

REPORT 01 OF THE COUNCIL ON MEDICAL SERVICE (I-22)  
Incentives to Encourage Efficient Use of Emergency Departments  
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American Medical Association (AMA) to study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternate sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments (EDs).

Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED visits than Medicare, privately insured, and even uninsured individuals, thereby utilizing higher-cost services than those provided in other ambulatory care settings. To address this issue, and contain costs, states—and managed care plans that enroll Medicaid patients—have long sought ways to incentivize more efficient ED use. Financial incentives, including increased patient cost-sharing and retrospective payment denials, are among the variety of strategies that have been employed across states to try to reduce ED visits perceived to be non-emergency, nonurgent, or avoidable. Consistent with Policy D-130.959, the Council reviewed the literature on these financial incentives and finds that: 1) modest cost-sharing requirements, on their own, may not be very effective at either reducing ED services or generating significant cost-savings; and 2) diagnosis-based payment and coverage denials for non-emergency ED services may potentially harm some patients—by dissuading them from seeking emergency care when needed—as well as physicians and hospitals, when payment is denied.

The Council believes that interventions aimed at reducing ED use for services that could be provided elsewhere, and at lower cost, are worthy of ongoing monitoring and testing by the Centers for Medicare & Medicaid Services and other stakeholders. Accordingly, the Council recommends support for continued monitoring and testing of strategies and best practices for reducing non-emergency ED use, particularly among patients with the highest number of ED visits. Given the abundance of AMA policy that is relevant to this report topic, and the need for state flexibility to design strategies well suited to a state’s Medicaid population, the Council also recommends support for state efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. Finally, the Council recommends reaffirmation of AMA policies supporting the prudent layperson standard of determining when to seek emergency care (Policy H-130.970); criteria to be used in Medicaid managed care monitoring and oversight (Policy H-290.985); and reasonable Medicaid payment (Policy H-290.959).

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 01-I-22

Subject: Incentives to Encourage Efficient Use of Emergency Departments

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

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1 At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of  
2 Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American  
3 Medical Association (AMA) to study and report on the positive and negative experiences of  
4 programs in various states that provide Medicaid beneficiaries with incentives for choosing  
5 alternate sites of care, for physical and mental health conditions, when it is appropriate to their  
6 symptoms and/or conditions instead of hospital emergency departments (EDs). The Board of  
7 Trustees assigned this policy to the Council on Medical Service for a report back to the House of  
8 Delegates at the 2022 Interim Meeting. This report describes the positive and negative experiences  
9 of two commonly used incentives intended to reduce non-emergency ED use (increased patient  
10 cost-sharing and retrospective payment denials), summarizes relevant AMA policy, and makes  
11 policy recommendations.  
12

## 13 BACKGROUND

14  
15 Medicaid spending makes up an increasingly large share of most state budgets and continues to be  
16 a focus of policymakers seeking ways to contain costs without compromising care quality. EDs  
17 have been targeted for cost-savings in many states because, for a variety of complex reasons,  
18 Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED use than  
19 Medicare, privately insured, and even uninsured individuals.<sup>1,2</sup> Because services cost significantly  
20 more when provided in EDs than in other ambulatory care settings (e.g., physician offices and  
21 outpatient clinics), states—and managed care plans that enroll Medicaid patients—have long  
22 prioritized incentivizing more efficient ED use by Medicaid enrollees. Financial incentives,  
23 including increased patient cost-sharing and retrospective payment denials, are among the variety  
24 of strategies employed to try to reduce ED visits perceived to be non-emergency, nonurgent, or  
25 avoidable. Although there is no standard definition of what constitutes non-emergency, nonurgent,  
26 avoidable ED care, it is generally described as that which can be appropriately provided in a  
27 primary care or other outpatient setting at reduced cost.  
28

29 Due to the lack of consensus around defining non-emergency, nonurgent, avoidable ED visits,  
30 researchers have employed an array of methodologies to assess the effectiveness of strategies to  
31 reduce those patient visits that could be effectively treated elsewhere. As a result, studies have  
32 produced a range of estimates of ED visits classified as non-emergency, nonurgent, or avoidable,  
33 depending on methodology and how these visits are defined. Importantly, a 2013 *JAMA* study  
34 revealed what many physicians already knew—that non-emergency visits cannot easily be  
35 discerned from patients’ presenting complaints and symptoms, since symptoms for many non-  
36 emergency conditions overlap with symptoms of conditions that require emergency care.<sup>3</sup> This  
37 suggests that, in many cases, decisions about emergency versus non-emergency care are far from  
38 clear-cut and may not be evident at triage. Although exact percentages are not known, most

