January 28, 1996

MEMORANDUM TO GENE SPERLING, JENNIFER KLEIN, AND CHRIS JENNINGS

FROM: MARILYN YAGER

RE: MEETING WITH THE LEADERSHIP OF THE AM. ASSN. OF FAMILY PHYSICIANS

DATE/TIME: Monday, January 29
1:30 pm to 2:00 pm

LOCATION: Room 180 OEOB

PURPOSE: They requested this meeting (while their President Bob Graham is in town) to share some ideas about health care reform for the next term/Congress. I told them we had not begun that discussion, but that we were happy to hear their views.

ATTENDEES:

Dr. Bob Graham, Executive Vice President
Charlie Huntington, Director, Washington Office
Rosie Sweeney, Director, Policy Analysis

BACKGROUND:

As the largest Physician organization representing primary care physicians, the AAFP tends to be more liberal than your average physician group and their position papers certainly mirror our own positions. They started out as an early supporter of the Health Security Act, but towards the end of 1994 we began to have a rocky relationship, largely as a result of our inability to get the President or the First Lady to any of their meetings (nor have we been able to get a small meeting with the President for their Board - this is truly my fault, I thought I could get the meeting and have never been able to).

They have also taken strong issue with our HCFA policies which they view as favoring specialists over primary care physicians, and our reduced funding for primary care public health programs. However, in turn, we have been disappointed in their muted involvement this year in our stalwart defense of Medicaid (although they signed on to the ACP physician press conference on behalf of our Medicaid policy).

However, despite this rocky relationship, we endeavor to keep a good relationship because they represent the physicians that tend to support the President.

American College of
Emergency Physicians

LEE R. GODOWN
Congressional Lobbyist

1111 19th Street, N.W., Suite 650 • Washington, D.C. 20036
(202) 728-0610 Ext. 3015 Fax (202) 728-0617

In Coalition plan

Congress of the United States

Washington, DC 20515

December 14, 1995

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

We write to you today to urge your strong support for the adoption of the "prudent layperson" definition of emergency for the Medicare program as you undertake negotiations with the Republican Congressional Leadership on the final reconciliation package.

The "prudent layperson" definition of emergency was offered as an amendment by Sen. Bob Graham (D-FL) and was adopted unanimously by the Senate during its floor consideration of the reconciliation package. The prudent layperson definition of emergency is the principle provision of legislation introduced earlier this year by Rep. Ben Cardin (D-MD) and Sen. Barbara Mikulski (D-MD). The Cardin bill, HR 2011, has 61 Democratic cosponsors. In addition, all of the Democrats on the Ways and Means Committee supported a Stark amendment that included the prudent layperson definition, though the amendment lost on a strict party line vote. An amendment was also approved by voice vote in the Commerce Committee to include the prudent layperson definition. Despite strong Democratic support and even Republican support, the Republican leadership unfortunately chose to strip this important patient protection for Medicare beneficiaries from the Conference report.

The "prudent layperson" definition is a needed and necessary protection for senior citizens who enroll in Medicare HMOs. The Graham amendment would have ensured that Medicare beneficiaries who seek emergency care are not denied coverage by participating HMOs when it is determined "after-the-fact" that their condition was not "life-threatening." Unfortunately, the language agreed to by the Republican Conference Committee and subsequently adopted would allow this practice to continue. An independent study advised that unless we adopt the prudent layperson definition of emergency, Medicare beneficiaries will be subjected to unexpected and inappropriate out-of-pocket expenses which, at times, can be catastrophic.

We are calling on the Administration to support this provision because it clearly reflects the values we all share by protecting patients in extremely vulnerable situations. Mr. President, imagine the following scenario: a senior citizen develops sudden and severe chest pain, goes to an emergency department and, upon evaluation, is not diagnosed as experiencing a heart attack. Under the Republican Conference report, this person could be denied Medicare coverage. In fact, this is happening every day in the private sector insurance market and we

should not allow Medicare beneficiaries to be subject to this type of "Russian roulette" with respect to emergency services.

A broad coalition supports the prudent layperson definition, including the American College of Emergency Physicians, the Coalition for American Trauma Care, the Emergency Nurses Association, the International Association of Fire Fighters, the American Heart Association, the American Academy of Pediatrics, Consumers Union, Citizen Action, Public Citizen, and the National Committee to Preserve Social Security and Medicare. It is pro-consumer pro-senior, and a vital improvement over current regulation.

While inclusion of this provision may appear to be a relatively minor one in the scheme of Medicare reform, if it is not corrected it could have a serious impact on any efforts to transform Medicare. It is important that the Administration not overlook this issue, and we are hopeful that you will make sure that it is on the list of items you bring up during your negotiations.

Again, Mr. President, we urge you to support inclusion of the "prudent layperson" definition of emergency in any final reconciliation compromise that is concluded in your negotiations with the Congress.

Sincerely,

David E. Bonior, MC

Benjamin L. Cardin, MC

Sam Gibbons, MC

John D. Dingell, MC

Pete Stark, MC

Henry A. Waxman, MC

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 104th CONGRESS, FIRST SESSION

Vol. 141 WASHINGTON, FRIDAY, OCTOBER 27, 1995 No. 168

Senate

FRIDAY, OCTOBER 27, 1995

GRAHAM AMENDMENT NO. 3014

Mr. DOMENICI (for Mr. GRAHAM) proposed an amendment to the bill S. 1357, supra, as follows:

Beginning on page 476, strike line 20 and all that follows through page 477, line 3 and insert the following: such individuals have contracted for) available and accessible to each such individual, within the medicare service area of the plan, with reasonable promptness, and in a manner which assures continuity.

On page 481, between lines 15 and 16, insert the following:

"(h) TIMELY AUTHORIZATION FOR PROMPTLY NEEDED CARE IDENTIFIED AS A RESULT OF REQUIRED SCREENING EVALUATION.—

"(1) ACCESS TO PROCESS.—A medicare choice plan sponsor shall provide access 24 hours a day, 7 days a week to such persons as may be authorized to make any prior authorizations required by the plan sponsor for coverage of items and services (other than emergency services) that a treating physician or other emergency department personnel identify, pursuant to a screening evaluation required under section 1867(a), as being needed promptly by an individual enrolled with the organization under this part.

"(2) DEEMED APPROVAL.—A medicare choice plan sponsor is deemed to have approved a request for such promptly needed items and services if the physician or other emergency department personnel involved—

"(A) has made a reasonable effort to contact such a person for authorization to provide an appropriate referral for such items and services or to provide the items and services to the individual and access to the person has not been provided (as required in paragraph (1)), or

"(B) has requested such authorization from the person and the person has not denied the authorization within 30 minutes after the time the request is made.

"(3) EFFECT OF APPROVAL.—Approval of a request for a prior authorization determination (including a deemed approval under paragraph (2)) shall be treated as approval of a request for any items and services that are required to treat the medical condition identified pursuant to the required screening evaluation.

"(4) DEFINITION OF EMERGENCY SERVICES.—In this subsection, the term 'emergency services' means—

"(A) health care items and services furnished in the emergency department of a hospital (including a trauma center), and

"(B) ancillary services routinely available to such department,

to the extent they are required to evaluate and treat an emergency medical condition (as defined in paragraph (5)) until the condition is stabilized.

"(5) EMERGENCY MEDICAL CONDITION.—In paragraph (4), the term 'emergency medical condition' means a medical condition, the onset of which is sudden, that manifests itself by 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—

"(A) placing the person's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

ORGANIZATIONS THAT SUPPORT THE PRUDENT LAYPERSON DEFINITION OF EMERGENCY

American College of Emergency Physicians
National Association of EMS Physicians
Coalition for American Trauma Care
American Ambulance Association
Emergency Medical Services Section of the International Association of Fire Chiefs
International Association of Firefighters
Emergency Nurses Association
National Association of Emergency Medical Technicians
Association of Air Medical Services
National Association of State EMS Directors
American College of Cardiology
American College of Surgeons
Congress of Neurological Surgeons
American Association of Neurological Surgeons
American Association for the Surgery of Trauma
Consumer's Union
Citizen Action
Public Citizen
National Committee to Preserve Social Security and Medicare
American Heart Association
American Academy of Pediatrics

JENNER & BLOCK LEGAL ANALYSIS
HOUSE/SENATE DEFINITIONS OF EMERGENCY SERVICES
MAJOR FINDINGS

(1) "We conclude that the House definition of emergency services, by codifying the HCFA's regulatory definition, will make it much more difficult to remedy the flaws in the current system....By contrast, the prudent layperson standard in the Senate bill will likely alleviate the problems with the current claims review process for emergency services while preserving administrative flexibility to issue implementing standards and guidelines." (Page 2)

(2) "Under the House bill, coverage for emergency services performed by either an in-network or out-of-network provider can be denied because of an after-the- fact determination by the MedicarePlus organization that the patient's condition did not meet the criteria for emergency services." (Page 3)

(3) "The House definition is crafted to cover only out-of-network emergency services....Indeed, the bill is silent on the provision of emergency services by the MedicarePlus organization." (Page 3)

(4) "...the [House] bill apparently permits a network organization to adopt its own definition of in-network emergency services and to develop its own guidelines and standard of review for reimbursing such treatment." (Page 3)

(5) "The House definition of emergency services, on its face, leaves no room for consideration of the patient's personal judgement of the seriousness of his or her presenting condition." (Page 4)

(6) "By codifying HCFA's regulation, the definition of "emergency medical services" in the House reconciliation bill could have the unintended effect of exacerbating the disproportionate rate of emergency services denials by Medicare HMOs and other managed care organizations." (Page 6)

(7) "...there is nothing in the House language that states or even implies that MedicarePlus organizations need give any weight to the patient's symptoms and subjective feelings. Instead, like HCFA's regulations, the language focuses on whether the patient was actually diagnosed with a condition that posed an immediate risk of serious damage to the patient's health." (Page 7)

(8) "It is fair to say, then, that the problem of disproportionate denials of emergency services by MedicarePlus organizations will likely worsen if the House bill is enacted." (Page 8)

(9) "By codifying the prudent layperson standard into statute, the Senate bill would likely lead to fewer rather than more denials of emergency services claims." (Page 10)

(10) "The prudent layperson standard is derived from the longstanding reasonable person test used in contract and tort law." (Page 10)

(11) "Enacting the prudent layperson standard into statute should engender greater compliance by MedicarePlus organizations and provide beneficiaries with stronger grounds for appealing improper denials. (Page 11)

(12) "...the prudent layperson standard will not emasculate the claims review process. MedicarePlus organizations will still review the reasonableness and medical necessity of claims and deny those that are frivolous. Nor does the adoption of the prudent layperson standard force the claims reviewer to defer to the subjective judgement of the enrollee."

