Talking Points for Physicians

(Focus First on physician-developed Plan)

Non-Emergent Visits to the ED Should Be Addressed. We agree that the issue of Medicaid patients misuse of the ED is a problem, in terms of costs to the state and ED overcrowding and should be addressed. That is why we, the physicians on the front lines caring for these patients, have come up with a plan that does not impose an arbitrary cap on or completely prohibit emergency room visits. Instead we have developed a plan that will save the state millions and will ensure that our Medicaid population has adequate access to quality health care.

Our Plan Addresses the Root of the Problem. At the center of this debate is overutilization. Our plan does not impose an arbitrary cap on emergency room visits. Our solutions are based on the fact that non-emergent use results primarily from inadequate access to primary care, chronic medical conditions, and from substance abuse issues. Additionally, many conditions present with life-threatening symptoms, but after extensive testing and evaluation prove to have a more benign cause. Our plan works toward the goal of real cost savings for the state and encompasses an effort to coordinate and integrate medical care and wellness within each community.

Our plan includes savings by:

- Reducing ED visits for narcotic-seeking behavior
- Improving access to primary care and reducing ED "misuse" by collaborative use of next-day or same-day visits to primary care, and
- Creating a "Generics First" initiative spearheaded by physicians to voluntarily develop a statewide formulary
- Instituting an extensive case management program to reduce inappropriate ED utilization by frequent users
- Tracking visits to reduce ED shopping

A Reasonable Solution that Improves the Quality of Care. Our plan is based on reasonable savings that improves the quality of care and does not shift the cost of care to the patients or the providers. The state's plan does nothing to get the patient to the right place for treatment at the right time. Nothing has been done by the state to address the fundamental challenges in access to care. Medicaid patients, when faced with chest pain, an injury to the ankle that they cannot walk on, or a migraine will need urgent or emergent care. Emergency physicians and other providers will still be obligated to care for them, they just won't get paid. How will this cost shift, that doesn't involve the patient, reduce unnecessary ED visits? It doesn't. It simply saves the state money on the back of the medical profession and the general public by shifting the cost of this uncompensated care to those that are privately insured. It also does nothing to address the problem of patients with urgent conditions suffering through longer wait times at already overcrowded EDs.

Uncompensated 'Covered' Care. Emergency rooms are required by federal law to treat all patients. In addition, the state has mandated that care be provided, but stated they will not pay for any visit they deem non-emergent after the fact. As a result critical access to hospitals, emergency physicians and affiliated

health providers are expected to provide an additional $51 million in uncompensated care in 2012, adding to the hundreds of millions of dollars of uncompensated care that already occurs.

The Physicians and Hospitals are at Risk. If a patient is turned away for an emergent condition, despite the state's erroneous definition of non-emergent, the physician and hospitals are in violation of federal law and face hefty fines and liability risks.

HCA's Plan is Bad Policy

The HCA is pointing the finger squarely at Medicaid patients and is distorting the problem to deny care to people with real emergencies. The fact is 8% of emergency visits are non-emergent visits according to the CDC analysis. Emergency care represents only 2% of all health care spending and arbitrarily denying service is not the solution to the problems that exist in Medicaid.

Zero Tolerance Policy for Over 400 Diagnoses. The new plan the HCA has is even more alarming and less transparent than the original. The new plan sets a zero tolerance policy for over 400 diagnoses including headache, back pain, hundreds of traumas, and other serious and emergent conditions. For the chronically ill with serious medical conditions like the elderly who are dual eligible with Medicare, the HCA will review every visit to the emergency department and consider any condition possibly non-emergent, including visits for chest and abdominal pain.

Patient safety Protections have been Removed. The state plan eliminates patient safety protections such as the "expedited prior authorization process." This process would have ensured that patients brought to the emergency department by ambulance or from nursing facilities, or with abnormal vital signs and tests, would be considered emergencies. Under the new plan, these patients are no longer protected. The state has also removed the exemptions and exceptions that provided some degree of patient safety. This new approach has removed every clinical safeguard. Patients are at serious danger.

Undue Influence on Physician/Patient Relationship. Decisions about what is emergent will no longer reside with the physician treating a patient, but instead faceless bureaucrats in Olympia that will decide after the fact if there was an emergency. We are back to the days before the prudent layperson protection for individuals was enacted to prevent insurance companies from unreasonably denying access to emergency room care. The state stopped these practices in the 1990s, but now believes that it is appropriate for them to reinstate them for the lowest income and most medically vulnerable population.