants under twelve months), children ages one to nine used the ED most frequently for “avoidable” (defined as primary care treatable) visits.⁹³ The May 2013 CDC report similarly found that children in all payor groups were more likely to be seen in the ED and their visits more likely to be triaged as being “semiurgent.”⁹⁴ As a matter of common sense, children’s symptoms can be hard for parents to diagnose and warrant a lower threshold for concern.

III. POTENTIAL OF A SYSTEMIC RESPONSE

Fundamentally, focusing on the issue as largely a matter of individual behavior, as a reflection of poor judgment on the part of patients, sidesteps key systemic factors that drive non-emergent ED use by Medicaid patients and by others. As demonstrated in several studies over the years, “[a] complex interplay of community, patient, and health system factors influence ED use.”⁹⁵ To reduce Medicaid ED usage, a better, though more complex, strategy would target the disparate reasons why Medicaid patients with non-emergent conditions end up in the ED and aim to facilitate their care in a more appropriate setting. And, as the problem of overuse is not unique at all to the Medicaid population, such a systemic strategy would ultimately address ED overuse among the privately insured, those with Medicare coverage, and the uninsured as well. A systemic strategy is now underway in Washington State, where all of the state’s EDs have agreed to implement a constellation of “best practices” in cooperation with the state’s Medicaid agency.

⁹² See, e.g., Stucke, *supra* note 66; *Wash. to Limit Medicaid Emergency Room Visits*, *supra* note 65; see also *supra* text accompanying notes 65, 66.

⁹³ DELMARVA FOUND., *supra* note 40, at 6.

⁹⁴ HEALTH 2012, *supra* note 12, at 20, 24.

⁹⁵ Raven et al., *supra* note 8, at 1152 (citing studies published between 1996 and 2012). See discussion *supra* Part I.

Washington State’s policy of denying payment for all “nonemergency” Medicaid visits, as significantly defined by reference to a list of about 500 diagnoses, was set to take effect April 1, 2012. The day before, the governor suspended its implementation in light of legislative negotiations.⁹⁶ The legislature ultimately adopted a budget proviso specifying that “in order to achieve the twelve percent reduction in emergency room expenditures[,]” HCA, in consultation with the state hospital association, state medical association, and the state chapter of the college of emergency physicians “shall designate best practices and performance measures to reduce medically unnecessary emergency room visits of [M]edicaid clients.”⁹⁷

A. *The Seven “Best Practices”*

The proviso goes on to state that if by July 1, 2012 HCA had not received declarations of participation from hospitals that saw seventy–five percent of ED Medicaid visits, then HCA could proceed to “implement a policy of nonpayment of medically unnecessary emergency room visits, with appropriate client and clinical safeguards such as exemptions and expedited prior authorization.”⁹⁸ By that date, all the state’s hospitals had agreed to participate.⁹⁹ HCA was to report by January 15, 2013 whether the assumed savings were being realized and, if not, what other actions should be implemented.¹⁰⁰ In the year following this budget proviso, HCA representatives have met monthly with an ED workgroup that includes representatives of the state’s medical, emergency physicians, and hospital associations.¹⁰¹ The “best practices” are also known as the “ER is for Emergencies” campaign.¹⁰²

While a Medicaid non–payment policy is practically, legally, and ethically problematic, is it politically astute? Maybe. It did prompt change—at least, to date, in the short term—in Washington State.¹⁰³ The state’s Medicaid chief

96 Carol M. Ostrom, *Gregoire Suspends Plan to Limit Medicaid Emergency–Room Visits*, SEATTLE TIMES (Mar. 31, 2012), http://seattletimes.com/html/localnews/2017883768_medicaidoim.html.

97 Supplemental Operating Budget, ch. 7, § 213(43), 2012 Wash. Sess. Laws 2225, 2298–99.

98 *Id.*

99 Press Release, WASH. STATE HOSP. ASS’N, 100% of Washington Hospitals Enrolled in Program to Reduce Preventable Medicaid Emergency Department Visits, Saving State Millions of Dollars (June 25, 2012), http://www.wsha.org/files/257/ER%20Enrollment%206_25_12.pdf.

100 Supplemental Operating Budget ch. 7, 2012 Wash. Sess. Laws 2225, 2299.

101 Wash. State Health Care Auth., *Report to the Legislature: Emergency Department Utilization: Assumed Savings from Best Practices Implementation 3* (2013), <http://www.hca.wa.gov/documents/legreports/Report-3ESHB2127EmergencyDeptUtilization.pdf> [hereinafter *Emergency Department Utilization*] (program on track to save Medicaid thirty–three million dollars the first year; visits by ED high utilizers down 23% in first five months).

102 *ER Is for Emergencies*, *supra* note 6.