1 estimates of non-emergency ED visits as a proportion of all ED visits are relatively small. Analyses  
 2 by the Centers for Disease Control and Prevention (CDC) of ED data from the National Hospital  
 3 Ambulatory Medical Care Survey found that 5.5 percent of all ED visits in 2015,<sup>4</sup> 3.9 percent in  
 4 2017,<sup>5</sup> and 3.1 percent in 2018,<sup>6</sup> were classified as nonurgent. A 2015 report of the Washington  
 5 Health Alliance found that nearly 12 percent of Medicaid enrollee ED visits in the Puget Sound  
 6 region could be described as avoidable, compared to 8.5 percent of ED visits by privately insured  
 7 individuals.<sup>7</sup>

8  
 9 Experts have long posited that a lack of regular access to primary care drives many patients to EDs  
 10 for nonurgent reasons. Furthermore, Medicaid enrollees, and individuals dually eligible for  
 11 Medicare and Medicaid, are known to experience added barriers to accessing health care, in part  
 12 because they are more likely to experience inequities in social determinants of health (SDOH) that  
 13 lead to complex and chronic health needs. Other factors that lower access to health care include a  
 14 lack of available transportation, the distance one must travel to obtain care (especially in rural  
 15 areas), an inability to get needed specialty care, difficulties taking time off to attend medical  
 16 appointments, cost concerns among patients, lack of community behavioral health resources, and  
 17 inadequate Medicaid physician payment rates.

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 19 **MEDICAID PAYMENT RATES AND ENROLLEE ACCESS TO CARE**

20  
 21 For decades, the AMA has highlighted the inadequacy of physician payment rates across state  
 22 Medicaid programs—rates that are substantially below Medicare and private insurance fees and  
 23 often do not come close to covering the cost of providing care. In enacting the equal access  
 24 provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, “without  
 25 adequate payment levels, it is simply unrealistic to expect physicians to participate in the  
 26 [Medicaid] program.”<sup>8</sup> While physicians have a strong sense of responsibility to provide care for  
 27 Medicaid patients, physician practices cannot remain economically viable if they lose money on  
 28 the care they provide. Without an adequate supply of participating physicians, Medicaid patients  
 29 have coverage but may lack access to care. And without access to needed primary and specialty  
 30 care, Medicaid enrollees tend to visit EDs more often for conditions that could be handled in  
 31 alternate sites of service.

32  
 33 Because physicians participating in Medicaid remain sparse in many areas of the country, enrollees  
 34 often experience lengthy wait times, travel long distances to access care, or may go without care  
 35 altogether. Medicaid payment rates have been shown to significantly impact patient access to care,  
 36 with increases in payments found to improve access to care.<sup>9</sup> Accordingly, the AMA has long  
 37 advocated at the federal and state levels that physicians be provided fair and reasonable Medicaid  
 38 payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA  
 39 further advocates that the Centers for Medicare & Medicaid Services (CMS) ensure that states  
 40 maintain Medicaid rate structures at levels that ensure there is sufficient physician participation, so  
 41 that Medicaid patients can access care in a timely manner.

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 43 **FACTORS CONTRIBUTING TO NON-EMERGENCY ED USE**

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 45 EDs have historically served as an essential source of care for people struggling with economic  
 46 marginalization, and research has shown an association between socioeconomic variables and  
 47 potentially avoidable ED use.<sup>10</sup> Medicaid enrollees experiencing inequities in SDOH—such as  
 48 housing instability, food insecurity, or lack of transportation—may be more likely to use the ED for  
 49 non-emergency care.

1 As previously noted, patients who do not have an established relationship with a primary care  
 2 provider may be more likely to seek care at an ED for non-emergency conditions. Moreover, across  
 3 some states, and especially in rural areas, it can be difficult for some Medicaid enrollees to obtain  
 4 needed specialty care; in turn, these patients may visit EDs because alternative care sites are simply  
 5 not available. Lack of access to behavioral health and substance use disorder services may be an  
 6 additional barrier in some areas. Physician workforce shortages in certain specialties likely  
 7 compound these access barriers that contribute to higher ED use among Medicaid enrollees.

