PHYSICIANS' GUIDE TO STATE LEGISLATION

CASE STUDY

HMO PREAUTHORIZATION REQUIREMENTS (COBRA RECONCILIATION ACT)

Issue

Calling health maintenance organizations (HMOs) for authorization to provide care in the ED is dangerous to ill patients, burdensome to ED providers, time consuming, and potentially in conflict with (COBRA/EMTALA) regulations.

ACEP Position

Needed emergency evaluation and stabilization should not be delayed in order to obtain insurance information or authorization for payment. Emergency physicians should be equitably reimbursed for all services provided, including the provision of mandated medical screening examinations.

Background Information

New EMTALA regulations, as of June 22, 1994, require not only a (comprehensive) screening exam, but also treatment for "stabilization" without "delay to inquire into insurance status." The problem is that patients will not consent to be examined without an "official" authorization from their HMO, whether or not the situation is an emergency. A woman in Baltimore died less than 24 hours after leaving an ED without authorization, even though the ED triage nurse entreated her to stay. Of course, the ED was blamed "because they wouldn't see her."

A related problem occurs when a patient is sent to the ED by the HMO in some manner, but the HMO requires a duplicative authorization after the patient's arrival in the ED. Often the initial direction to the ED is by someone (possibly by answering machine) who does not document that guidance. Sometimes a patient attempts to seek prior authorization but the HMO representative does not return the call in a timely manner. The documentation by the primary care provider approving the ED

visit can be "lost" between the office and the claims payment unit. At other times, the primary care provider may be signed out to a nonparticipating provider. Even with inappropriate use by patients, the primary care provider may be reluctant to second-guess the symptoms once the patient is already in the ED. Many subscribers are enrolled by their employers but are never educated about where to go or whom to see, even many months after enrollment.

As HMO penetration in Maryland approached the 50% mark in 1994, there were over 600,000 authorization events that year, often with multiple calls per event. Therefore, in October 1994, before the start of that year's legislative session, Maryland ACEP's Public Policy Committee made the dilemma of HMO authorization versus EMTALA an item for legislative relief. Although the chances of enacting a law providing that emergency physicians do not have to call for authorization seemed formidable, MACEP went ahead with the legislation at the urging of the Public Policy Committee.

The main focus of the bill was reconciliation of EMTALA with the outdated authorization requirements of the HMOs, and included the following provisions:

- If the visit was a bona fide emergency, approval was automatic, as established by prior legislation;
- If the patient was directed to the ED by the HMO in some manner, the visit would be approved, also pursuant to previous legislation;
- If the patient came to the ED because the HMO did not return a call in a timely manner, the patient should be seen so as not to wait longer in fear of not getting prompt attention;
- If the education provided by the HMO was insufficient to keep the patient out of the ED, the visit should be approved; and
- If the patient came to the ED because the ED is more convenient or attractive than the HMO office, for whatever reason, the visit should be approved.

Legislative History in Maryland

This bill originally was written by MACEP and added to certain statutes regulating reimbursement for noncontracting providers by HMOs. The Maryland Hospital Association was a natural ally; the bill was edited by their lobbyist, a former legislative staff member and bill crafter.

The chapter was able to enlist the assistance of House leadership, who recommended the appropriate legislator to sponsor the bill. The gathering of support was much easier in 1994, because the chapter had been deemed reliable and consistent based on previous work. In addition, member Dan Morhaim, MD, FACEP, had been elected to the House and was quickly identified as an expert resource by his fellow delegates. Furthermore, the shine had faded for the HMOs, leaving them on the defensive.

The state medical society was pushing its Patient Access Act using aggressive techniques that often focused on economic issues. As before, MACEP thought it prudent to keep at arm's length from this initiative, although it was not adversarial.

This bill was filed only in the House. The strategy was to bring an endorsed bill to the Senate. The hearing before the House Economic Matters Committee was "pro forma" and hurried at the end of the day. At the time, the HMOs professed not to understand the bill and said that it was poorly written. It was pointed out that they had used this tactic previously when they were unprepared for opposition. The committee vote was held for informal

negotiations. Several amendments were proposed and discarded; other were adopted.

Eventually, the committee was presented with a choice between a broad bill and a narrower one. They opted for the broader bill that said in essence that emergency physicians treat all HMO enrollees as they present, they don't need to call first, and that HMOs must reimburse all claims from the ED for their enrollees.

MACEP had reservations that this was too aggressive, but it would have been awkward to openly doubt the legislators' judgment. However, the House committee members were right, and the bill passed the House easily and went to the Senate Finance Committee.