103 This is not the first time this sort of tactic has prompted progressive system reform. Washington State is one of the few that has on its books a law requiring all licensed hospitals to provide subsidized treatment to uninsured people with incomes up to two hundred percent of the federal

medical officer contended in early 2012 that he had long offered to provide the hospitals with a list of about 4,000 frequent ED utilizers, many of them narcotics seekers. Until the state threatened non-payment, however, he perceived that they were not interested and not doing enough to deter inappropriate ED use.¹⁰⁴

The “best practices” are summarized by HCA as:

1. Adoption of a system to exchange patient information electronically among emergency departments . . .
2. Adoption of a system to educate patients that the emergency department should be used only for true emergencies.
3. Implementation of a process to disseminate lists of frequent users to hospital personnel to ensure they can be identified by the electronic information exchange system discussed above.
4. Implementation of processes to assist frequent users with their care plans, and to make appointments for these patients to see their primary care provider within 72–96 hours of their emergency room visit.
5. Adoption of strict guidelines for the prescribing of narcotics . . .
6. Enrollment of at least 75 percent of ED prescribers in the state’s Prescription Monitoring Program by July 1, with a goal of 90 percent enrollment by December 31, 2012 . . .
7. Designation of hospital personnel to review feedback reports regarding ED utilization and to take appropriate action in response to the information provided by those reports.¹⁰⁵

Individually, the elements of this program are not new. They focus on several recognized root causes of unnecessary ED use: chronic medical conditions, substance abuse issues, and lack of primary care connections. They include recommended systemic elements: care plans for repeat patients, utilization of a state-wide prescription database, limits on narcotics prescriptions, procedures to connect patients with primary care services following discharge, and educational outreach. A number of states have programs tracking Medicaid ED use generally or as to high utilizers specifically.¹⁰⁶ The California collaborative, for example, focuses on actions by the state’s Medicaid managed care plans

poverty level (FPL). WASH. REV. CODE § 70.170.060 (2008) (requirement to establish charity care policy); *see also* WASH. ADMIN. CODE § 246-453-050(2) (2012) (examples of sliding-scale treatment subsidies). In 2006, a bill before the state legislature proposed raising this to four hundred percent of the FPL. Sub. H.B. 2574, 59th Leg., Reg. Sess. (Wash. 2006), *available at* <http://apps.leg.wa.gov/documents/WSLdocs/2005-06/Htm/Bills/House%20Bills/2574-S.htm>. In response, the state’s hospitals agreed to several changes to their financial assistance programs, including more prominent notice to patients and restrictions on some collection practices. By virtue of the ACA, similar provisions now apply to all hospitals that have been granted 501(c)(3) federal tax exemption. *See* 26 U.S.C. § 501(r) (2012) (requiring, *inter alia*, written charity care policies and limiting certain collection actions).

¹⁰⁴ Ostrom, *State Medicaid Program to Stop Paying for Unneeded ER Visits*, *supra* note 69.

¹⁰⁵ *Emergency Department Utilization*, *supra* note 101, at 2–3 (alphabetic ordering changed here to numeric for ease of reference). *See also* Melissa Burgess, Policy Alternatives to Address Repeat Use of the Emergency Department by Medicaid Recipients in the State of Washington 25–26 (March 15, 2013) (unpublished manuscript) (on file with author) (analyzing genesis of the “best practices” program, its elements, and interventions and policies associated with reduced ED Medicaid utilization).

¹⁰⁶ *See, e.g.*, SMITH, MOVING AHEAD, *supra* note 46, at 99–107 (table listing various state programs).

in conjunction with several hospitals.¹⁰⁷ The Washington program, though, is novel in important ways. It is explicitly a cooperative effort involving the state Medicaid agency, the hospital association, and state medical associations. It includes all of the state's hospitals. And it takes a deliberately multifaceted approach.

The first element, tracking emergency department visits to reduce “ED shopping,” involves adoption of a regional or statewide electronic system to exchange information, particularly as to patients who are high utilizers and/or have care management plans in place.¹⁰⁸ One of the key purposes of this database is to allow ED physicians to identify frequent users and share information regarding their care. It potentially allows review of all patient visits to Washington State EDs in the past 12 months, not merely those with Medicaid. This tracking is managed through the Emergency Department Information Exchange (EDIE), which is a proprietary system.¹⁰⁹ For cost reasons, critical access hospitals were exempted from this requirement, though it is expected that many will participate.¹¹⁰

The patient education “best practice,” the second element, includes printed brochures and discharge instructions in various languages.¹¹¹ The brochures are captioned “Doctor’s Office, Urgent Care Clinic or Emergency Room: A guide to help you choose the best place for your care.” They include the after-hours help line for several insurers. In addition, hospitals attest that they have trained their ED physicians in how to talk to patients about where they should receive routine care. One interesting effort in this regard from another state is the “California ER Alternative Finder” webpage sponsored by the insurer Anthem.¹¹² It utilizes Google Maps to identify urgent care and retail clinics,

107 CAL. DEPT OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE DIVISION, MEDI-CAL MANAGED CARE PROGRAM: QUARTERLY UPDATE TO THE LEGISLATURE FOR THE REPORTING PERIOD APRIL THROUGH JUNE 2012, at 3–4 (2012), http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Managed%20Care%20Quarterly/Mgd_Care-Qtrly-April-June_2012.pdf.

108 Claudia Sanders et al., *Best Practice: Information Exchange*, WASH. STATE HOSP. ASS’N (Apr. 27, 2012), available at http://www.wsha.org/files/EDIE%20webcast%20April%2024_Final.pptx (detailing Emergency Department Information Exchange (EDIE), a proprietary system).