8  
 9 Although some people may seek non-emergency care at EDs out of convenience, or on weekends  
 10 or evenings when other outpatient care is not available, analyses have been mixed and some  
 11 hospitals have found that non-emergency visits predominantly occur during regular hours when  
 12 physician offices are open. A subset of Medicaid enrollees may turn to hospital EDs for services  
 13 that cannot be accessed at primary care offices, while others may be motivated to have multiple  
 14 health concerns addressed during a single ED visit. Patients who perceive that they cannot access  
 15 timely or needed care in another setting, including individuals with mental health needs and/or  
 16 substance use disorder, may also seek non-emergency ED care, as will patients who believe they  
 17 are experiencing emergencies requiring immediate attention.

18  
 19 Insurer prior authorization (PA) requirements are also important drivers of non-emergency ED use,  
 20 especially when they preclude patients from getting timely needed care. In some cases, patients  
 21 may resort to EDs for certain medically indicated services that would otherwise be delayed while  
 22 approval is sought from the patient’s insurer. PA rules that impede quick access to services ranging  
 23 from mental health and substance use disorder treatment to imaging may lead some patients to seek  
 24 care at EDs. According to one study, a new outpatient PA process for radiologic studies may have  
 25 led to an increase in ED visits for outpatient MRI scans.<sup>11</sup>

26  
 27 Lack of insurance, or limited insurance, also impacts ED use, although people with health  
 28 insurance still experience time and access barriers to receiving regular care. Although the  
 29 expansion of Medicaid under the Affordable Care Act has been found to reduce the number of  
 30 uninsured individuals and increase access to primary care,<sup>12</sup> research findings on the association  
 31 between Medicaid expansion and ED use have been mixed, in part because newly insured patients  
 32 may use more health care services.

33  
 34 **STRATEGIES TO REDUCE NON-EMERGENCY ED USE**

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 36 Beyond financial incentives, strategies to reduce non-emergency ED use are numerous and varied  
 37 and have produced mixed results in the literature in terms of their impact. One strategy that is  
 38 central to many state efforts is care coordination designed to connect Medicaid enrollees to services  
 39 that address their physical and mental health needs as well as non-medical issues such as housing,  
 40 nutrition, and transportation. To improve care coordination, many states have focused on enrolling  
 41 Medicaid patients in patient-centered medical homes that use a physician-led team approach to  
 42 coordinating and managing care for individuals. Consistent with value-based care, care  
 43 coordination and the use of patient-centered medical homes assist patients in getting the right care  
 44 at the right time in the appropriate setting. Many medical home programs have successfully  
 45 reduced hospitalizations and ED use including, for example, Community Care of North Carolina,  
 46 which was found to decrease ED visits among individuals enrolled compared to those not  
 47 enrolled.<sup>13</sup> In the Medicare population, enrollees with patient-centered medical homes have also  
 48 been found to have slower growth in ED use than those not treated by medical homes.<sup>14</sup>

49  
 50 Additional mechanisms employed to help reduce non-emergency ED use include integrating  
 51 behavioral health care into primary care and expanding access to after-hours primary care, which

1 have been implemented by some health systems along with expanded telehealth availability. In the  
 2 Netherlands, linkages between primary care physician cooperatives and EDs have significantly  
 3 reduced ED use.<sup>15</sup> Rural health clinics, community health centers, and federally qualified health  
 4 centers serving economically marginalized communities may also play a role in reducing non-  
 5 emergency ED visits by providing accessible and timely care that would otherwise not be available.  
 6 Research has shown that the availability of health centers lowers ED use, and that many centers  
 7 actively work with local hospitals to further reduce ED visits.<sup>16</sup>

8  
 9 Ensuring the availability of community mental health resources is also key to addressing ED use by  
 10 mental health and substance use disorder patients and enabling them to access treatment outside of  
 11 EDs. Crisis response services and same-day access to treatment in one’s community have also been  
 12 cited as important mechanisms for reducing the use of EDs.<sup>17</sup> Notably, some states, health plans,  
 13 hospitals and health systems pursue cost-savings opportunities by targeting high-need, high-cost  
 14 Medicaid patients who have the greatest number of ED visits. Case management/care management  
 15 interventions of varying designs are often employed to help meet these patients’ complex physical,  
 16 behavioral, and social needs, thereby reducing their use of EDs. Extensivist clinics, employed by  
 17 some hospitals and health systems to coordinate and manage care for patients with multiple  
 18 complex health needs, have also been found to incur cost-savings by decreasing ED utilization and  
 19 hospitalizations.<sup>18</sup> Consistent with Policy D-130.959, this report summarizes the literature on two  
 20 commonly used financial incentives—increased cost-sharing for non-emergency ED use and  
 21 retrospective payment denials for non-emergency diagnoses.

