American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 10, 2011

Donald M. Berwick, MD, MPP, FRCP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Washington State Medicaid Program Limits on Non Emergency Use of EDs: effective October 1, 2011

Dear Dr. Berwick:

On behalf of the American College of Emergency Physicians' (ACEP) more than 29,000 members, I am writing to convey our serious concerns with the State of Washington Health Care Authority's new policy that cuts off payment after a Medicaid beneficiary's third "non-emergent" visit to the emergency department.

We understand the financial stress that states are under and we support efforts at the state and national level to link Medicaid beneficiaries to primary care practitioners, but those resources have to be available and accessible.

As clinicians who staff the nation's EDs, what troubles us the most is the list (attached) of over 700 diagnoses that Washington State will treat as "non-emergent." This list includes chest pain, shortness of breath, miscarriage, diverticulitis, and abdominal pain, five of the most frequent presenting conditions/symptoms that our members see (and documented annually by the CDC) that require protocol-driven workups to rule out what could be extremely serious and life threatening conditions. In these cases, Medicaid beneficiaries will be denied coverage, and physicians and hospitals denied payment, for visits that the beneficiary may have justifiably believed to be an emergency. Specifically, use of discharge diagnoses instead of presenting symptom/conditions is a violation of the prudent lay person standard required for Medicaid managed care organizations under section 1932(b)(2)(B)(ii) of the Social Security Act. With Washington having close to 60 percent of its Medicaid population enrolled in managed care, how will the state comply with the law?

Washington's State Health Care Authority agreed to several meetings with providers/stakeholders as part of a process to create a list, which is based on the work of John Billings[1], that resulted in a list of "ambulatory sensitive conditions."

[1]Billings J, Parikh N, Mijanovish T. Emergency department use in New York City: A substitute for primary care? Issue Brief. The Commonwealth Fund. November 2000.

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The negotiations process broke down when the state realized that this list included diagnoses that Dr. Billings identified as emergent 100% of the time. Unfortunately, the HCA had already proposed this list to the state and based the budget on this error. Despite realizing their error, they refused to remove these emergent diagnoses and have since added an additional 200 diagnoses independently without basis in clinical care to meet their budget. This expansion, designed to generate more savings, includes hundreds of potential emergencies and endangers patient safety.

As a practical matter, it is not possible or desirable to deny treatment for many of the listed conditions when a screening, often requiring laboratory and radiographic diagnostic tests, determines a case is not an emergency. Under the Washington policy, physicians and hospitals will be systematically underpaid for the services provided. Current Medicaid payments are already well below the costs of providing care, and no payment for fee-for service and a nominal payment for a medical screening examination for managed care will exacerbate the problem since by the time the medical screening exam has been completed, most of the costs for the visit have been incurred. As a result, the physicians and hospitals will be financially penalized for providing the services required by EMTALA.

Specifically, we ask CMS to ensure that Washington's State Plan Amendment includes:

- Requirement for the State to create a notification system or website so providers will know that an individual has reached his/her third annual "non-emergent" visit.
- Require the State to ensure that patients who reach this status have access to viable primary care services before imposing this policy.
- Ensure that the state does not apply this policy to managed care patients in violation of federal law.

Optimally, we believe that CMS should reject this entire list of diagnoses because it includes emergency diagnoses that clearly threaten access to "the right care at the right place at the right time." The Deficit Reduction Act of 2005 (Sec. 6043) gave states the option to allow hospitals to impose co-pays for non-emergency Medicaid enrollee visits to EDs under certain conditions including proof that the individual has "available and accessible alternatives to non-emergency services," something that appears to be undermined by Washington's policy .

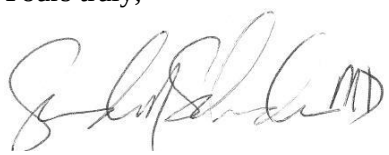
Not only is there a dearth of primary care physicians with openings for Medicaid patients in their practices, many specialists also limit the number of Medicaid patients they treat due to payment rates well below their costs. Therefore, a significant proportion of the Medicaid population uses and will continue to use the safety net provided by the ED, which is never closed.

In CMS' recent draft regulation- **Methods for Assuring Access to Covered Medicaid Services - (**CMS 2328-P), the Agency proposed a framework for states to assess Medicaid and CHIP access to medical services. We believe changes in volume in Medicaid ED visits will be an effective indicator of primary care availability.

Finally, we want to remind you that the Sec. 6043 of the DRA provided $ 50 million in federal grant funding over four years (2007-2010) to 20 states, including Washington. Most of the grants were designed to enhance primary care alternatives and wean Medicaid enrollees from using ED for primary care. In spite of the importance of this effort to the ACA's reform initiatives such as medical home, ACOs, and care coordination, this grant program has never been formally evaluated for replication, best practices, etc. Instead, states like Washington and many others are moving to reduce use of emergency

departments without ensuring alternative sources of care and by simply shifting the cost to the providers and hospitals without improving access at all. We hope to continue to work with CMS to consider ways that emergency physicians can assist states in directing patients to primary care providers who can take them into practices and are accessible to enrollees. To date, we have met several times with CMS and HRSA staff to discuss ways in which our members can help track high Medicaid users of EDs. If you have any questions about our comments and previous proposals in this area, please contact Barbara Tomar, ACEP's Federal Affairs Director at (202) 728-0610, ext. 3017.

Yours truly,



Sandra Schneider, MD, FACEP
President

cc: Marilyn Tavenner
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