109 *Emergency Department Information Exchange*, COLLECTIVE MEDICAL TECHNOLOGIES, <http://collectivemedicaltech.com/edie-2/> (last visited Nov. 22, 2013).

110 See Sanders et al., *supra* note 108.

111 See, e.g., WASH. STATE HOSP. ASS’N, DOCTOR’S OFFICE, URGENT CARE CLINIC, OR EMERGENCY ROOM? A GUIDE TO HELP YOU CHOOSE THE BEST PLACE TO GO FOR HEALTH CARE, available at <http://www.wsha.org/files/82/ERBrochure.pdf> (last visited May 20, 2013); WASH. STATE HOSP. ASS’N, VĂN PHÒNG BÁC SĨ, PHÒNG MẠCH KHẨN CẤP, HAY PHÒNG KHẨN CẤP NHÀ THƯỜNG?, available at <http://www.wsha.org/files/EDBrochure2C-VietnameseFINAL.pdf> (last visited Nov. 22, 2013) (Vietnamese); WASH. STATE HOSP. ASS’N, OFICINAS DE DOCTOR, CLÍNICAS DE CUIDADO URGENTE, O SALAS DE EMERGENCIA?, available at http://www.wsha.org/files/257/EDBrochure2C_SpanishFINAL.pdf (last visited Nov. 22, 2013) (Spanish).

112 Anthem, *California ER Alternative Finder*, MEE MO MEDIA LABS, <http://www.mecmolabs.com/wellpoint/ca.php> (last visited Nov. 22, 2013).

and provide links to their hours and services (e.g. whether the clinic has an x-ray).

An ongoing patient education campaign in the United Kingdom is interesting to consider in this light. Although the rate of unnecessary ED use is lower in the United Kingdom than in the United States,¹¹³ it is a concern. Under the National Health Service system, ED and other services are free to the patient at the point of service,¹¹⁴ so cost-sharing is not an available tool. An NHS ad captioned “you can choose better” features a row of people, each with a caption. The man with a stomach ache “should be at the GP;” the woman with the painful cough “should be at the Pharmacy;” and the older man unsure or confused about an illness “should have called NHS Direct.” At the end of the line is a funeral wreath labeled, “severe chest pain” and the notation, “should have been at the front of the queue.”¹¹⁵ While this ad gets at the same ultimate point as the “ER is for Emergencies” campaign, it does reflect at least a couple of significant system differences. In the UK, many pharmacists have some degree of prescriptive authority.¹¹⁶ In addition, there is a single national consultation telephone line (“NHS direct”).¹¹⁷

The third and fourth elements of the “best practices” focus on care coordination for high utilizers of ED (and other) services. These elements involve hospital personnel, including ED physicians, in supporting care plans for those in the Medicaid Patient Review and Coordination (PRC) program. As to PRC patients, the facility must document efforts to make an appointment for the patient to see the designated primary care provider within a maximum of 72 hours after an ED visit for which primary care follow-up is appropriate. In practice, this requires calling a patient’s primary care provider during and after the visit, and potentially engaging in significant care coordination.¹¹⁸

The fifth and sixth “best practices” focus on narcotics use. All the state’s hospitals are now implementing the “Washington Emergency Department Opioid Prescribing Guidelines”¹¹⁹ which are based on those drawn up by the

¹¹³ Davis, *supra* note 11, at 12–13.

¹¹⁴ Donald W. Light, *Universal Health Care: Lessons from the British Experience*, AM. J. PUB. HEALTH, Jan. 2003, at 27, available at www.ncbi.nlm.nih.gov/pmc/articles/PMC1447686/.

¹¹⁵ YOU CAN CHOOSE BETTER, <http://www.choosebetter.org.uk> (last visited Nov. 22, 2013) (slight alterations to original text format).

¹¹⁶ U.K. Nat’l Health Service, *Who Can Write a Prescription?*, NHS CHOICES, <http://www.nhs.uk/chq/Pages/1629.aspx?CategoryID=68&SubCategoryID=161> (last visited Nov. 22, 2013).

¹¹⁷ *NHS Direct and NHS Choices*, YOU CAN CHOOSE BETTER, http://www.choosebetter.org.uk/_NHSDirectNHSChoices.aspx (last visited Nov. 22, 2013).

¹¹⁸ Carol Wagner et al., *Best Practices: PRC Clients and Care Plans*, WASH. STATE HOSP. ASS’N (May 1, 2012), available at <http://www.wsha.org/files/PRC%20webcast%20May%201%202012%20Final.pptx> (webinar on Patient Review and Coordination, “PRC”). See also Burgess, *supra* note 105, at 25–26 (analyzing aspects of case management interventions associated with reduced ED use).

¹¹⁹ AM. COLL. OF EMERGENCY PHYSICIANS, WASH. CHAPTER, WASHINGTON EMERGENCY DEPARTMENT OPIOID PRESCRIBING GUIDELINES, available at <http://washingtonacep.org/Postings/edopioidabuseguidelinesfinal.pdf> (last visited Nov. 22, 2013).