22  
 23 **INCREASED PATIENT COST-SHARING FOR NON-EMERGENCY ED VISITS**

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 25 Although federal law prohibits the imposition of cost-sharing for certain services in Medicaid,  
 26 including “emergency services,”<sup>19</sup> the Deficit Reduction Act of 2005 (DRA) gave states the option  
 27 to impose cost-sharing for “non-emergency services.”<sup>20</sup> In 2013, CMS established through  
 28 rulemaking that a maximum eight dollars in cost-sharing for non-emergency use of the ED could  
 29 be imposed by states without an approved waiver.<sup>21</sup> Accordingly, over the ensuing years, many  
 30 states have imposed limited cost-sharing amounts of eight dollars or less. Although the Kaiser  
 31 Family Foundation reported in 2020 that 21 states had mandated cost-sharing requirements for non-  
 32 emergency use of EDs,<sup>22</sup> it is unclear how many states have waived those requirements for the  
 33 duration of the COVID-19 public health emergency. Notably, South Dakota’s Medicaid program  
 34 informs enrollees that they will be responsible for paying the full cost of non-referred, non-  
 35 emergency ED services.<sup>23</sup>

36  
 37 A handful of states have used Section 1115 demonstration waivers to establish cost-sharing  
 38 amounts exceeding the eight-dollar maximum, although most of these waivers—including those  
 39 from Kentucky and New Mexico—are no longer in effect. Under Georgia’s current waiver, \$30  
 40 can be retroactively deducted from enrollees’ Member Rewards Accounts—used to deduct and  
 41 deposit non-monetary dollar-value equivalent credits for healthy behavior activities—for non-  
 42 emergency use of EDs. Because enrollees are not charged with any out-of-pocket costs, the \$30  
 43 deduction in Georgia is considered an incentive but is not true cost-sharing.<sup>24</sup> Other states have  
 44 provided prepaid cards to cover cost-sharing expenses that may allow enrollees to keep remaining  
 45 amounts on the card at the end of the year; however, no analyses of such programs were located  
 46 during the development of this report.

1 *Relevant Research*

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The landmark RAND Health Insurance Experiment, conducted between 1971 and 1982, is frequently cited as the benchmark study of cost-sharing and its effects on health care utilization, quality of care, and health. This experiment found that cost-sharing reduced utilization of almost all services, whether needed or not, and that the sickest and lowest-income people had better outcomes under free plans, suggesting that cost-sharing should not be applied to them.<sup>25</sup> Prior to enactment of the DRA, research had found that even minimal cost-sharing could lead Medicaid enrollees to use fewer health care services.<sup>26</sup>

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More recent studies of cost-sharing requirements for ED visits labeled non-emergency or nonurgent have produced mixed results. A study of state ED cost-sharing requirements in the five years following DRA enactment found no differences in ED use between states with and without those cost-sharing requirements, and no increases in the use of alternative outpatient settings.<sup>27</sup> A 2010 study of data in nine states that had imposed cost-sharing for non-emergency ED visits also suggested that cost-sharing requirements did not reduce these visits and were therefore not effective.<sup>28</sup> However, a 2015 analysis of nine years of data (from 2001 to 2009) concluded that ED visits by Medicaid enrollees in states with cost-sharing requirements were less likely to be nonurgent.<sup>29</sup>

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*Positive and Negative Experiences*

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Cost-sharing requirements are intended to incentivize appropriate health care utilization while discouraging unnecessary or inappropriate care. The DRA policy allowing limited cost-sharing requirements intended to incentivize Medicaid enrollees to reduce their reliance on EDs for services that can be provided in alternate settings at reduced costs. Cost-sharing requirements have also been touted for encouraging personal responsibility and incentivizing patients to make better health care choices, which could benefit both patients and the Medicaid program overall.

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However, increased cost-sharing in state Medicaid programs has been somewhat controversial because of the risks that imposing even limited cost-sharing amounts will dissuade economically marginalized enrollees from seeking ED care in emergency situations. Critics of these cost-sharing requirements maintain that most Medicaid enrollees use EDs for actual emergencies and, as discussed earlier in this report, a relatively small percentage of enrollees turn to EDs for non-emergency services that could be provided elsewhere. Accordingly, on their own, cost-sharing requirements may not incur much cost-savings and could lead some patients to avoid seeking or delay needed care.