(13) "...the Senate language would give HCFA flexibility to interpret the prudent layperson standard through regulations, guidelines or policy statements. Accordingly , the agency could restrict the definition in the unlikely event that Medicare enrollees began to overuse emergency services. By the same token, HCFA could further expand the definition if MedicarePlus organizations fail to apply it correctly or continue to deny a disproportionate number of emergency services claims." (Page 11)

LAW OFFICES

JENNER & BLOCK

A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

601 THIRTEENTH STREET, N.W.
SUITE 1200
WASHINGTON, D.C. 20005

(202) 639-6000
(202) 639-6066 FAX

CHICAGO OFFICE
ONE IBM PLAZA
CHICAGO, IL 60611
(312) 222-9350
(312) 527-0484 FAX

MIAMI OFFICE
ONE BISCAYNE TOWER
MIAMI, FL 33131
(305) 530-3535
(305) 530-0008 FAX

LAKE FOREST OFFICE
ONE WESTMINSTER PLACE
LAKE FOREST, IL 60045
(708) 295-9200
(708) 295-7810 FAX

MEMORANDUM

TO: John H. Scott

CC: Michael E. Gallery, Ph.D., CAE

FROM: Jerald A. Jacobs
Robert M. Portman

DATE: November 1, 1995

SUBJECT: Analysis of Definitions of Emergency Services in House and Senate Reconciliation Bills

You have asked us to analyze the language in the House and Senate reconciliation bills relating to the definition of "emergency medical services" provided to MedicarePlus enrollees. The House definition of "emergency services" provided by MedicarePlus organizations appears to be intended to codify the Health Care Financing Administration's (HCFA's) existing regulatory definition for Medicare health maintenance organizations (HMOs). The HCFA definition has reportedly led to a disproportionate rate of claim denials by Medicare HMO enrollees for reimbursement of emergency services. Meanwhile, the Senate reconciliation bill adopts language introduced by Senator Bob Graham that is intended to reduce the excessive rate of denials for emergency services by managed care organizations. Most notably, the Senate bill avoids the House bill's distinction between in-network and out-of-network emergency services and incorporates a "prudent layperson" standard that shifts the claims review process from an evaluation of the patient's final diagnosis to a review of the patient's presenting symptoms.[1/]

[1/] The Senate bill is identical to an amendment introduced by Rep. Greg Ganske, which was passed by the House Commerce Committee, but omitted from the final House reconciliation bill. The definition of emergency medical services in both the Senate bill and the Ganske bill were derived from H.R. 2011, the Access to Emergency Services Act of 1995, a bill introduced by Rep. Benjamin Cardin and Rep. Marge Roukema.

We conclude that the House definition of emergency services, by codifying the HCFA's regulatory definition, will make it much more difficult to remedy the flaws in the current system, either through administrative action or legal challenges by beneficiaries, emergency physicians, or hospitals. By contrast, the prudent layperson standard in the Senate bill will likely alleviate the problems with the current claims review process for emergency services while preserving administrative flexibility to issue implementing standards and guidelines.

We will start by analyzing the language of the two bills. We will then discuss the possible legal implications of each bill.

I. Analysis of Bill Language

A. The House Bill

Sec. 1853 of House reconciliation bill contains the patient protection standards for the MedicarePlus program. MedicarePlus is the managed care program that is created by the Medicare reform bill. Among other things, the patient protection standards set forth the rules governing reimbursement for emergency medical services obtained by MedicarePlus enrollees. Section 1853(b)(4) of the bill defines emergency services as follows:

> In this subsection, the term 'emergency services' means, with respect to an individual enrolled with [a MedicarePlus] organization, covered inpatient and outpatient services--
>
> (A) are furnished by an appropriate source other than the organization,
>
> (B) are needed immediately because of an injury or sudden illness, and
>
> (C) are needed because the time required to reach the organization's providers or suppliers would have meant risk of serious damage to the patient's health.

Except for minor differences, this language essentially codifies HCFA's current regulatory definition of emergency services provided to Medicare HMO enrollees.[2/]

[2/] HCFA's regulatory definition of emergency services is as follows:

> Emergency services mean covered inpatient or outpatient services that--

(continued...)

However, HCFA has issued interpretive guidelines that significantly expand upon the plain meaning of its definition. Medicare and Medicaid Guide (CCH) ¶ 13,960.22 (1994). The House language incorporates some, but not all, aspects of these guidelines. The House bill's distinction between in-network and out-of-network services and its after-the-fact standard of claims review merit special discussion.

In-Network vs. Out-of-Network Distinction. The House definition is crafted to cover only out-of-network emergency services. It does not purport to cover emergency services provided by in-network providers. Indeed, the bill is silent on the provision of emergency services by the MedicarePlus organization. By contrast, the HCFA guidelines at least require Medicare HMOs to make medically necessary emergency care available 24 hours a day, 7 days a week. The House language does require that MedicarePlus organizations provide services "with reasonable promptness," (b)(1)(A), on a "24 hours a day and 7 days a week" basis, (b)(1)(B), but it does not speak to emergency services per se. Thus, while the House language requires that coverage of out-of-network emergency services must be provided without prior authorization and without regard to the provider's contractual relationship, the bill apparently permits a network organization to adopt its own definition of in-network emergency services and to develop its own guidelines and standard of review for reimbursing for such treatment.

After-the-Fact Standard of Review. Under the House bill, coverage for emergency services performed by either an in-network or out-of-network provider can

---

[2/] (...continued)

> (1) Are furnished by an appropriate source other than the HMO or CMP [competitive medical plan];
>
> (2) Are needed immediately because of an injury or sudden illness; and
>
> (3) Cannot be delayed for the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) without risk of permanent damage to the patient's health.
>
> These services are considered to be emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or designated alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition.

42 C.F.R. 417.401. Note that a competitive medical plan or CMP is a prepayment organization that does not meet the strict requirements of the HMO provisions of the Public Health Service Act but which is still capable of providing services to Medicare beneficiaries on a prepaid basis. 42 C.F.R. 417.407(c).

be denied because of an after-the-fact determination by the MedicarePlus organization that the patient's condition did not meet the criteria for emergency services. For instance, what reasonably appeared to the patient to be a heart attack, may have been something less serious. Nonetheless, the attending physicians would have to run a series of costly tests to rule out the possibility of heart attack. As a result, reimbursement can be denied for potentially expensive services, leaving the beneficiary with the bill or, in many cases, leaving the physician and hospital without payment. The House definition of emergency services, on its face, leaves no room for consideration of the patient's personal judgment of the seriousness of his or her presenting condition.

HCFA's guidelines clarify that it did not intend for its regulations to have this harsh effect. Instead, the guidelines adopt a patient-oriented claims review standard. First, the guidelines state that an emergency is determined at the time service is delivered, not when the claim is being reviewed. So, after-the-fact evaluations are not permitted. Second, HMOs are told not to retroactively deny a claim because a condition which appeared to be an emergency turns out to be a non-emergency in fact. This standard is comparable to the prudent layperson standard in the Senate bill.

Notably, even with HCFA's guidelines, there have been reports of significant problems in the review of emergency services claims submitted by Medicare HMO enrollees. According to a study by Network Design Group, the organization that administers the appeals system for Medicare HMO claims, emergency services are prone to a disproportionately high rate of denial. Daivd A. Richardson, James Phillips, Dean Conley Jr., A Study of Coverage Denial Disputes Between Medicare Beneficiaries and HMOs, Network Design Group, Inc. 3 (September 1993) ("NDG Study").[3/] For instance, over half of Medicare HMO denials involve emergency services even though they represent a much lower percentage of total HMO services. Id.. As stated in the report:

> Nearly 60% of the sample cases involved disputes over *in-area emergency services* and *'urgent' out-of-area services*. Plans' denials were upheld in 75% and 60% of these cases, respectively, The authors conclude that these case types are "dispute prone" and most often decided against the beneficiary due to HCFA's regulatory definitions of 'emergency' and 'urgent.' These definitions place enrollee's in the unreasonable position of making quasi-clinical evaluations of their symptoms and conditions and do not, expressly, make allowances for subjective experience (e.g., pain or suffering). As a consequence,

---

[3/] See also Special Report: "MCOs, Emergency Room Doctors, at Odds over Coverage of Urgent Care, 4 BNA's Health Law Reporter 1545 (Oct. 12, 1995); Robert Pear, H.M.O's Refusing Emergency Claims, Hospitals Assert, New York Times, July 9, 1995, at 1.

> enrollees who appear to act prudently from a lay perspective may face substantial or even catastrophic out-of-pocket liabilities.

Id. It is evident from NDG's conclusions that HCFA's definition is being followed, but its guidelines are not, particularly the rule against after-the-fact denials. The NDG authors believe a large percentage of denials may be attributed to the claims reviewer's retrospective evaluation that a particular condition treated was not an emergency. In other words, what seemed like an emergency to the patient at the time, turned out to be something less serious. In addition to shifting costs to patients or providers, a disproportionately high rate of denials may discourage HMO enrollees from using emergency room services and from calling 911. The problems associated with excessive denial rates may be particularly acute for seniors, whose symptoms are more difficult to diagnose, who often are unable to understand complicated gatekeeper rules, and who typically are in no position to pay expensive medical bills.

Excessive denials of emergency services claims also put physicians and hospitals in a difficult situation. Under the federal Emergency Medical Treatment and Act Labor Act (EMTALA), physicians and hospitals that participate in Medicare must provide "an appropriate medical screening examination" to any patient who presents in an emergency room, without regard to insurance coverage or ability to pay. 42 U.S.C. § 1395dd(a). If an emergency condition exists, the patient must be stabilized before transfer or release. § 1395dd(b).[4/] But, if the emergency condition is ruled out and the HMO denies reimbursement because the criteria for an emergency were not met, the physician and/or hospital either have to bill the patient or forgo payment. This may be true even though the non-emergent care provided was medically necessary if the HMO's gatekeeper or prior authorization rules were not followed.