The Senate Finance Committee had a new chair friendly to MACEP. In fact, he was the Senate sponsor of their Emergency Definition bill in 1993, a fact of which he was quite proud.

Then a problem was discovered. Despite the attention of experienced bill drafters, the language "emergency services" instead of "services in the ED" had been used. The former term had already been defined. The wording of the bill meant that it would apply only for bona fide emergencies, not for nonurgent services as MACEP had intended.

Because all of the testimony up to that point had been on nonurgent care, including that designation in the title of written testimony, the Senate committee chair elected to report favorably on the bill as written. This tactic was used so the House would have to concur with a technical amendment added in the Senate. The House leadership agreed to "not concur" with the bill they had previously passed, sending the bill to a conference committee. In the committee, the language was updated favorably (this necessitated urgent action by MACEP, including one member calling his Senator while on vacation in Arizona) and the report was sent to the floor of each chamber. The bill passed 135 to 4 in the House and 47 to 0 in the Senate, with only 3 hours to spare before the end of the legislative session!

Then the HMOs began to put tremendous pressure on the Governor. They stated that the previously enacted Emergency Definition bill was prudent public policy, even though they had fought it. They also came up with "conceptual" numbers showing that there would be a huge cost to the state. Maryland intends to place Medicaid recipients in managed care programs, so this issue was very significant. The governor's private physician intervened against the bill, as he was a supporter of HMOs, as well as the president of the Maryland Medical Society. The governor used one of his 13 vetoes (out of 1300 bills passed). The bill failed.

On the bright side, work on this bill gained MACEP much sympathy and positive publicity. The public and the legislators were educated about EMTALA and now know more about EMTALA than most physicians do. The governor received early support from MACEP during the elections, but now had incurred its ire. The sponsors have already prepared to file a similar bill for the next session. Stay tuned!

Arguments in Favor of this Position

- Emphasize that the ED is society's safety net.
- HMOs cannot be successful without emergency physicians' help, yet they place too many roadblocks to appropriate patient care.
- Use data to show that the cost for all services in the ED is only 1% to 2% of the health budget. Very few patients are there without a legitimate reason. Thus, the extra cost is not worth the tussle when the policymakers consider the essential public service provided. There may even be cost savings if hospital admissions can be avoided.
- HMOs were wrong about the Emergency Definition; they will be

found wrong about the entire authorization process.
- See Background Information above for other arguments.

Arguments Against this Position

- Premiums will rise! Premiums will rise! Premiums will rise!
- Patients, particularly Medicaid enrollees, will flood the ED.
- The HMOs need to keep continuity of care by requiring the involvement of a gatekeeper.
- Emergency physicians use EMTALA to justify unnecessary and expensive tests, therefore padding the bill.
- "This is not a problem."

Potential Proponent Organizations

State hospital association, state medical society, social workers, specialty physician societies (on call to the ED), nursing lobby, emergency medical services groups, and consumer groups (including advocates for uninsured and handicapped).

Potential Opponent Organizations

HMOs and mental health managed care companies.

The AFL-CIO and Chamber of Commerce (in Maryland) generally follow the HMO's lead because of the threat of raising premiums.

The State Department of Health (in Maryland) is in charge of reducing costs to the Medicaid program. Managed care is their "great hope." They were skeptical of the proponents' cost figures.

The State Budget Office. In this case, they were confused and persuaded by the conceptual numbers provided by HMOs.

Possible Strategies

Obtain a list of EMTALA investigations and outcomes. MACEP plans to have a hospital CEO testify about his experience with an EMTALA investigation.

Get the Numbers

MACEP provided a "snapshot" of emergency medicine in Maryland for the last two weeks in October 1995 in preparation for the next legislative session. These data included the cost to the HMOs for services in the ED, denials for failure to "jump through hoops," time to return calls, percentage of emergency, semiurgent, and nonurgent patients, and, most importantly, patient experiences.

As a corollary, do not depend on anecdotes alone.

When the HMOs say "fine, don't call for authorization," note how many patients will not give consent to be treated without this assent from the HMO, even when in distress.

Comment that the HMOs need a "stick" to motivate educational efforts for their enrollees.

Emphasize the poor logic of a remote reviewer overriding the on-scene evaluation by the emergency physician.

For more information on this issue,
please contact Craig Price in the State Legislative Office at
800/798-1822, ext. 3236, or e-mail cprice@acep.org

David S. Davis, MD, JD, FACEP
Member, State Legislative/Regulatory Committee
Maryland Chapter, American College of Emergency Physicians
410/544-9185 or e-mail standad@juno.com