American College of Emergency Physicians. The hospitals also attest that they have trained ED physicians in how to enforce these guidelines. These guidelines do not mention Medicaid and by their terms apply to all patients. For example, long-acting opioids will generally not be prescribed from the ED, and treatment of chronic pain within the ED is ideally to be coordinated with the patient's primary care provider.¹²⁰ The guidelines are supplemented by a requirement of near-universal enrollment by ED physicians in the Prescription Monitoring Program, "an electronic online database used to collect data on patients who are prescribed controlled substances. It enables prescribers to see which prescriptions have been previously filled by a patient."¹²¹

The seventh "best practice" attempts to track whether the program is having an impact on Medicaid utilization and to identify ways to improve the program. Hospital staff and an ED physician are to be designated as responsible for reviewing usage information and providing feedback. This involves the development of metrics to provide a common method of tracking the results of the other interventions and issues they raise.¹²² One use of the metrics and feedback is to inform the required reports to the state legislature.

The January 2013 interim report from Washington State's Health Care Authority to the state legislature indicates that under a "very preliminary" analysis of early data the constellation of seven "best practices" is on track to save the Medicaid program more than \$30 million the first year, half of which would be state dollars and the other half federal.¹²³ Visits by Medicaid frequent ED users declined by 23% in the five months considered in this interim report.¹²⁴ Hospital participation in electronic sharing of ED information increased dramatically, as did physician registration in the Prescription Monitoring Program.¹²⁵

As noted in HCA's interim report, the seven "best practices" "represent just the first step . . . our state must [also] address the larger, systemic reasons why Medicaid clients go to the emergency room for their care."¹²⁶ These larger, systemic reasons include: "a lack of adequate or timely access to primary care,"¹²⁷

¹²⁰ *Id.*

¹²¹ *Emergency Department Utilization*, *supra* note 101, at 3.

¹²² *Best Practice G) Use of Feedback Information*, WASH. STATE HOSP. ASS'N, <http://www.wsha.org/erfeedback.cfm> (last visited Nov. 22, 2013).

¹²³ *See Emergency Department Utilization*, *supra* note 101, at 4.

¹²⁴ *Id.* at 4.

¹²⁵ *Id.* at 3–4.

¹²⁶ *Id.* at 5.

¹²⁷ *Id.* The report also identifies as a "supply side" issue a concern that free-standing emergency departments and urgent care clinics are competing with primary care clinics, thus drawing some patients away from consistent care. *Id.*

lack of dental care, and unmet mental health and substance abuse treatment needs. On the latter point, the report notes that:

[M]any frequent users of the emergency department are challenged by mental illness (over 80%) and/or chemical dependency (over 40%). Finding appropriate treatment for them quickly can be difficult and securing ongoing treatment is critical. Without it, these patients may end up becoming seriously ill and return to the emergency department at a higher cost to the health care system. The best practices adopted to date, such as better at-risk patient identification and coordination through use of health information technology, are promising system changes to improve care. However, ultimately, more service integration with mental health and primary care is necessary. . . . Coordination of care across the social, physical, and psychological spectrum as well as integrated care between local providers is necessary for the highest utilizers of the emergency department.¹²⁸

B. Primary Care Access and High-Utilizer Programs

The “best practices” rely on primary care support. They are targeted at the ED, though, and do not in themselves support expanded availability of routine care. A number of ACA provisions, however, do aim to expand primary and preventative care through a range of policy and payment incentives. Impacts on primary care access will not be immediate, but, if successfully implemented, should be significant. For example, Community Health Centers (CHCs) received \$1.5 billion for construction and renovation in preparation for the influx of newly insured under both the Medicaid expansion and the insurance exchanges.¹²⁹ CHCs also will receive additional financial supports going forward.¹³⁰

Other ACA provisions aim to increase the number of primary care providers through, among other means, scholarship support for physicians and mid-level providers.¹³¹ The law also provides a temporary Medicaid reimbursement boost (to Medicare rates) for 2013 and 2014 as to primary care and some specialty care.¹³² This is meant to partially address one reason—low reimbursement—for physicians’ reluctance to see many Medicaid patients. It is unfortunate that implementation of this provision has been delayed; as of mid-2013 few eligible physicians had seen the higher payments.¹³³

¹²⁸ *Id.* (citations omitted).

¹²⁹ 42 U.S.C. § 254b-2 (2012). This Community Health Center Fund includes \$9.5 billion for expanded services. It is possible that this fund will be reduced or used to backfill CHC cuts in other areas.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² 42 U.S.C. § 1396a(a)(13)(C) (2012) (boosting Medicaid rates for primary care services to match those paid to physicians treating Medicare patients).

¹³³ Bruce Japsen, *Obamacare’s 73% Medicaid Pay Raise for Doctors Is Delayed*, FORBES (Mar. 15, 2013, 8:43 AM), <http://www.forbes.com/sites/brucejapsen/2013/03/15/obamacares-73-medicaid-pay-raise-for-doctors-is-delayed/>.