Based on its statistical analysis of HMO denials of emergency claims, NDG recommends that the definitions of "emergency" in the Medicare regulations be modified so that a reasonable and prudent lay person can anticipate claims that would be covered versus denied. NOG Study at 3.

B. **The Senate Bill**

The Senate bill defines both "emergency services" and "emergency condition." The bill defines "emergency services" to mean:

> (A) health care items and services furnished in the emergency department of a hospital (including a trauma center), and

---

[4/] Ironically, EMTALA does not impose a similar duty on HMOs or other managed care organizations. Dearmas v. Av-Med, Inc., 814 F. Supp. 1103 (S.D. Fla. 1993) (EMTALA does not apply to HMOs or similar health plan providers).

(B) ancillary services routinely available to such department,

to the extent they are required to evaluate and treat an emergency condition (as defined in paragraph (5)) until the condition is stabilized.

Paragraph 5 then defines "emergency condition" as:

a medical condition, the onset of which is sudden, that manifests itself by 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--

(A) placing the persons health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

Thus, the Senate bill addresses the two principal problems identified by NDG with the current system of reviewing claims for emergency medical services. First, it applies a prudent layperson standard of review. Second, the definition of emergency condition applies equally to in-network and out-of-network emergency services.

The Senate bill would codify the HCFA guidelines, rather than the HCFA regulation. In doing so, it would change the focus of the claims review process for emergency services from the patient's discharge diagnosis to the patient's presenting symptoms. It also could reduce much of the confusion between in-network or out-of-network services by eliminating this distinction from the definition of emergency medical condition.

The Senate bill also links the definition of emergency medical services for purposes of the Medicare managed care program with the screening and treatment requirements of the EMTALA. Likewise, the bill requires 24-hour-a-day, 7 day-a-week access to those persons empowered to provide prior authorization for non-emergency care identified as promptly needed by an EMTALA screening examination. These provisions should help reduce confusion in the claims review process while relieving physicians and hospitals of the "Catch-22" created by the overlap of these programs.

II. Legal Implications of Alternative Bills

A. House Bill

By codifying HCFA's regulation, the definition of "emergency medical services" in the House reconciliation bill could have the unintended effect of exacerbating the disproportionate rate of emergency services denials by Medicare HMOs and other managed care organizations. The enactment of the House language will make it more difficult to address these problems through administrative change or legal challenge by patients or emergency providers.

First of all, any attempt by HCFA to enforce those aspects of its guidelines that are inconsistent with or not clearly authorized by the House reconciliation language (including, principally, the agency's version of the prudent layperson standard) would be highly vulnerable to legal challenge. "It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress." Bowen v. Georgetown University Hospital, 488 U.S. 204, 208 (1988). See also Ashton v. Pierce, 716 F.2d 56, 60 (D.C. Cir. 1983) (subsequent history omitted) ("'for regulations to be valid they must be consistent with the statute under which they were promulgated'"). It is doubtful whether HCFA's guidelines would meet this test if the House bill were enacted. For instance, there is nothing in the House language that states or even implies that MedicarePlus organizations need give any weight to the patient's symptoms and subjective feelings. Instead, like HCFA's regulations, the language focuses on whether the patient was actually diagnosed with a condition that posed an immediate risk of serious damage to the patient's health.

In these circumstances, a MedicarePlus organization could successfully argue that the HCFA guidelines are beyond the scope of the agency's legislative authority and inconsistent with the statutory definition of emergency services. A federal court would then be justified in invalidating the guidelines as in direct conflict with the Medicare Act or as "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" under the Administrative Procedure Act, 5 U.S.C. 706. See, e.g., Cosgrove v. Bowen, 898 F.2d 332 (2d Cir. 1990) (HHS method of recalculating physician reimbursement under Medicare Part B was arbitrary and capricious and not required by the Medicare Act).

One could argue that the HCFA guidelines may already be subject to challenge if they are inconsistent with the agency's own regulations. But, while it is true that an agency policy statement can be overturned if it is inconsistent with agency regulations, it is also true that courts tend to give agencies extensive deference in interpreting their own rules--significantly more than when agencies are interpreting their statutory authority. Udall v. Tallman, 380 U.S. 1, 16-17 (1965).

Thus, HCFA has been able to at least try to address the problems associated with excessive denials of emergency services claims by issuing interpretive

guidelines. So far these guidelines have not been attacked as inconsistent with HCFA's regulatory definition. It is doubtful whether HCFA could continue to evade a legal challenge if its regulations were codified into statute. It is fair to say, then, that the problem of disproportionate denials of emergency services by MedicarePlus organizations will likely worsen if the House bill is enacted.

Enactment of the House language will also help to insulate the MedicarePlus claims review process from legal attack by patients and providers. The problems described in the NDG study arguably implicate the property rights of patients, physicians, and hospitals. Medicare enrollees are reportedly being denied claims for emergency services that are medically necessary, but which do not strictly meet the criteria for an emergency or for which prior authorization was not given. Denials are also occurring in situations where the patient reasonably believes an emergency exists, but the subsequent screening evaluation shows otherwise. In addition, patients who seek in-network emergency services may be more likely to have their claims denied than those who seek comparable out-of-network services. Based on these facts, a Medicare enrollee or a group of enrollees could potentially attack the claims review system as inconsistent with the HCFA guidelines and arbitrary and capricious under the Administrative Procedure Act. A hospital or physician could likewise argue that requiring providers to screen all patients, including all Medicare patients, for emergency conditions and then withholding payment in a disproportionate number of cases, is both arbitrary and capricious. See, e.g., Bowen v. Georgetown University Hospital, 488 U.S. 204, 216 (1988) (Scalia, J., concurring) (striking down HHS retroactive attempt to recoup payments from Medicare hospitals as both beyond statutory authority and arbitrary and capricious); Cosgrove, supra.

By contrast, if the House bill were enacted, the current problems in the claims review process would be much less vulnerable to legal attack by patients and emergency providers. To mount such a challenge, an enrollee or provider would have to argue that the claims review system was fundamentally unfair, in violation of substantive due process or the equal protection clause. Alternatively, a provider might argue that requiring a hospital to screen all Medicare patients and then withholding payment for such screenings is an unconstitutional taking without just compensation.

But such claims would be very difficult to sustain. Although courts afford agencies considerable deference in implementing their statutory authority, the presumption of regularity afforded to agency decisionmaking is not nearly as strong as the presumption of constitutionality afforded legislation. Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Auto. Ins. Co., 463 U.S. 29, 43 n.9 (1983). This presumption is particularly formidable for economic and social legislation, as opposed to fundamental privacy rights or suspect classifications. Williamson v. Lee Optical of Oklahoma, Inc., 348 U.S. 483, 487-88 (1955). Moreover, the relevant constitutional standards (substantive due process, equal protection, taking of property without just compensation) are themselves heavily weighted in favor of duly enacted legislation. See, e.g., Nebbia v. New York, 291 U.S. 502, 537 (1934) ("If the laws passed are seen to have a reasonable relation to a proper legislative purpose, and are neither

arbitrary nor discriminatory, the requirements of [substantive] due process are satisfied"); New Orleans v. Dukes, 427 U.S. 297, 303 (1976) (unless provisions challenged under equal protection clause infringe upon a fundamental liberty interest or contain a suspect classification, the courts "presume the constitutionality of the statutory discrimination and require only that the classification challenged be rationally related to a legitimate [government] interest").

Thus, courts have routinely rejected substantive attacks on Medicare and Medicaid fee limits, finding these laws to be rationally related to a legitimate legislative purpose. See, e.g., Whitney v. Heckler, 780 F.2d 963, 968-972 (11th Cir.), cert. denied, 479 U.S. 813 (1986) (temporary freeze on fees that physicians can charge Medicare patients did not violate substantive due process); Minnesota Ass'n of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare, 742 F.2d 442 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985) (Minnesota statute limiting the rates that nursing homes participating in Medicaid program may charge patients who do not receive Medicaid benefits not unconstitutional). They have been even more reluctant to hear unjust takings claims. See, e.g., Garelick v. Sullivan, 987 F.2d 913, 916-18 (2d Cir.), cert. denied, 114 S. Ct. 78 (1993) (limits on amounts physicians may charge Medicare patients over reimbursement levels do not effect an unconstitutional taking because physicians voluntarily participate in Medicare).[5/] Indeed, one court has held that the EMTALA requirement that physicians screen indigent patients does not violate the takings clause because physicians who treat emergency patients voluntarily work for hospitals that participate in Medicare and are otherwise not specifically required by EMTALA to treat patients. Burditt v. U.S. Dept. of Health and Human Services, 934 F.2d 1362, 1376 (5th Cir. 1991). This precedent would make it particularly difficult for an emergency physician or hospital to challenge the MedicarePlus claims review system for emergency services.

While the logic of these cases may be subject to question, they are generally indicative of a judicial antipathy for constitutional attacks on the Medicare statute. See also New York State Ophthalmological Society v. Bowen, 854 F.2d 1379 (D.C. Cir. 1988), cert. denied, 490 U.S. 1098 (1989) (constitutional privacy doctrine did not protect cataract patients' medical choice, which was substantially impeded by Medicare amendment prohibiting physicians from billing for an assistant cataract surgeon).

In short, passage of the House bill will effectively codify the HCFA regulations and the problems that have been associated with those rules. See NDG Study, supra. Putting this language into statutory form could effectively prevent HCFA from applying a prudent layperson standard or other administrative innovations. It will

---

[5/] See also Metrolina Family Practice Group, P.A. v. Sullivan, 767 F. Supp. 1314, 1322 (W.D.N.C. 1989) (various Medicare fee-related amendments do not violate Fifth Amendment rule against takings); AMA v. Bowen, 659 F. Supp. 1143, 1150 (N.D. Tex. 1987) (OBRA-86 price regulations not an unconstitutional taking).

also serve to insulate the current flawed claims review system from legal attack by Medicare enrollees and emergency providers.

B. Senate Bill

As discussed above, the Senate Bill addresses the two principal problems with the House reconciliation definition of emergency services. First, it adopts a review standard based on the patient's symptoms and subjective feelings at the time the patient goes to the emergency room. Second, the bill does not distinguish between in-network and out-of-network services.