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An additional drawback of cost-sharing increases for non-emergency ED visits is that it can be challenging for hospitals to administer since, in many cases, it is frequently not possible to determine at triage whether services will be considered non-emergency and thus subject to cost-sharing. Moreover, hospitals may be hesitant to request that cost-sharing be paid upfront due to potentially violating the Emergency Medical Treatment and Labor Act (EMTALA), which requires individuals to be stabilized and treated, regardless of insurance status or ability to pay. Lastly, the administrative burden on hospitals of collecting cost-sharing amounts after care is provided may be higher than any savings incurred from the minimal cost-sharing that is collected.<sup>30</sup>

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RETROSPECTIVE PAYMENT DENIALS FOR NON-EMERGENCY ED SERVICES

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Some states and insurers have attempted to rein in Medicaid costs by reducing or denying payment and coverage for ED services when the diagnosis is retrospectively determined to be non-

1 emergency. One state using a variation of this incentive is Indiana, where the Indiana Health  
 2 Coverage Program (IHCP) will pay hospitals for emergency services only if a screening determines  
 3 that the patient has an emergency condition. Although the IHCP does not deny payment for non-  
 4 emergency services, a site-of-service payment reduction is applied to those services so that  
 5 payment is based on office visit rates.<sup>31</sup>

6  
 7 In 2011, the Washington State Health Care Authority made headlines by announcing its intention  
 8 to limit non-emergency ED visits to three per year and to deny payment to physicians and hospitals  
 9 for services related to a lengthy list of diagnoses labeled non-emergent.<sup>32</sup> Facing significant  
 10 opposition from physicians and hospitals, this policy was nixed at the last minute and replaced by  
 11 an alternative plan that arose from a partnership between the Washington State Medical  
 12 Association, the Washington Chapter of the American College of Emergency Physicians, the  
 13 Washington State Hospital Association, and the Health Care Authority. This multifaceted effort to  
 14 reduce nonurgent ED visits coalesced around a series of best practices that saved nearly \$34  
 15 million in the program’s first year, during which ED visits by Medicaid enrollees declined by 10  
 16 percent.<sup>33</sup> The following “ER is for Emergencies” best practices became integral to Washington  
 17 State’s efforts to reduce avoidable ED visits:

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- 19 1. Adoption and use of an interoperable health information exchange;
- 20 2. Dissemination of materials intended to educate patients about appropriate care utilization
- 21 and the difference between emergencies and non-emergencies;
- 22 3. Identification by hospitals of frequent ED users;
- 23 4. Development of care management plans for frequent ED users that incorporate information
- 24 on social determinants of health;
- 25 5. Implementation of state guidelines for prescribing opioids;
- 26 6. Implementation of the state’s prescription monitoring program; and
- 27 7. Engaging ED and care management staff to track ED utilization data and provide
- 28 feedback.<sup>34</sup>
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30 While not specifically targeting Medicaid, large private insurers have periodically proposed  
 31 coverage denials that limit payment for ED services retrospectively determined to have non-  
 32 emergency ED discharge diagnoses. The AMA has advocated against such policies, as it did in  
 33 2017, when Anthem implemented policies in several states that denied coverage for many ED  
 34 services and shifted the cost burden onto patients.<sup>35</sup>

35  
 36 *Relevant Research*

37  
 38 Some studies have questioned the accuracy of retrospective payment denial policies for nonurgent  
 39 ED services, which are based on claims data and assume there is a clear association between  
 40 presenting symptoms and discharge diagnoses. The findings from the 2013 *JAMA* study, cited  
 41 earlier in this report, cast doubt on this association and further suggest that policies that deny or  
 42 limit payment based on diagnosis at discharge are not appropriate and may put some patients at risk  
 43 of not getting emergency care that they need. According to the *JAMA* study:

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 45 Among ED visits with the same presenting complaint as those ultimately given a primary care-  
 46 treatable diagnosis based on ED discharge diagnosis, a substantial proportion required  
 47 immediate emergency care or hospital admission. The limited correspondence between  
 48 presenting complaint and ED discharge diagnosis suggests that these discharge diagnoses are  
 49 unable to accurately identify nonemergency ED visits.<sup>36</sup>

1 Similar results were found in a 2018 study of a large private insurer’s policy to deny coverage for  
 2 ED visits when the ED discharge diagnosis is determined to be nonurgent.<sup>37</sup> This analysis of ED  
 3 visits of privately insured patients between 2011 and 2015 found that nearly 40 percent of the more  
 4 than 15 percent of visits with non-emergency diagnoses were in fact urgent, as evidenced by the  
 5 fact that patients received emergency care. Furthermore, the presenting symptoms of patients in  
 6 nearly 90 percent of the ED visits were the same as symptoms of those patients with diagnoses  
 7 labeled nonemergent.<sup>38</sup>