The ACA also promotes primary care coordination and increased preventative services through support of Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs).¹³⁴ Both of these organizational frameworks center on the theory that better and more coordinated routine care will improve patients' health, as measured partly by reduced hospital and ED use.¹³⁵ The ACA's PCMH and ACO programs specifically target Medicare and Medicaid, but are intended to also support their use as to people covered by private insurance.¹³⁶

As the ACA's access provisions roll out over the next many years, it will be particularly important to effectively implement the primary care supports found in the ACA and in other initiatives, both private and public. Washington State will expand its Medicaid program in 2014; it will also run its state-based exchange.¹³⁷ The state anticipates that in 2014, 250,000 newly eligible people will enroll in Medicaid and 340,000 will buy subsidized insurance on the exchange, with both those numbers increasing in subsequent years.¹³⁸ This is a lot of newly insured people. The health care system will need to accommodate them and expanded primary care will be key. After Massachusetts expanded its low-income coverage options in ways similar to the ACA, its EDs initially saw more patients for emergent and non-emergent conditions.¹³⁹ This experience suggests that newly insured people who do not have a regular source of medical care might turn to the ED.

It will also be important to address some of the most challenging issues raised by many of the high utilizers of EDs. Substance abuse, poorly managed mental health conditions, and some consequences of homelessness land people in the ED, but this is an expensive route and the ED cannot provide treatment

134 See Sallie Thieme Sanford, *Designing Model Homes for the Changing Medical Neighborhood: A Multi-Payer Pilot Offers Lessons for ACO and PCMH Construction*, 42 SETON HALL L. REV. 1519, 1519–20 (2012).

135 See *id.*

136 See *id.*

137 MaryAnne Lindeblad & Nathan Johnson, *2014 Medicaid Expansion Overview*, WASH. ST. HEALTH CARE AUTH., 21–53 (Jan. 22, 2013), http://www.hca.wa.gov/documents/legreports/012213_senate_health_hca_overview_medicaid_expansion.pdf (a presentation to Washington State Senate Health Care Comm.); See WASH. HEALTHPLANFINDER, <http://www.wahealthplanfinder.org/> (last visited Nov. 22, 2013).

138 Lindeblad & Johnson, *supra* note 137, at 24.

139 P. B. Smulowitz et al., *Change in Acuity of Emergency Department Visits After Massachusetts Health Care Reform*, 54 ANNALS EMERGENCY MED. S84 (2009). A study published in 2014 reinforces this concern about the potential for increased ED usage, at least in the short term. It compared thousands of low-income adults in Oregon who were randomly selected in a 2008 lottery to get Medicaid coverage with those who entered the lottery but did not get coverage. The study concluded that in the 18 months following the lottery those who gained coverage made significantly more ED visits than those who remained uninsured. Sarah L. Taubman et al., *Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment*, *Science* (Jan. 2, 2014), available at http://thinkprogress.org/wp-content/uploads/2014/01/science.1246183_full_.pdf (early online publication).

to truly stabilize those circumstances. While some in this population of low-income childless adults will be newly insured under expanded Medicaid, having insurance will not be sufficient without good connections to appropriate services. John Jacobi discusses this issue in a similar context in his 2012 article about the Camden Coalition, a project in New Jersey targeting high utilizers of ED services.¹⁴⁰ The project involves primary care clinics working with EDs to provide intensive case management and connections with community-based resources. It aims to improve the health and social circumstances of this challenging population and also to save New Jersey money by reducing Medicaid payments and social services expenditures. A key element is strong connections to services outside of the ED.

A related model involves “housing first” projects such as one in Seattle, Washington that focused on the ED at Harborview Medical Center, the county hospital. The program targeted chronically homeless patients with severe alcohol problems and compounding mental health issues who had frequent contact with the county ED, police, and other government services.¹⁴¹ They were offered housing and supportive services, controversially without a requirement that they stop drinking. A study published in the *Journal of the American Medical Association* reported that per person costs associated with the ninety-five housed participants were substantially lower than for thirty-nine wait-listed individuals.¹⁴²

What the high utilizer project in Camden crucially lacks, Jacobi argues, is a sustainable funding mechanism.¹⁴³ This is a cost conundrum common to many health reform endeavors, including Washington State’s seven “best practices” program. There are a variety of interventions now underway that are probably appropriate from a quality and an overall cost perspective, but in a fragmented health system impose costs on a different entity than that which sees the savings. One example is the Patient-Centered Medical Home model, with its added costs for care coordination and preventative services that, if successful, reduce expenditures for hospital and specialty services. In some cases, the interventions, if successful, also reduce the revenues to the entity that expends the costs, a double financial hit. The shared savings that are integral to ACOs attempt to address this. Thus, under the Medicare ACO program, savings to the Medicare program are to be shared with the responsible ACO, assuming it meets quality targets. This sort of alignment of interests is, of course, central to integrated managed care models that predate the current public and private reform efforts.

140 Jacobi, *supra* note 45, at 36–37.

141 Mary E. Larimer et al., *Health Care and Public Services Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 JAMA 1349, 1350 (2009); Stuart Eskenazi, 75 *Hard-Core Alcoholics to Be Offered Apartments*, SEATTLE TIMES (Dec. 15, 2005, 2:05 PM), http://seattletimes.com/html/localnews/2002684566_eastlake15m.html.