The prudent lay person standard has been applied to the HMO claims review process for emergency services in three states: Maryland, Virginia, and Arkansas. It is based on the premise that the patient's subjective assessment of the severity of his or her symptoms is central to the patient's decision to seek emergency medical services. However, the standard itself is not subjective. Rather, it creates an objective test by comparing the patient's assessment with that of an average or reasonably prudent layperson. In other words, it requires the claims reviewer to ask whether a reasonable person of average sensibilities and intelligence would have gone to the emergency room if he or she were presented with similar circumstances (*e.g.*, pain, bleeding, discomfort).

The prudent layperson standard is derived from the longstanding reasonable person test used in contract and tort law. See Corbin on Contracts, § 560 at 274; Prosser and Keeton on Torts § 32 at 173 (5th ed. 1984). As Prosser and Keeton states, "Sometimes he is described as a reasonable person, or a person of ordinary prudence, or a person of reasonable prudence, or some other blend of reason and caution." Id. at 174. The conduct of the reasonable person varies with the situation. Negligence, for example, "is a failure to do what the reasonable person would do 'under the same or similar circumstances.'" Id. at 175 (quoting Second Restatement of Torts, § 283).

The term "prudent layperson" has been used specifically to interpret insurance agreements, but has been employed in many other contexts as well. See, e.g., Bausch & Lomb, Inc. v. Utica Mutual Ins. Co., 330 Md. 758, 778, 625 A.2d 1021 (1993) ("A word's ordinary signification is tested by what meaning a reasonably prudent layperson would attach to the term"). See also Martin v. Griffin, 117 Wis. 2d 438, 443, 344 N.W.2d 206, 209 (Ct. App. 1984) ("Excusable neglect [in responding to a court's scheduling orders] is 'that neglect which might have been the act of a reasonably prudent person under the same circumstances'. . . .") (citations omitted).

By codifying the prudent layperson standard into statute, the Senate bill would likely lead to fewer rather than more denials of emergency services claims. The NDG study shows rather clearly that despite the presence of provisions in HCFA's guidelines that arguably resemble the prudent layperson standard, HMOs have been disproportionately denying claims for emergency services. At the same time, NDG has

upheld 60-75% of these denials. This suggests that both HMOs and NDG are following the regulatory definition of emergency services rather than the HCFA guidelines. See NDG Study at 3 (concluding that denials most often decided against the beneficiary because of HCFA's regulatory definitions of "emergency" and "urgent"). Enacting the prudent layperson standard into statute should engender greater compliance by MedicarePlus organizations and provide beneficiaries with stronger grounds for appealing improper denials.

On the other hand, the prudent layperson standard will not emasculate the claims review process. MedicarePlus organizations will still review the reasonableness and medical necessity of claims and deny those that are frivolous. Nor does the adoption of the prudent layperson standard force the claims reviewer to defer to the subjective judgment of the enrollee. Rather, the prudent layperson standard only serves to shift the focus of the inquiry from an objective review of the reasonableness of the ultimate medical diagnosis to an equally objective evaluation of the reasonableness of the patient's response to his or her symptoms, as judged from the perspective of a layperson of ordinary prudence.

Of course, the Senate language would give HCFA flexibility to interpret the prudent lay person standard through regulations, guidelines, or policy statements. Accordingly, the agency could restrict the definition in the unlikely event that Medicare enrollees began to overuse emergency services. By the same token, HCFA could further expand upon the definition if MedicarePlus organizations fail to apply it correctly or continue to deny a disproportionate number of emergency services claims.

We hope this analysis is helpful. Please call us if you have any questions.

K:\...\RMP\ACEP\SCOTT1.MEM

which the other entity agrees to furnish specified services to Medicare enrollees of the HMO or CMP, but the HMO or CMP retains responsibility for those services. Under an arrangement, Medicare payment to the HMO or CMP discharges the beneficiary's obligation to pay for the service.

Benefit stabilization fund means a fund established by HCFA at the request of an HMO or CMP with a new risk contract to withhold a portion of the per capita payments available to the HMO or CMP for payment in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits provided by the HMO or CMP to its Medicare enrollees.

Demonstration project means a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b–1 (note)), relating to the provision of services for which payment is made under Medicare on a prospectively determined basis.

Emergency services means covered inpatient or outpatient services that—(1) Are furnished by an appropriate source other than the HMO or CMP;

(2) Are needed immediately because of an injury or sudden illness; and

(3) Cannot be delayed for the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) without risk of permanent damage to the patient's health.

These services are considered to be emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or designated alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition.

Geographic area means the area found by HCFA to be the area within which the HMO or CMP furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means an individual who is entitled to Medicare benefits (Part A and Part B or Part B only) and who has been identified on HCFA records as an enrollee of an HMO or CMP that has a contract under section 1876 of the Act.

New Medicare enrollee means a Medicare enrollee who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part;

(2) Is entitled to both Part A and Part B benefits under Medicare or Part B benefits only at the time of the enrollment; and

(3) Was not enrolled with the HMO or CMP at the time he or she became entitled to benefits under Part A or eligible to enroll in Part B of Medicare.

Risk contract means a contract entered into under section 1876(g) of the Act on or after February 1, 1985.

Urgently needed services means covered services required in order to prevent serious deterioration of an enrollee's health that results from an unforeseen illness or injury if—

(a) The enrollee is temporarily absent from the HMO's or CMP's geographic area; and

(b) Receipt of the health care service cannot be delayed until the enrollee's return to the HMO's or CMP's geographic area.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 28573, Aug. 8, 1986; 56 FR 46569, Sept. 13, 1991; 56 FR 51986, Oct. 17, 1991; 58 FR 38072, July 15, 1993]

§417.402 Effective date of initial regulations.

The changes made to section 1876 of the Act by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 became effective on February 1, 1985, the effective date of the initial implementing regulations.

[58 FR 38072, July 15, 1993]

§417.404 Introduction.

(a) *General requirements.* In order to participate as an HMO or CMP under Medicare, an entity must—

(1) Establish that it is an HMO or CMP; and

(2) Satisfy the contract requirements for an HMO or CMP to enter into a contract with HCFA.

(b) *Applicable regulations.* (1) Sections 417.406 and 417.407 set forth the require-

- Physician assistants (see MCM § 5259);
- Nurse practitioners (see MCM § 2156) *;
- Clinical nurse specialists *;
- Nurse midwives (see MCM § 2138); and
- Certified registered nurse anesthetists (see MCM § 5261).

See § 2153.4 for a discussion of the coverage of auxiliary personnel when furnished without physician supervision.

* Section 4155 of the Omnibus Budget Reconciliation Act of 1990 amended coverage of nurse practitioners in rural areas and added coverage of clinical nurse specialists effective January 1, 1991.

B. *Transplants.*—You are required to cover organ and tissue transplants that the Secretary determines are not experimental. Required transplants include:

- Kidney (see CIM § § 35-35, 35-58, 45-22, and 50-26 [¶ 27,201]);
- Heart (see CIM § 35-87);
- Liver (see CIM § 35-53);
- Bone marrow (see CIM § 35-30); and
- Cornea.

You are required to provide or arrange for certain transplants in out-of-area hospitals. Heart and liver transplants may only be performed in Medicare approved transplant centers. Not all hospitals performing transplants are Medicare approved transplant centers, even if they are participating hospitals for other services.

If one of your Medicare enrollees is a candidate for heart or liver transplant surgery, give him/her written notification that the procedure is a covered Medicare service and that it is performed in facilities approved by Medicare. The transplant facility makes the determination as to whether the enrollee meets the patient selection criteria. Refer your enrollees who are appropriate candidates only to Medicare approved heart or liver transplant facilities for evaluation. HCFA notifies you of each new Medicare approved transplant facility. The Regional Office (RO) has a complete list of these facilities. The facility determines whether to perform the transplant. Failure to refer appropriate candidates to, or to provide or arrange for the service in, a Medicare approved heart or liver transplant center is subject to a civil money penalty of up to $25,000 for each violation.

C. *Midyear Coverage Changes.*—As benefits become covered, they must be made available to Medicare enrollees on the effective date of Medicare coverage. The cost of providing new or expanded benefits which are mandated by Congress midyear must be borne in its entirety by contracting risk HMOs and CMPs. However, when the Secretary expands benefits which the Secretary identifies as involving significant costs, and these benefits were not included in the adjusted average per capita cost (AAPCC) calculation, risk-based HMOs and CMPs are not responsible for providing or paying for these benefits. When HMO/CMP enrollees receive such services, Medicare pays the benefits under fee-for-service until the next contract year, when the benefits are included in the AAPCC.

HMO/CMP Manual § 2102 (as revised by Trans. 9, Jan. 1992).

The Secretary is required to study the availability of covered chiropractic services in HMOs and present its findings to the congressional committees no later than January 1, 1993 (¶ 17,805).

Sec. 4204 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). [A summary of the law was originally reported at NEW DEVELOPMENTS ¶ 38,951.]

.22 **Emergency and urgently needed services.**—HCFA guidelines state as follows:

Emergency Services

Assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See § 2107 [¶ 13,960.35] for the permissible limits on the amount you must pay.)

Definition.—Use the definition provided in 42 CFR 417.401. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

Example: While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the HMO/CMP is required to pay for the physician's services because the enrollee's

medical condition appeared to require immediate medical services.

There does not need to be threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treates a skin lesion. You are not responsible for any costs, such as biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, pay the cost of medically necessary follow-up care. (See § 2105.)

Transfers.—If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under § 1867 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See § 1867(c)(2) of the Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:

—Provides medical treatment to minimize the risks to the individual,

—Forwards all relevant medical records, and

—Uses qualified personnel and transportation equipment for the transfer;

- The receiving facility:

—Has available space and qualified personnel, and

—Except for specialized facilities that under § 1867(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and

- The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO/CMP.

HMO/CMP Manual § 2104 (as revised by Trans. 9, Jan. 1992).

Urgently Needed Services

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or an injury. Cover these services if:

- The enrollee is temporarily absent from your geographic area, and

- The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. Your marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee's rights in these situations.

Example: A 72 year old man had a left femoral bypass graft 6 weeks ago. He goes on his previously scheduled vacation to his sister's house who lives out of the service area. While there, he beings to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

Pay for the physician's services because the enrollee's medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to your service area.