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 9 *Positive and Negative Experiences*

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 11 Although retrospective payment denials are likely to save money, they also violate important  
 12 patient protections and undercut the practice of emergency medicine. Federal law requires  
 13 insurance coverage of emergency services as defined using a prudent layperson standard that is  
 14 based on symptoms, not eventual diagnoses.<sup>39</sup> Retrospective payment denial policies run the risk of  
 15 violating the prudent layperson standard and also disregard patients’ perceptions of their own  
 16 symptoms and whether they need emergency care. Patients make care decisions based on  
 17 symptoms and they should be neither encouraged to second guess their instincts that emergency  
 18 care is needed nor expected to self-diagnose to determine whether, for example, chest pain is a  
 19 heart attack or indigestion. Finally, the impact of policies that deny coverage and payment for  
 20 emergency services based on diagnoses risks leading Medicaid patients, who may be seriously ill,  
 21 to either not seek or delay seeking needed emergency medical care.

22  
 23 **AMA POLICY**

24  
 25 The AMA has long-standing policy supporting the prudent layperson standard (Policy H-130.970).  
 26 Accordingly, this policy states that emergency services should be defined as those services  
 27 provided in a hospital emergency facility after the sudden onset of a medical condition that  
 28 manifests itself by symptoms of sufficient severity, including severe pain, that the absence of  
 29 immediate medical attention could reasonably be expected by a prudent layperson, who possesses  
 30 an average knowledge of health and medicine, to result in: (1) placing the patient’s health in  
 31 serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any  
 32 bodily organ or part. Policy H-130.970 also directs the AMA to work with state insurance  
 33 regulators, insurance companies and other stakeholders to take action to halt the implementation of  
 34 policies that violate the prudent layperson standard of determining when to seek emergency care.  
 35 Policy H-290.965 supports the use of ED best practices that are evidence-based to reduce avoidable  
 36 ED visits.

37  
 38 Policy H-290.982 supports modest copays or income-adjusted premiums in Medicaid for non-  
 39 emergent, non-preventive services. Policy H-165.855 states that children qualified for Medicaid  
 40 should have no cost-sharing obligations. Under Policy H-290.985, the AMA advocates that  
 41 enrollees in Medicaid managed care plans be educated about appropriate use of services, including  
 42 at the emergency department, and availability of off-hours, walk-in primary care. This policy also  
 43 maintains that Medicaid managed care plans should be responsive to cultural, language and  
 44 transportation barriers to access, and provide intensive case management for high utilizers and  
 45 realistic financial disincentives for beneficiary misuse of services.

46  
 47 Policy H-450.941 supports initiatives that protect patient access and that do not contain  
 48 requirements that permit third-party interference in the patient-physician relationship, and it  
 49 strongly opposes attempts to steer patients towards certain physicians primarily based on cost.  
 50 Policy H-450.938 states that physicians should encourage their patients to participate in making  
 51 value-based health care decisions, while Policy H-155.960 supports value-based decision-making



1 and broad strategies for addressing rising health care costs. Policy H-155.960 also encourages  
2 third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are  
3 determined based on the clinical value of a health care service or treatment, and tailoring cost-  
4 sharing requirements to patient income and other factors known to impact compliance. Policy  
5 H-185.939 supports value-based insurance design (VBID), consistent with several principles  
6 including that coverage and cost-sharing policies must be transparent and that VBID should not  
7 restrict access to care. Policy D-185.979 encourages national medical specialty societies to  
8 collaborate with payers to promote alignment of patient financial incentives with utilization of  
9 high-value services.

10  
11 Under Policies H-385.921 and H-290.976, the AMA advocates for reasonable physician payments  
12 within Medicaid/CHIP, defined as a minimum of 100 percent of Medicare rates. Policy H-400.957  
13 encourages CMS to expand the extent and amount of payment for procedures performed in the  
14 physician's office, to shift more procedures from the hospital to the office setting, which is more  
15 cost effective. Policy D-240.994 advocates that third-party payers be required to assess equal or  
16 lower facility cost-sharing for lower-cost sites of service.