142 Larimer et al., *supra* note 141, at 1353–54.

143 Jacobi, *supra* note 45, at 43.

The “best practices” program is probably of the double-hit type: the added costs to the hospitals (for the EDIE system and care coordination) are likely to be associated with decreased revenue (because of reduced ED visits). Of course, the threat here was that revenues would be more significantly reduced if the state refused to pay for a significant percentage of ED visits. The calculus here is complicated by the rising use of EDs and the coming expansion of the insured population. Figuring out this particular ED coverage cost conundrum will be just one piece of the larger, ongoing public and private effort to improve health care payment and delivery systems.

Indeed, the Washington program dovetails with other ongoing public and private efforts to reduce ED usage. For example, a current Washington State multi-payor medical home pilot includes, as a key measure for potential shared savings, reduction in ED usage among privately insured patients.¹⁴⁴ Preventing these sorts of downstream costs is an inherent aim of ACOs as well. Indeed, given these overlapping initiatives with similar aims, it might be difficult to precisely attribute any ED usage reductions to interventions targeted at the privately insured, those with Medicare, or those with Medicaid.

A potential legislative solution in New Jersey for the Camden Coalition and projects like it is the creation of Medicaid ACOs. Jacobi describes this as “a gainsharing program, by which community-based ACOs would share program savings with New Jersey’s Medicaid agency and Medicaid-participating HMOs.”¹⁴⁵ This Medicaid ACO initiative bears watching, as does Oregon’s new, ambitious payment and delivery system reform involving Coordinated Care Organizations (CCO) in Medicaid. CCOs have been described as “accountable care organizations on steroids.”¹⁴⁶ They are community-based groups of diverse health care providers offering comprehensive, wide-ranging healthcare services to Medicaid recipients for a global payment and at financial risk if costs do not moderate and quality measures do not improve.¹⁴⁷ The program, which is gearing up in 2013, operates under a Medicaid waiver and with additional federal funding for its initial years.¹⁴⁸ Significant challenges will be the alignment of interests and division of financial resources among the different entities—hospitals, physician groups, and dental offices—within a CCO. If successful, the hope is that that this program will leverage

¹⁴⁴ See Sanford, *supra* note 134, at 1519 (describing pilot project that aims, in part, to establish an appropriate funding mechanism in the PCMH context).

¹⁴⁵ Jacobi, *supra* note 45, at 44; N.J. STAT. ANN. § 30:4D-8.1 (West Supp. 2013) (authorizing creation of Medicaid ACOs).

¹⁴⁶ Teresa A. Coughlin & Sabrina Corlette, *ACA Implementation—Monitoring and Tracking: Oregon, Site Visit Report*, URBAN INSTITUTE, 6 (Mar. 2012), <http://www.urban.org/UploadedPDF/412498-ACA-Implementation-Monitoring-and-Tracking-Oregon-Site-Visit-Report.pdf>.

¹⁴⁷ Eric C. Stecker, *The Oregon ACO Experiment—Bold Design, Challenging Execution*, 368 NEW ENG. J. MED. 982, 983 (2013).

¹⁴⁸ *Id.*

system-wide reform beyond the Medicaid program.¹⁴⁹

In a similar way, the Washington State “best practices” program has a potential impact beyond the Medicaid population it targets. The narcotic guidelines, for example, apply to all patients, and the EDIE program to all high utilizers. Many of the patient education materials are broadly applicable. And elements that *are* explicitly Medicaid-focused—such as coordinating with primary care clinics and collaborating with case managers—hold broader promise. The case management concept in general is being promoted for patients with complicated chronic conditions and/or high utilization patterns regardless of their insurance source. Certainly many of the public and private sector reforms now underway involve more coordinated discharge planning for those leaving the ED or the hospital.¹⁵⁰

C. Co-Pays for Non-Emergent ED Use

These “best practices” do not include co-pays for nonemergency use of the ED. “Prior to the Deficit Reduction Act (DRA) of 2005, federal law limited Medicaid copayments to nominal amounts, generally defined as three dollars or less per service, and also prohibited states from applying copayments to certain services (e.g., emergency services).”¹⁵¹ The DRA gave states greater flexibility with regard to Medicaid cost-sharing, and the federal government has granted several waiver requests to impose copayments of more than nominal amounts on certain populations.¹⁵² Federal waiver authority is not without limit; in 2011, the Ninth Circuit struck down a waiver granted to Arizona’s Medicaid program to apply copayments ranging from four dollars to thirty dollars for various services provided to childless, non-disabled adults.¹⁵³ The court found that the waiver granted to Arizona was arbitrary and capricious in that it did not reflect a consideration of the impacts of the copayments on patients.¹⁵⁴

An increasing number of states do impose co-pays for ED use by some people with Medicaid coverage, particularly those with incomes above 150% of the federal poverty level (FPL). A table prepared by the Kaiser Family Foundation of rules in effect as of January 2012 shows that

149 *Id.* This Article highlights many of the challenges with this new model. These include the difficulty non-integrated providers will have in coordinating care, and the mixed reimbursement models at play.

150 *See, e.g.*, 42 U.S.C. § 1395ww (2012) (Medicare 30-day readmission program).