Services that can be foreseen are not considered urgently needed services, and you are not required to pay for these services without prior authorization.

For example, you are not required to pay without prior authorization when a member who needs routine dialysis or oxygen therapy travels outside your service area for a personal emergency or a vacation. Develop a clear policy on your responsibility and the beneficiary's financial responsibility in these situations. Consider making special arrangements with providers outside your service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application. Marketing materials must clearly describe the limits of your out-of-area coverage.

Assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in your plan. However, if the enrollee is absent for an extended period (beyond 90 consecutive days) and you have not been notified and have not arranged for membership to continue, you may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If you do not disenroll the beneficiary and you knew that he/she is absent for more than 90 consecutive days, then you are liable for all services rendered, including routine care. (See § § 2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

HMO/CMP Manual § 2105 (as revised by Trans. 9, Jan. 1992).

.25 ESRD treatment setting.—HCFA guidelines for HMOs/CMPs are as follows:

Patients may be treated at a facility or at home. Since it is not likely that all enrollees with ESRD are good candidates for home dialysis, be prepared to make the service available in either setting. It is not appropriate for you to have an across-the-board policy that all of your patients dialyze at home.

Your physician must develop, in consultation with the ESRD patient, a personalized patient care plan reflecting the psychological, social and functional needs of the patient as well as medical considerations. Patients must also be consulted when changes are made in a treatment plan.

If you wish to transfer a patient from facility to home dialysis, you must give the patient advance notice to ensure orderly transfer. A patient may be transferred only for medical reasons, for the patient's welfare or that of other patients, or for nonpayment of fees. An ESRD patient may not be forced into home dialysis solely for economic reasons.

HMO enrollees may appeal the ESRD treatment that you provide through the HMO and Medicare appeals procedures. Enrollees may also appeal through the ESRD network patient grievance procedure. Information on the latter appeals process is provided to the beneficiary directly by the ESRD treatment facility.

HMO/CMP Manual § 2114 (as revised by Trans. 9, Jan. 1992).

.30 Health screening.—HCFA guidelines for HMOs and CMPs are as follows:

Except as provided below, do not require a Medicare enrollee, as part of enrollment, reenrollment or receipt of any services, to submit to or pass a health examination. This prohibition on health screening applies to any service or set of services offered to Medicare enrollees, whether they are required services under Medicare, additional services, or mandatory or optional supplemental services. This prohibition applies to HMOs/CMPs which contract with HCFA on a risk or cost basis.

There are penalties specified in law for violations of the health screening prohibitions. (See § 1016.)

Exceptions.—Do not enroll persons who have been medically determined to have end stage renal disease (ESRD) or who have elected the Medicare hospice benefit (unless they are already enrolled in the organization and convert to the Medicare contract when they become Medicare eligible, in which case you may not disenroll them). Question the applicant to determine whether he/she has ESRD or has made a Medicare hospice election. You may also question Medicare beneficiaries about whether they reside in an institution for purposes of determining proper payment under a risk contract.

HMO/CMP Manual § 2111 (as revised by Trans. 9, Jan. 1992).

.31 Hospice care limitation.—HCFA guidelines are as follows:

You are not required to furnish hospice care. If an enrollee elects Medicare hospice coverage, the care

John

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Washington, D.C. 20201

MAR 27 1995

TO: CURRENT MEDICARE-CONTRACTING HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SUBJECT: FINANCIAL RESPONSIBILITY FOR EMERGENCY SERVICES

Dear Sir/Madam:

As a result of complaints received regarding access to emergency services in managed care, we are sending this letter to remind all Medicare-contracting HMOs and CMPs of policies relating to the provision of emergency services for Medicare beneficiaries.

The enclosed document (Operational Policy Letter 95-5) references regulatory and HMO/CMP manual citations relating to emergency services.

Sincerely,

Rodney C Armstead MD

Rodney C. Armstead, M.D.
Director

cc: OMC Management Team
RO Managed Care Contacts
Network Design Group
PASS System

Enclosure

Office of Managed Care
Operational Policy Letter 95-5

Issue:

Policies relating to the provision of emergency services for Medicare beneficiaries.

Policy:

Federal regulations at Title 42 Part 417.414(c)(1) state:

> An HMO or CMP must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in § 417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the HMO or CMP <u>even in the absence of the HMO's or CMP's prior approval</u>. [Emphasis added].

Therefore, Medicare-contracting managed care plans cannot require prior authorization for emergency services. This policy is also stated in section 2104 of the HMO/CMP manual: "Do not require prior authorization."

In addition, section 2104 of the HMO/CMP manual states "Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature." Therefore, if emergency services appeared to be needed, plans may not decide upon retrospective review to refuse to cover emergency services provided.

Refer to section 2104 of the HMO/CMP manual for further detail on Medicare policies relating to emergency services.

Contact Person:

Anne Manley, Office of Managed Care, (202) 619-3166

A STUDY OF COVERAGE DENIAL DISPUTES BETWEEN MEDICARE BENEFICIARIES AND HMOs

A STUDY OF COVERAGE DENIAL DISPUTES BETWEEN MEDICARE BENEFICIARIES AND HMOs

by David A. Richardson, Project Director
James Phillips, Research Associate
Dean Conley Jr., Project Consultant

Federal Project Officer: Alma McMillan

Network Design Group, Inc.

HCFA Cooperative Agreement No.: 17-C-90070/2-01

September 1993

TABLE OF CONTENTS

TABLE OF CONTENTS
(CONTINUED)

EXECUTIVE SUMMARY

Almost 2 million Medicare beneficiaries are enrolled in Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). Compared with fee-for-service Medicare, these Plans offer expanded benefits and reduced beneficiary cost sharing. But HMOs/CMPs restrict enrollee access to networks of participating providers and subject members to gatekeeper systems and utilization controls. These managed care features can result in HMO/CMP denial of members' insurance claims or withheld authorization for referrals. To address claim denial conflicts between enrollees and Plans, HCFA regulations prescribe a mandatory multi-level appeal system. An initial appeal is provided by the Plan itself. But if this appeal is not totally favorable to the enrollee, the case is automatically referred to HCFA for an impartial/independent "Reconsideration". Since 1989 these on-the-record Reconsiderations have been conducted by Network Design Group, Inc. (NDG), a contractor to HCFA and grantee for this Study. Over 10,000 Reconsideration cases were processed by NDG from 1989 to 1992.

Some level of coverage disputes between enrollees and Plans is probably inevitable and may even be a positive sign of experimentation. But higher rates of disputes increase Plan and HCFA administrative costs and may negatively impact subscriber satisfaction and enrollment growth. Moreover, if an enrollee errs in understanding of HMO benefits and loses a Reconsideration, that individual can be faced with a large and unexpected medical claim. Conversely, if the HMO errs it will inappropriately shift liability for a medical claim to the enrollee or withhold a medically necessary service. Accordingly, the general objective of this research was to gain an understanding of types, causes and outcomes of Reconsideration cases with the hope that strategies for reducing enrollee/Plan disputes might emerge.

The Study's literature review failed to identify *any* published studies or reports on Medicare HMO/CMP Reconsiderations or managed care benefit dispute programs. But the literature did suggest many factors (e.g., Medicare beneficiary confusion about insurance coverage) that are logically related to enrollee/Plan coverage disputes. The authors offer a description of the Medicare Reconsideration system to fill this void in the literature and suggest characteristics of managed care Plans and enrollees that might lead to claim denials and disagreements.

Secondly, this Study reports summary statistics on Reconsideration disputes taken from an administrative data system maintained by HCFA and the contractor, NDG. From 1989 through 1991, the volume of Reconsideration disputes increased substantially from 1,688 to 3,700 cases. This volume increase exceeded growth in Medicare HMO/CMP enrollment and produced a "Reconsideration Rate" ranging

by year from 1.7 to 2.2 Reconsiderations per 1,000 members. In these years, NDG's independent Reconsideration decisions "upheld" Plans (approved their claim denial) in 56% to 63% of cases. Conversely, in 37% to 44% of cases, by year, it was determined that HMO/CMPs improperly denied benefits and then maintained the inappropriate denial in the Plan level appeal hearing. The total of dollars in dispute in the four year set of Reconsideration cases was over $24 million, with an average case value of $2,753. Of this total, over $13 million in HMO/CMP claim denials were deemed inappropriate via Reconsideration. The authors conclude that while Reconsideration rates are modest program wide, nearly 2,500 enrollees would have faced inappropriate claim liability, averaging about $2,500, absent the independent appeal system. Although Plans legitimately denied claims in approximately two-thirds of Reconsideration cases, enrollees in these cases may have misunderstood managed care rules and hence still faced unexpected, but often large, out-of-pocket liabilities.

The third and major emphasis of this Study was a more detailed analysis of Reconsideration cases based upon a modified content analysis of a random sample (N = 747) of narrative 1991 case files.

Enrollees in the sample cases were found to be a diverse group on a host of demographic measures. A small portion of them were dependent and/or evidenced functional limitations which contributed to problems of understanding or complying with HMO/CMP gatekeeper and related rules. But the majority of enrollees did not evidence such problems, so special limitations of enrollees are not a primary cause of coverage misunderstandings and disputes. Ten percent of the disputes occurred within the first 90 days of enrollment and a third within the first year. The novelty of the HMO experience may thus account for some, but not the majority, of disputes. Forty-two percent of a random sub-sample of enrollees disenrolled within two years following the disputed service and 63% of these individuals disenrolled within 90 days of the contested service. Claims disputes therefore contribute to the general Medicare HMO problem of turnover via disenrollments.

Study of the Reconsideration process revealed that approximately one third of enrollees are represented in their appeal by another person--most often a family member. Enrollee's present their appeal to the HMO in person or by phone in less than 10% of cases and most Reconsideration case files contain minimal written arguments from the enrollee. Based upon job titles found with in the case records, Plan administrators versus medical personnel most frequently manage the Plan's appeal. The involvement of Plan medical personnel in denials and Reconsideration does not increase when the Plan's basis for denial is a medical necessity issue. It appears that enrollees could be more vigorous and effective in presenting their

appeal arguments. But, Plans could also more thoroughly explain and document their reasons for claim denials.