17  
18 The AMA has adopted principles for patient-centered medical homes, including that each patient  
19 has an ongoing relationship with a personal physician trained to provide first contact, continuous  
20 and comprehensive care (Policy H-160.919). These principles also maintain that enhanced access  
21 to care is available through systems such as open scheduling, expanded hours and new options for  
22 communication between patients, their personal physician, and practice staff. ED boarding and  
23 overcrowding are addressed by Policies H-130.940 and H-130.945. The latter policy encourages  
24 hospitals to use appropriate criteria to triage patients so those with simpler medical needs can be  
25 redirected to other appropriate ambulatory facilities. EMTALA is addressed by Policy D-130.982.

26  
27 Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet  
28 critical health needs and the underlying social determinants of health; (2) supports continued efforts  
29 by public and private health plans to address social determinants of health in health insurance  
30 benefit designs; and (3) encourages public and private health plans to examine implicit bias and the  
31 role of racism and social determinants of health. Policy H-185.920 supports continuity of care  
32 principles for financial incentive programs, including that these programs never interfere with a  
33 patient-physician relationship, and that only treating physicians can determine whether a lower-cost  
34 care option is medically appropriate. This policy also supports objective studies of the impacts of  
35 financial incentive programs.

36  
37 Policy H-373.994 recognizes the increasing use of patient navigator and patient advocacy services  
38 to help improve access to care and help patients manage complex aspects of the health care system.  
39 Policy H-290.995 supports primary care case management programs for Medicaid enrollees: on a  
40 voluntary basis with incentives provided toward a prudent choice of care source; and on a  
41 mandatory basis only for those identified as overutilizers or mis-utilizers of services; and  
42 comparative analyses of these programs to determine their relative effectiveness regarding patient  
43 access, quality of and satisfaction with care, and cost reduction.

#### 44 45 DISCUSSION

46  
47 Policies aimed at reducing ED use for services that could be provided elsewhere, and at lower cost,  
48 have been debated for decades and are worthy of continued monitoring and testing. Since many  
49 states incorporate such policies into Section 1115 demonstration waivers and state Medicaid plan  
50 amendments, the Council recommends support for continued monitoring and pilot testing, by CMS  
51 and other stakeholders, of strategies and best practices for reducing non-emergency ED use among

1 Medicaid/CHIP enrollees, particularly among patients with the highest number of ED visits. The  
 2 Council believes that ongoing study of state approaches to reducing ED use, and dissemination of  
 3 study results, will greatly benefit state Medicaid programs as they strive to manage health care  
 4 costs without compromising care quality.

5  
 6 State Medicaid programs, hospitals and health systems have employed a variety of strategies to  
 7 reduce non-emergency ED use, and the Council supports state flexibility in this regard since best  
 8 practices will depend in part on the health needs of a state’s Medicaid population. Recognizing the  
 9 abundance of AMA policy that is relevant to this topic, the Council recommends support for state  
 10 efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with  
 11 the standards and safeguards outlined in AMA policy on ED services.

12  
 13 The Council understands that a complex mix of factors influences ED use and that the share of  
 14 visits that are non-emergency, while difficult to discern, is relatively low. We also recognize that  
 15 modest cost-sharing for non-emergency ED visits for adult Medicaid enrollees, but not for children,  
 16 is consistent with AMA policy (Policies H-290.982 and H-165.855) and may incentivize some  
 17 patients to make better health care choices. Although we do not recommend changes to existing  
 18 policy, we conclude from the literature that modest cost-sharing requirements, on their own, may  
 19 not be very effective at either reducing nonurgent ED services or generating significant cost-  
 20 savings. We further question whether the cost of administering nominal cost-sharing requirements  
 21 may, in some cases, be higher than any savings they generate.

22  
 23 Although diagnosis-based payment and coverage denials for non-emergency ED services may  
 24 effectively contain costs, the Council affirms that these policies risk violating important patient  
 25 protections and may potentially harm some patients—by dissuading them from seeking emergency  
 26 care when needed—as well as physicians and hospitals, when payment is denied. Accordingly, the  
 27 Council recommends reaffirming Policy H-130.970, which supports the prudent layperson standard  
 28 for determining the need for emergency services and directs the AMA to work with state insurance  
 29 regulators, insurers, and other stakeholders to halt the implementation of policies that violate this  
 30 standard.