151 SMITH, MEDICAID TODAY, *supra* note 31, at 42 (describing cost-sharing options and state policies); *see also* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6041, 120 Stat. 4, 81-85 (2006) (codified as amended at 42 U.S.C. § 1396o-1 (2012)).

152 *See* SMITH, MEDICAID TODAY, *supra* note 31, at 42, 90.

153 *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011); *see also* Teri Walker, *Federal Appeals Court Says No More Medicaid Co-Pays*, ARIZ. J. (Sept. 2, 2011), <http://www.azjournal.com/2011/09/02/federal-appeals-court-says-no-more-medicare-co-pays/> (describing specifics of the copayments).

154 *Betlach*, 660 F.3d at 381.

just shy of half the states impose some level of cost-sharing for ED use (emergent and non-emergent) for some higher income Medicaid patients.¹⁵⁵

A number of states, including ones with substantial Medicaid populations, are considering adoption or expansion of co-pays for non-emergency ED use.¹⁵⁶ The California Collaborative, for example, includes expanded use of co-pays for non-emergent care as one possible future element of its program.¹⁵⁷ Many of these approaches limit or prohibit the imposition of co-pays on children, pregnant women, or other populations.¹⁵⁸ In early 2013, the Centers for Medicare and Medicaid Services (CMS) proposed rules that would allow states to impose cost-sharing for non-emergency use of the ED of up to \$8 per visit for those with incomes between 100% and 150% FPL, and at any amount for those with incomes above 150% FPL.¹⁵⁹ These proposed rules would not require a state waiver.¹⁶⁰ CMS' proposed rules envision that an appropriately designed co-pay could "complement a range of other strategies" to reduce ED use.¹⁶¹

The proposed rules caution that states will need to specify how "non-emergency" is determined for purposes of this co-pay, and stress that relying solely on discharge diagnosis will generally not be appropriate as it would risk

155 See MARTHA HEBERLEIN ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAM. FOUND., PERFORMING UNDER PRESSURE: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES IN MEDICAID AND CHIP, 2011-2012, at 69 (Jan. 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8272.pdf>.

156 SMITH, MEDICAID TODAY, *supra* note 31, at 40-41 (discussing Florida, California and Texas, among other states).

157 DELMARVA FOUND., *supra* note 40, at 14-15.

158 See, e.g., OHIO ADMIN. CODE 5101:3-1-09 (2013) (exempting pregnant women and those under age twenty-one from copayments).

159 Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4594, 4659, 4703 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. pts. 430, 431, 433, 435, 440, 447, 457 & 45 C.F.R. pt. 155). This lengthy proposed rule focuses on a number of implementation aspects of the ACA's insurance affordability programs. As to Medicaid cost-sharing generally, the rule proposes several changes to simplify the requirements, in addition to specifically allowing higher cost-sharing for non-emergency ED use and non-preferred drugs.

160 78 Fed. Reg. at 4659 (proposed Jan. 22, 2013) (implementing § 1916(a)(3) and § 1916(b)(3) of the ACA). Commenting on these proposed rules, the American Medical Association wrote: "Instead of focusing on cost sharing, which we think could result in harm to patients, we would encourage CMS to review the best practices adopted in a partnership [in Washington State]. . . . We encourage CMS to monitor this program and provide it as a guide for other states." Letter from James Madra, Exec. Vice President, Am. Med. Ass'n, to Marilyn Tavenner, Acting Adm'r, Centers for Medicare & Medicaid Servs., (Feb. 21, 2013), *available at* www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0317 (click "view attachment" to download pdf).

161 78 Fed. Reg. at 4659.

denying coverage for care that was prudently sought.¹⁶² “[T]he EMTALA screening requirements combined with the prudent layperson standard for an emergency medical condition make it difficult to determine a service as non-emergency just based on CPT [diagnosis] codes.”¹⁶³

Chest pains, for example, could easily be considered an emergency condition under the prudent layperson standard, though a medical screening may indicate that the individual is suffering from heartburn or anxiety, which may not otherwise be considered emergency medical conditions. While the applicable CPT code might indicate a non-emergency condition, such chest pains would meet the definition of emergency medical condition and therefore may not be assessed a copayment.¹⁶⁴

This statement is particularly interesting in light of the JAMA study described above. After identifying the presenting complaints connected to the 192 “non-emergency” diagnoses, the study considered all patients who presented to EDs that year with those complaints. The most common diagnoses associated with those complaints were “abdominal pain or unspecified site, acute respiratory infection and chest pain, unspecified.”¹⁶⁵

The proposed rules also specify that hospitals and physicians would be required to take specific steps in order to collect the copayment. After having provided an appropriate screening and determined that a patient’s condition was non-emergent, a provider would be required to “identify an available and accessible alternative non-emergency provider” with lesser cost sharing and establish a referral to coordinate scheduling.¹⁶⁶ Before releasing the patient from the ED, the hospital must determine that an alternate site can provide the services in a “timely manner.”¹⁶⁷ Only then could the copayment be imposed for the non-emergent treatment subsequently provided. These steps are similar to the requirements for billing a Medicaid patient for a non-covered service.¹⁶⁸

These steps are problematic in an ED context and, depending on how implemented, could be ethically troubling. In their comments on the proposed rules, the American College of Emergency Physicians (ACEP) writes that “[t]he presumption by many policy-makers that there is a bright line during the course of an ED visit where the screening portion of the visit is over and the treatment (subject to a co-pay) begins, does not reflect the reality of care

¹⁶² *Id.* at 4659–60.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ Raven et al., *supra* note 8, at 1150–51.