Data describing attributes of the substance of these disputes (e.g., type of denied medical care, cost, provider characteristics, and use of gatekeeper procedures, etc.) are presented. Although on the surface Reconsideration cases often appear idiosyncratic, combined use of the Study's descriptive measures yielded a structure of seven underlying case types.

Six percent of the sample cases fell within the first case type, *retroactive disenrollment.* These cases represent a total breakdown in the enrollee's understanding of, or compliance with, managed care and are five times more costly than other case types. The *skilled nursing* (5% of cases) case type is also of above average cost. This is the only type in which Plan denials are overturned more frequently than they are upheld, primarily because Plans and their SNF providers fail to comply with Medicare's "Notice of Non Coverage" rules. The *chiropractic* (2.4% of cases) case type is small, but noteworthy again because of benefit rules which cause Plans particular difficulties.

Nearly 60% of the sample cases involved disputes over *in-area emergency services* and *"urgent" out-of-area services.* Plans' denials were upheld in 75% and 60% of these cases, respectively. The authors conclude that these case types are "dispute prone" and most often decided against the beneficiary due to HCFA's regulatory definitions of "emergency" and "urgent". These definitions place enrollee's in the unreasonable position of making quasi-clinical evaluations of their symptoms and conditions and do not, expressly, make allowance for subjective experience (e.g., pain or suffering). As a consequence, enrollees who appear to act prudently from a lay perspective may face substantial or even catastrophic out-of-pocket liabilities.

The final two case types, *in-area plan provider* and *non-plan provider,* are the "garden variety" controversies which one would expect to predominate in a managed care setting, but play a lessor role (27% of cases) due to the high rate of emergent and urgent Reconsiderations. These cases span all possible categories of medical services and arise for a variety of reasons that defy any single or simple explanation.

The authors conclude that neither enrollees nor Plans can be uniformly criticized for lack of understanding or compliance with the many rules and conditions of the Medicare managed care model. A minority of cases evidence abuse or unacceptable behavior by one of these parties. But, in general, the problems are more subtle and reflect the dynamic tension between enrollees seeking "comprehensive care" and Plans seeking to profit by obtaining appropriate

utilization. One theme which does emerge is that the HMO model should not make unreasonable demands on enrollee or Plan understanding and judgement, but does in some areas (e.g., emergency and urgent care). Secondly, while the need for Plans to manage utilization is acknowledged, there is a clear difference between changing utilization behavior (i.e., preventing an "unnecessary" service) and denying claims after "inappropriate" utilization has occurred. The former is the goal of managed care and the latter is an administrative action which reduces HMO/CMP expense, but not costs in the health care system overall. Finally, some denials place enrollees who make "honest and reasonable" mistakes at risk of catastrophic out-of-pocket liabilities to providers who thereby profit from the enrollee's error. These penalties to Medicare enrollees seem, to the authors, out of proportion to the offense while creating perverse provider incentives.

The major recommendations offered by the authors are as follows:

1) Research on "inappropriate utilization" and its control by managed care systems should be better balanced by additional research on "inappropriate" denials occurring in these same systems. Statistical and monitoring systems, now largely geared to measurement of paid utilization and cost, should be expanded to report on managed care denials and "unpaid" utilization. Ideally, Reconsideration rates could be directly compared, by service category, with both rates of utilization and rates of initial HMO denials.

2) The existing Medicare Reconsideration system can be improved, primarily by better documentation and articulation of enrollee arguments and Plan denial rationales. But this system of mandatory and independent review of disputes is necessary. Payors other than Medicare (e.g., employers, States and coalitions) should also provide for mandatory/independent appeal systems.

3) The rate of disputes in the Medicare HMO/CMP program could be substantially reduced by focused corrective action on certain "dispute prone" utilization scenarios, particularly emergency and out-of-area. Definitions of "emergency" in regulation should be modified so that a reasonable and prudent lay person can anticipate claims that would be covered versus denied. Congress and HCFA should consider eliminating "out-of-area" services from the HMO/CMP benefit package with coverage of such services as a "residual" Medicare fee-for-service benefit, and with corresponding HMO/CMP premium reduction. If not, changes in the definition of "urgent out-of-area" care are also required.

4) HMO/CMPs, or HCFA should be permitted to force enrollees to surrender Medicare ID cards at the time of HMO enrollment. This action, which might require legislation, would eliminate one source of enrollee confusion and would preclude enrollees from knowingly or inadvertently presenting to non HMO providers as "Medicare beneficiaries."

5) Medicare enrollees require better protection, or expanded "limits of liability" from claims expense when such enrollees make honest errors in use of denied and non covered services. On the other hand, 15% of appeals are for claims under $100. Because HMO/CMP and HCFA costs for Reconsiderations are both well above this level, it may be fair and advisable for HCFA to set a minimum dollar threshold for Reconsiderations.

6) HMO/CMPs could reduce disputes to the extent they can influence their providers to improve communications with enrollees regarding managed care rules and coverage issues. Further reductions in disputes might be obtained if HMO/CMPs could motivate enrollees who perceived issues of quality and satisfaction to seek redress within the Plan, rather than seeking out-of-plan care.

7) The Medicare Reconsideration experience demonstrates that a broad uniform benefit package (i.e., the Medicare HMO benefit package) does not guarantee uniform coverage nor fully protect consumers from unexpected claims expense. Within the payor's (e.g., Medicare) benefit policies, insurers have considerable latitude to fashion technically and clinically complex micro-policies. The result is that a utilization scenario covered by one Plan may be denied by another. If "uniform coverage" is a goal of national health reform, but a "single payor" model is rejected in favor of regional, State or purchasing cooperative administration, the issue of non uniform benefit interpretation will be significant. Policy makers should provide for a national benefit policy interpretation system and policy enforcement by means including a national system for benefit denial appeals.

Am. Occup.

Am Ambulance

Emergency Physicians

Pafford Ambulance Service, Inc.

FAX Transmittal

P.O. Box 130
214 Main Street
Hermitage, AR 71647

FAX Number (800)532-7571
(501)463-8591
Office Number (800)451-8036

TO: Jennifer Klein

FAX Number: 202-456-2878

Date: 12-6-95

Number of Pages
(Including Header Page) 2

DEC 6 P12 :19

From: James Lyford

Comments: Thanks for your help -
P.S. Does anybody in your office know the name of the Memorabilia Shoppe on the corner (around from the White House) (We need to get a White House ornament) Big deal ☺

Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, AR 71647

Via facsimile 1-202-4562878

December 6, 1995

TO: Jennifer Klein

From: Jamie Pafford-Gresham

Thank you for returning my phone call. I am sorry to have missed you.

I was calling for several reasons. First, I have providers calling me all day asking what the situation is, and is there anything they can do to help. (nationwide) I do not Know what to tell them. If you can enlighten me with an answer I would appreciate it.

Second, The American Ambulance Association has been working with the democratic leadership. The input they are getting is that a fee schedule alone will not be enough to pass this, more has to be brought to the table. So, They are working with them to come up with a two part plan, short term providing a $$ amount (attached numbers being scored by CBO), and Long term being comprehensive reform.

Please let me know your thoughts on this, (are we working on the right thing?) Any input you have will be greatly appreciated. Normally, I can be reached at 1-800-451-8036, or 501-463-2653 in the evening.

Jennifer, I want to thank you and Julie, both for your patience you have had with me. I am slowly learning how things work and look forward to keeping on top of this issue.

Pafford Ambulance Service, Inc.

FAX Transmittal

P.O. Box 130
214 Main Street
Hermitage, AR 71647

FAX Number (800)532-7571
(501)463-8591
Office Number (800)451-8036

TO: Julie Demeo—

FAX Number: 1-202-456-2878

Date: 11-21-95

Number of Pages
(Including Header Page) 15

From: Janice Pafford

Comments: Help me out with the meeting with Carol K.
Call me if I can be of further Help—
Be Careful & Have a Happy Thanksgiving—

Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, AR 71647

VIA FACSIMILE 1-202-456-2878

November 21, 1995

To: Julie Demeo

From: Jamie Pafford-Gresham

As per our phone conversation, here are the documents I discussed with you. I have also attached a letter to Carol Rasco, asking for a meeting as soon as possible. (Try to help me out on this one!!)

Senator Pryor and Bonnie Hogue of his staff, have agreed to help in any way possible and are willing to change their schedule to attend the meeting if we can get one set up.

We helped with the language on H.R. 2485 and were hoping to get this adopted. Instead they went with the senate bill S.1357. This freezes us, puts us in a BELT, and only allows us to receive ALS payments when ALS is utilized. NO rural exceptions!!

Please let me know something as soon as possible. I hope you have a safe and Happy Thanksgiving.

104TH CONGRESS
1ST SESSION

H. R. 2485

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 1995

Mr. ARCHER (for himself, Mr. BLILEY, Mr. BILIRAKIS, Mr. THOMAS, Mr. HYDE, Mr. GREENWOOD, Mr. HASTERT, Mrs. JOHNSON of Connecticut, and Mr. MCCRERY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PURPOSE.

The purpose of this Act is to reform the medicare program, in order to preserve and protect the financial stability of the program.

NC

VOLUME 1

II

Calendar No. 216

104TH CONGRESS
1ST SESSION

S. 1357

To provide for reconciliation pursuant to section 105 of the concurrent resolution on the budget for fiscal year 1996.

IN THE SENATE OF THE UNITED STATES

OCTOBER 23, 1995

Mr. DOMENICI, from the Committee on the Budget, reported the following original bill; which was read twice and placed on the calendar

---

A BILL

To provide for reconciliation pursuant to section 105 of the concurrent resolution on the budget for fiscal year 1996.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Balanced Budget Reconciliation Act of 1995".

SEC. 2. TABLE OF TITLES.

The table of titles for this Act is as follows:

Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, AR 71647

VIA FACSIMILE 1-202-456-2878

November 21, 1995

Carol H. Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC

Dear Ms Rasco:

Sorry we missed you on the South Lawn of the White House on the 29th of September. We were able to converse with Mrs. Clinton for a few minutes. She spoke highly of you and your capabilities to help with our ambulance issues. She informed my father and I to keep in touch with you on any changes we felt necessary for the President to know about.

Congress has adopted Senate bill S.1357. This bill kills all work we have done on the rural issue, and will devastate the ambulance industry nationwide. House bill H.R. 2485, contains language pertaining to the ambulance industry that we helped develop. I have faxed several things to Julie Domeo, of your office staff to be reviewed. She has been a great help to us and is asset to your staff.