31  
 32 The Council believes that most Medicaid enrollees turn to EDs when they do not have access to  
 33 primary care or needed specialty care—including mental health and substance use disorder  
 34 treatment—and when few or no other care options are available. We further believe that strategies  
 35 may be more effective if they specifically target individuals with the highest numbers of ED visits,  
 36 generally a small percentage of enrollees who account for a disproportionately high amount of ED  
 37 utilization. Facilitating these patients’ treatment for non-emergency services in alternate settings  
 38 and linking them with primary care, mental health care, and other needed services, are more likely  
 39 to significantly reduce ED use and incur some cost-savings. The Council emphasizes that strategies  
 40 targeting frequent ED users should be comprehensive and multifaceted, addressing not only  
 41 physical and mental health needs but also socioeconomic factors that could contribute to higher  
 42 rates of ED utilization. Such strategies should strive to ensure access to primary, preventive and  
 43 behavioral health care, as well as substance use disorder treatment, outside of EDs through the  
 44 availability of community providers and resources.

45  
 46 Before the COVID-19 pandemic, available state Medicaid data showed that more than 60 percent  
 47 of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that  
 48 enrollees of color experienced poorer outcomes and more barriers to care than whites.<sup>40</sup>  
 49 Accordingly, state Medicaid programs should consider the potential health equity implications of  
 50 strategies to reduce ED visits and address SDOH. Consistent with numerous AMA site-of-service  
 51 policies (i.e., Policies H-400.957 and D-240.994), state Medicaid program strategies should

1 focus—through patient education and empowerment, 24/7 telephone triage, and telehealth  
2 availability, among other efforts—on ensuring that all patients receive health care services in the  
3 outpatient setting most appropriate to their symptoms and needs. Accordingly, the Council  
4 recommends reaffirmation of Policy H-290.985, which advocates that a long list of criteria be used  
5 to monitor and oversee Medicaid managed care plans, including that enrollees are educated about  
6 appropriate use of services, including ED services; plans are responsive to cultural, language and  
7 transportation barriers to access; off-hours, walk-in primary care is available; there is geographic  
8 dispersion and accessibility of participating physicians and other providers; intensive case  
9 management is provided to high utilizers; and payment levels are realistic and based on costs of  
10 care and predicted utilization levels.

11  
12 Because increases in Medicaid payment rates have been found to increase enrollee access to care,  
13 the Council recommends reaffirming Policy H-290.976, which affirms the AMA’s commitment to  
14 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.  
15 Finally, the Council recommends rescinding Policy D-130.959, which called for the development  
16 of this report.

17  
18 RECOMMENDATIONS

19  
20 The Council on Medical Service recommends that the following be adopted and the remainder of  
21 the report be filed:

- 22  
23 1. That our American Medical Association (AMA) support continued monitoring, by the Centers  
24 for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for  
25 reducing non-emergency emergency department (ED) use among Medicaid/Children’s Health  
26 Insurance Program (CHIP) enrollees, including frequent ED users. (New HOD Policy)  
27  
28 2. That our AMA support state efforts to encourage appropriate emergency department (ED) use  
29 among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined  
30 in AMA policy on ED services. (New HOD Policy)  
31  
32 3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and  
33 directs the AMA to work with state insurance regulators, insurers, and other stakeholders to  
34 halt the implementation of policies that violate the prudent layperson standard of determining  
35 when to seek emergency care. (Reaffirm HOD Policy)  
36  
37 4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in  
38 Medicaid managed care monitoring and oversight, including that enrollees are educated about  
39 appropriate use of services, including ED services; plans are responsive to cultural, language  
40 and transportation barriers to access; off-hours, walk-in primary care is available; and intensive  
41 case management is provided to high utilizers. (Reaffirm HOD Policy)  
42  
43 5. That our AMA reaffirm Policy H-290.976, which affirms the AMA’s commitment to  
44 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.  
45 (Reaffirm HOD Policy)  
46  
47 6. That our AMA rescind Policy D-130.959, which called for the development of this report.  
48 (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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**Appendix**  
**AMA Policies Recommended for Reaffirmation**

**Policy H-130.970, “Access to Emergency Services”**

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an “emergency medical condition” as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 807, I-18)

**Policy H-290.985, “Monitoring Medicaid Managed Care”**

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving

Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

- (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
- (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
- (3) Geographic dispersion and accessibility of participating physicians and other providers.
- (4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
- (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
- (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
- (15) Preservation of private right of action for physicians and other providers and beneficiaries.
- (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
- (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
- (18) Absence of gag rules.
- (19) Fairness in procedures for selection and deselection.
- (20) Realistic payment levels based on costs of care and predicted utilization levels.
- (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
- (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14)

**Policy H-290.976, “Enhanced SCHIP Enrollment, Outreach, and Reimbursement”**

1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.



2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21)