¹⁶⁶ 78 Fed. Reg. at 4659 (explaining the proposed rule); *see also id.* at 4703 (providing the proposed rule to be codified at 42 CFR § 447.54).

¹⁶⁷ 78 Fed. Reg. at 4703 (proposed Jan. 22, 2013). The proposed rules do not specify what “timely” means. If a nearby clinic has an appointment slot to see a child with an ear infection at 3:00 pm the next day, but the parents cannot get that time off of work, is the appointment “timely”?

¹⁶⁸ *See supra* note 55 (putting patients on notice of new billing requirements with WASH. ADMIN. CODE § 182-502-0160 (2013)).

in an ED.”¹⁶⁹ While certain medical situations might lend themselves to such a “bright line” demarcation, much of ED care is not of that type. “A patient who presents with a cough and a sore throat,” writes ACEP, “may have a virus or may have pneumonia.”¹⁷⁰ To stop in the course of the visit and discuss the need for a co-pay for non-emergent treatment potentially risks imparting the message that the patient should not have come into the ED, when in fact that might have been the appropriate action.

Fundamentally, patients’ potential fiscal risk for non-emergent ED use should not deter them from seeking needed treatment.¹⁷¹ The proposed federal rules run that risk for those with incomes above 150% FPL. For those people, the proposed rules do not set a cost-sharing limit. For those with incomes between 100% to 150% FPL, the proposed rules limit cost-sharing to \$8 per non-emergency visit. Although the amount sounds modest, it applies to people with very low incomes, and it will be important to consider its potential impact on patients before proceeding.

There are a number of studies on cost sharing at various levels and with various Medicaid populations. A well-regarded study from the mid-1990s found that co-pays led to a marked reduction in effective care among low-income adults and children.¹⁷² It will be important to carefully examine these studies’ applicability to this particular Medicaid population at these possible co-pay levels and with the primary care linkages. On the one hand, with the Medicaid expansion, those with incomes over 100% FPL are more likely to include adults without complicating conditions other than low income. On the other hand, in that economic band (and particularly at the level over 150% FPL at which the proposed rules suggest no limit on cost-sharing), children and pregnant women will predominate. As discussed earlier, children are relatively frequently seen in the ED for conditions ultimately diagnosed as non-emergent. As a common-sense matter, a heightened level of concern is warranted about unusual symptoms during pregnancy. As for all patients at that low-income level, even relatively small copayment amounts may have an inappropriate dissuasive impact.

Of course, as a practical matter, high cost-sharing obligations for ED use by a patient with any type of insurance (public or private) can effectively become cost-shifting to facilities. As typically structured in health insurance programs, cost-sharing amounts (in the form of co-pays or co-insurance) are

¹⁶⁹ Letter from Andrew Sama, *supra* note 78.

¹⁷⁰ *Id.*

¹⁷¹ For a strong critique of negative consequences of cost-sharing in the Medicaid program see Watson, *supra* note 48, at 411, 429–32 (summarizing study results and concluding that “cost-shifting to Medicaid patients hurts not only consumers but the health care system.”).

¹⁷² JOSEPH NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND INSURANCE EXPERIMENT 183–243 (1993); see also JONATHAN GRUBER, KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 5, 8 (Oct. 2006), <http://www.kff.org/insurance/upload/7566.pdf>.

part of the overall agreed fee, not an addition to it. If patients do not meet their cost-sharing obligation, those forgone costs are effectively shifted to the entity that provided the service. This fact provides added incentive for hospitals and physicians to support comprehensive strategies for appropriate ED use.

CONCLUSION

The ED cannot be the medical home of the twenty-first century. Overuse of the ED, whether by those covered by Medicaid or by private insurance, imposes added costs and undermines care continuity. The solution to this problem should not be denying ED payment based on the urgency of the discharge diagnosis. To do so raises legal, ethical, and practical problems grounded in the reality that nonemergency conditions often present with emergent symptoms. And, fundamentally, this sort of individualistic approach side-steps root causes of non-emergent ED use.

Particularly in light of the ACA's insurance expansions, states would be better served by an approach that views non-emergent ER use as less a reflection of poor judgment on the part of patients and more a consequence of poor access to primary care and poor systems for managing the complex circumstances of high utilizers. The strategy Washington State ultimately adopted—after tabling a Medicaid payment-restriction policy—takes a laudable, systemic approach with potential benefits for all patients. Washington's seven "best practices" program relies on, but does not itself provide, the necessary expansion of both primary care resources and also services for the complex needs of high utilizers. This expansion does find support in several ACA provisions and in other initiatives, both public and private. Their successful implementation in concert with ED-focused reforms will be crucial to support a high-quality, cost-effective health care system that has clinics available for routine care, and EDs available for emergency care.