At this time, on behalf of the Arkansas Ambulance Association and American Ambulance Association, We would like to set up a meeting next week with you at your earliest convenience. Bonnie Hogue, of Senator Pryors Office, is willing to attend and help out in any way possible. She mentioned that the Senator would also try to make the meeting. I feel that there will be six attendees, representing both, the Arkansas and American Ambulance Associations, with an emphasis on rural providers.

Please contact us at 1-800-451-8036 if you or your staff have any questions. We will be anxiously awaiting your reply. Have a safe and Happy Thanksgiving!!

Sincerely,

Jamie Pafford-Gresham
Vice-President
Pafford Ambulance Service, Inc.

encloseures

JPG/jlp

AMERICAN AMBULANCE ASSOCIATION

Executive Offices
3800 Auburn Blvd., Suite C
Sacramento, CA 95821-2102
(916) 483-3827
FAX (916) 482-5473

Ambulance Savings Proposals

There are two areas of ambulance service under the Medicare program where significant savings could be achieved if HCFA would immediately implement changes. Both areas were the subject of recent HHS Inspector General reports. The American Ambulance Association (AAA) has studied both areas, developed recommendations, presented these reform proposals to HCFA, and testified before Congress, yet no changes have been made.

The following policy changes would yield over $2 billion in savings to the Medicare program over seven years – greater savings than those achieved by the Senate plan to eliminate ambulance updates (see attached chart). Even more importantly, this proposal would not jeopardize the emergency and rural-based ambulance services in this country. The AAA urges your consideration of these proposals:

I. Advanced Life Support (ALS) Services versus Basic Life Support (BLS) Services

Background

There are two types of ambulance transportation approved by Medicare for payment: Advanced Life Support (ALS) and Basic Life Support (BLS). ALS services cost more due to a variety of factors such as skill level of personnel, sophistication of equipment, etc. Medicare currently allows coverage of ALS when provided, if (1) it is medically necessary; (2) the provider is mandated by local law to provide ALS; or (3) no BLS is available.

Recommendations

The American Ambulance Association believes significant savings can be achieved, without sacrificing patient care or EMS systems, by covering ALS *only* if one of the following criteria is met:

1. If ALS is medically necessary.

2. When mandated by local law, but only:
   a. for emergencies, based on the perceived need of the patient.
   b. in rural areas, as defined by the Secretary.

In all other situations, only BLS rates would be allowed.

Savings

Savings to the Medicare program by making this change in coverage have been estimated by the Inspector General's Office. In her testimony before the Senate Appropriations Committee on December 16, 1994, June Gibbs Brown, Inspector General of the Department of Health and Human Services, estimated that "policies which allowed payment at the ALS level when it was not needed amounted to $47 million in 1993" lost to the Medicare program. Based on the growth of ALS reimbursement reported by the HCFA Bureau of Data Management and Strategy from 1989 to 1994, the American Ambulance Association estimates the total savings to be $670 million over seven years (1996-2002).

Inspector Brown then "recommended that HCFA revise its policy to require that payment for non-emergency ambulance service at the ALS level be allowed only when medically necessary." The American Ambulance Association's recommendation is consistent with the IG's testimony.

II. Repetitive Patients

Background

The largest area of abuse in ambulance transportation involves repetitive non-emergency patients (e.g., dialysis, radiation therapy). For the most part, the problem involves dialysis patients. For example, the average End Stage Renal Disease patient requires six transports per week. This can result in legitimate per patient costs well in excess of $30,000 annually. The potential for abuse occurs due to criteria for coverage known as "medical necessity." With this patient population, medical necessity is often difficult to determine because the patient's condition may change daily. Thus, there is a large gray area, leaving significant room for multiple interpretations. Because of this uncertainty, overpayments are often made which have resulted in significant dollars lost to the Medicare program. These overpayments were the subject of a recent HHS Inspector General Report.

While the medical necessity issue concerns dollars lost to the Medicare program, a second issue -- destination -- concerns dollars lost to beneficiaries. Because of a restriction in the current regulations, medically necessary ambulance transportation for ESRD patients is covered only when the destination is a hospital-based dialysis facility. This restriction applies despite the fact that Medicare-approved freestanding dialysis facilities have been established that are often less costly than those affiliated with hospitals. It is the opinion of the American Ambulance Association that any Medicare-approved dialysis center should be covered as an appropriate

destination facility. If this change were made, additional out-of-pocket expenditures by beneficiaries would be eliminated, relieving them of a costly burden due to a "quirk" in the regulations.

Recommendations

The American Ambulance Association recommends the following:

1. A system of prior authorization should be implemented for repetitive non-emergency patients (i.e., dialysis, radiation therapy) in which the ambulance provider gives the Medicare carrier the medical documentation, origin and destination information. The carrier would then be required, perhaps within a 7-10 day period, to advise the provider if the trips would be authorized and, if so, for a specific period of time (e.g., 60 days) after which the process repeats. (This would eliminate the problem of varying interpretations of "medical necessity.")

2. Ambulance transportation to any Medicare-approved dialysis center should be covered regardless of the origin, if an ambulance is medically necessary.

Savings

The Inspector General report, Ambulance Services for Medicare ESRD Beneficiaries: Medical Necessity, August, 1994, found that 70 percent of the ambulance transports did not meet medical necessity guidelines, resulting in approximately $44 million in overpayments in 1991. Using Medicare Trustee projected ESRD expenditures, the American Ambulance Association estimates the total savings to be $1.5 billion over seven years (1996-2002).

Summary

The American Ambulance Association estimates that implementing these two proposals will yield over **$2 billion in savings** to the Medicare program over seven years -- greater savings than those proposed by the Senate plan to eliminate ambulance updates (please refer to the attached charts).

Medicare Savings, Part B Ambulance Service
(billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	7-Year Total
Current Senate								
Eliminate Ambulance Update	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
American Ambulance Association								
Limit ALS Reimbursement Levels to Medically Necessary	-0.00	-0.06	-0.07	-0.09	-0.12	-0.15	-0.19	-0.67
Require Prior Authorization Repetitive Non-emergency Patients	-0.00	-0.06	-0.17	-0.22	-0.22	-0.35	-0.49	-1.50
Total:	-0.00	-0.11	-0.24	-0.31	-0.33	-0.50	-0.68	-2.18

Note: Savings from ALS reimbursement limitations are calculated by taking IG (1992) estimated savings of $15.98 million in 1989, and projecting future amounts for the years 1997-2002 by the rate of growth in ALS total reimbursement (HCFA, 1994) from 1989 to 1994. Savings resulting from requiring prior authorization for ESRD non-emergency trips are calculated by taking the IG (August 1994) estimated overpayments of $44 million or 2.43% of total payments for all ESRD services in 1991, and applying this percentage to the Medicare Trustee projections of total ESRD payments for the years 1997-2002 (Trustee Report, 1995).

Sources:

Senate Finance Committee, Chart 2 - Medicare, September 26, 1995.
Board of Trustees, Report for Supplementary Medical Insurance Trust Fund, 1995.
HCFA, HHS, 1994 Part B Extract and Summary System (BESS) Procedure Report (Bureau of Data Management & Strategy).
IG, HHS, Review of Medical Necessity for Ambulance Services (October, 1992).
IG, HHS, Follow-Up to Review of Medical Necessity for Ambulance Services (June, 1995).
IG, HHS, Ambulance Services for Medicare ESRD Beneficiaries: Medical Necessity (August, 1994).
IG, HHS, Ambulance Services for Medicare ESRD Beneficiaries: Payment Practices (March, 1994).

Executive Offices
3800 Auburn Blvd., Suite C
Sacramento, CA 95821-2102
(916) 483-3927
FAX (916) 483-5473

MEDICARE REFORM
THE POSITION OF THE AMERICAN AMBULANCE ASSOCIATION

BACKGROUND

Ambulance services are covered under Medicare Part B. Both the House and Senate-passed versions of the Budget Reconciliation bills contained provisions which affected ambulance reimbursement. However, there were key differences between the House and Senate approaches. The Senate bill contained a blanket 7-year freeze on ambulance rates. The House bill did not contain a freeze but instead contained language which would place ambulance service on a fee schedule. Because the Senate freeze provision was "scorable" and was estimated to produce $800 million in savings over the next 7 years while the House fee schedule provision was not "scorable" (although it could yield far greater savings), the Senate provision was accepted in conference and ambulance rates are frozen under the bill for the next 7 years. The President, however, is expected to veto this measure shortly and a new version will be crafted. It is this new version to which the American Ambulance Association has now turned its attention.

AMERICAN AMBULANCE ASSOCIATION POSITION

The American Ambulance Association feels that a 7-year freeze on ambulance rates as contained in the current bill would be devastating to ambulance service in general and would be particularly devastating to rural and emergency service. The most frequent users of emergency ambulance services are the elderly. Therefore, Medicare dollars are critical to maintain this country's emergency response systems. Our country's 911 systems are carefully designed partnerships between government agencies, emergency physicians and ambulance providers, where there is only one designated provider of ambulance service. The rate freeze on that *single* provider will have a drastic effect on the level of emergency readiness in that system. Consequently, the dismantling of emergency ambulance services throughout America will be set in motion. The consequences of this have so alarmed the EMS community that the National Association of State EMS Directors, the people responsible for setting up and overseeing EMS

Government Relations: Fleishman-Hillard, Inc. • 1301 Connecticut Ave. NW, Washington, D.C. 20036 • (202) 296-4390 • FAX (202) 296-6119
Medicare Consultant: David Werfel, Esq. • One Rebro Drive, Hauppauge, NY 11788 • (516) 582-3285 • FAX (516) 582-3387

systems in the states, recently passed a resolution condemning the blanket freeze approach. A copy is attached. There is a better way to go.

THE PROPOSED SOLUTION

There is a solution which is better for the Medicare system, better for Medicare beneficiaries, and better for all those Americans who rely on available high-quality ambulance service in a time of need. That solution is to reform the ambulance reimbursement system from the bottom up - comprehensive reform - through the establishment of a fee schedule. This would likely save more money ultimately than a freeze and it allows the 30-year-old reimbursement system which the ambulance industry operates under to be brought up-to-date to reflect current health care trends. For instance, currently the Medicare regulations require that in order for reimbursement to be made to an ambulance company that responds to an emergency call, the patient must be transported to an emergency room. The process of putting the ambulance industry on a fee schedule would allow options such as "treat and release" to be considered thereby potentially saving millions of dollars in unnecessary emergency room admissions. But a 7-year blanket freeze as contained in the current measure simply freezes in place the distortions which are present in the ambulance reimbursement system today. This seems contrary to the spirit of making rational and beneficial changes to the Medicare system. Finally, all other provider groups have already been placed on a fee schedule. Ambulance is the last to go. This is the right time and the right way to correct this disparity, to achieve rational and meaningful savings, and, most importantly, to preserve our fragile EMS systems.

For questions or comments please contact Wendy Ruhlin at (202) 296-8390.

NATIONAL ASSOCIATION OF STATE EMS DIRECTORS

Wednesday October 25, 1995
Bismarck, North Dakota

RESOLUTION 95-08

URGING ADEQUATE REIMBURSEMENT FOR AMBULANCE SERVICES

WHEREAS, ambulance service is an essential component of all Emergency Medical Services (EMS) systems, and

WHEREAS, EMS is a critical safety net that ensures all citizens timely emergency medical care and access into the entire health care system, and

WHEREAS, financing of ambulance services through reasonable and appropriate reimbursement policies is essential to sustain current levels of service, and

WHEREAS, EMS, representing less than 1% of overall national health expenditures, already represents an extremely marginal cost to ensure such a critical, population-based service, and

WHEREAS, Congress is currently enacting reductions and changes to the Medicare program that may cap ambulance fees at current levels well beyond the Year 2000 and limit the overall amount available to reimburse ambulance services on an annual basis,

NOW, THEREFORE, BE IT RESOLVED, that the National Association of State EMS Directors urges that Congress adopt a bill that contains specific language to reform ambulance reimbursement through the development of a comprehensive, national fee schedule and reject language which would freeze ambulance service rates into the future, and

BE IT FURTHER RESOLVED that the National Association of State EMS Directors encourages the President, Congress, the Health Care Financing Administration and other public and private insurance officials to support adequate reimbursement for emergency medical care and transportation, with particular attention to rural constraints, to ensure the vitality and full geographic distribution of these critical health services.

Adopted in this form by unanimous vote of the membership, October 25, 1995:

Chair, Constitution, Bylaws, &
Resolutions Committee

Current Law

No provision

House Bill

The provision would require the Secretary to treat the State of Wisconsin as a single fee schedule area for physicians services beginning in 1997. The provision would be implemented in a budget neutral fashion. Nothing in the section is to be construed as limiting the availability to the Secretary, the contractor or the physicians in the State of otherwise applicable administrative procedures for subsequently modifying the fee schedule areas.

Senate Bill

No provision

Conference Agreement

The conference agreement does not include the House provision.

10. Payments for Ambulance Services (Sec. 15609A of House bill; Sec. 7049 of Senate bill)

Current Law

Payments for ambulance services are based on reasonable charge screens developed by individual carriers based on local billings (which may take a variety of forms). Based on these local billing methods, carriers develop screens for one or more of the following main billing methods: (i) a single all-inclusive charge reflecting all services and supplies, and mileage; (ii) one charge reflecting all services and supplies, with separate charge for mileage; (iii) one charge for all services and mileage, with separate charges for supplies; and (iv) separate charges for services, mileage, and supplies. Within each broad payment method, additional distinctions are made based on whether the service is basic life support or advanced life support service, whether emergency or nonemergency transport was used, and if specialized advanced life support services were rendered.

House Bill

a. Payment Amount. The provision would specify that beginning January 1,1998, payment for ambulance services would equal 80% of the lesser of the actual charge for the service or the fee schedule amount.

b. Fee Schedule. The provision would require the Secretary to establish a fee schedule through a negotiated rulemaking process. In establishing a fee schedule, the Secretary would be required to: (i) establish mechanisms to control increases in expenditures which fairly reflect the changing nature of the ambulance service industry;

(ii) establish definitions for ambulance services which promote efficiency and link payments (including fees for assessment and treatment services) to the type of services provided; (iii) take into account regional differences which affect cost and productivity, including differences in the costs of resources and the costs of uncompensated care; (iv) apply dynamic adjustments to payment rates to account for inflation, demographic changes in the population of Medicare beneficiaries, and changes in the number of participating providers; (v) phase-in the application of the payment rates in an efficient and fair manner.

The provision would require the Secretary to implement the provision in 1998 in a budget neutral fashion. Beginning in 1999, the payment amounts under the fee schedule would equal the previous year's payment amount updated by the increase in the consumer price index for the 12-month period ending the previous June.

The provision would require the Secretary to regularly consult with the following groups when establishing the fee schedule: American Ambulance Association, the National Association of State Medical Directors, and other national organizations representing individuals and entities who furnish or regulate ambulance services. The Secretary in establishing the fee schedule would be required to share with the associations and organizations the data and data analysis used in establishing the fee schedule, including data on variations in payments for years prior to 1998 among geographic areas and types of providers.

Senate Bill

a. Payment Amount. The provision would provide that when determining the reasonable cost or charge of ambulance services for fiscal years 1996 through 2002, the Secretary could not recognize any costs in excess of those recognized as reasonable in fiscal year 1995.

b. Fee Schedule. No provision

Conference Agreement

a. Payment Amount. The conference agreement includes the Senate provision.

b. Fee Schedule. The conference agreement does not include the House provision.

11. Standards for Physical Therapy Services Furnished by Physicians (Sec. 15609B of House Bill)

Current Law

No provision.

House Bill

Diana thinks this may be more your issue - PS. let me know - Thanks, Pat

MEETING REQUEST/TRACKING FORM

CAROL H. RASCO

DOMESTIC POLICY

Name of Requestor: Paul Robinson Date: 12/7/95

Affiliation: College of Emergency Physicians

Nature of Request: Law C+H to meet w/ John Scott & Lee Godown (& offic reps)

Contact Person Mr. Robinson Phone Number: 501-221-7146

Meeting Data: A. Date: next two weeks, if possible

B. Time: TBD

DC # 202-728-0617

C. Place: C+H's office

D. Purpose: discuss Emergency Medical Services Act & Graham Amen

E. Conflicts: 2 week grid attached

* would be willing to meet w designee if C+H not available

DECISION

____ Accept ____ Regret

____ Forward To: ____ Pending

Comments:

Set up w designee due to my heavy travel schedule.

American College of
Emergency Physicians
Washington Office
1111 19th Street, N.W., Suite 650
Washington, D.C. 20036-3603

FACSIMILE COVER SHEET

TO: **Jennifer Klein**
White House Domestic Policy
FAX#: **202-456-2878**
FROM: **Lee Godown**
ACEP Washington
DATE: **11 December 1995**
RE: **"Definition of Emergency" Medicare Issue**

NUMBER OF PAGES, INCLUDING THIS COVER: 5

Jennifer:

Thank you for your call this afternoon. Here is the issue we want to meet with Carol Rasco, Chris Jennings or Nancy-Ann Min about.

Obviously, from our point of view the sooner the better if that is possible.

Thanks!

Lee

Coalition For Access to Emergency Medical Services

1111 19th Street, NW Suite 650
Washington, DC 20036

Tel. 202-728-0610
Fax: 202-728-0617

December 8, 1995

The President
The White House
Washington, DC 20500

Dear Mr. President:

The undersigned organizations are writing to urge you to support the inclusion of the "prudent-layperson" definition of emergency services on the list of priorities which your Administration will pursue in negotiations with the Republican leadership regarding the budget reconciliation package.

The "prudent layperson" definition was adopted unanimously during Senate consideration of the reconciliation package, and was also approved unanimously by the House Commerce Committee during their consideration of the legislation. Unfortunately, the conference committee struck the provision from its final budget reconciliation bill which you vetoed on December 6. Despite strong Democratic support, and acknowledgement from some Republican Members that the prudent layperson definition was a needed protection for seniors enrolling in Medicare managed care plans, the conferees adopted language solely supported by the managed care industry.

A 1992 study conducted by the Network Design Group for the Health Care Financing Administration (HCFA) revealed that 60 percent of disputed claims in the current Medicare HMO program involved emergency services. The study clearly established that HCFA's current regulatory definition was the underlying cause for the disproportionate percentage of disputes over emergency services. The authors of the study recommended that the definition of emergency be amended so that a "reasonable or prudent layperson" could determine whether the emergency services would be covered versus denied.

As organizations who have long been on record for identifying and promoting necessary protections for patients seeking medical care, we are greatly concerned that seniors moving into Medicare managed care plans will have their access to and coverage for emergency services jeopardized without the benefit of the prudent layperson definition. While we agree that the Medicare system is in need of reform to ensure its viability into the next century, we share your concern that Medicare beneficiaries must be protected in the process. The "prudent layperson" definition is a needed and necessary patient protection provision that protects senior citizens who enroll in Medicare HMOs.

We also realize that your Administration is committed to balancing the federal budget through reasonable measures that will not jeopardize protections and services for our most vulnerable populations. The "prudent layperson" definition is an issue your Administration can take hold of that will not create additional fiscal obligations for the federal government. By including the prudent layperson definition, your Administration will be advocating a great service for the Medicare patient. It is pro-consumer, pro-senior, and a vital improvement over current regulation.

While inclusion of this provision may appear to be a relatively minor one in the scheme of Medicare reform and the overall budget reconciliation process, we see it as an opportunity to correct a serious problem that will only become worse. We hope that you will not overlook this issue, and are hopeful that you will place it on your list of priorities and fight for its inclusion in the final budget package.

The undersigned groups thank you for your consideration and urge you to support the inclusion of the "prudent layperson" definition of emergency in any final reconciliation compromise.

Sincerely,

American College of Emergency Physicians
National Association of EMS Physicians
Coalition for American Trauma Care
American Ambulance Association
International Association of Fire Chiefs, EMS Section
International Association of Fire Fighters
Emergency Nurses Association
National Association of Emergency Medical Technicians
Association of Air Medical Services
National Association for State EMS Directors
American College of Cardiology
American College of Surgeons
Congress of Neurological Surgeons
American Association of Neurological Surgeons
American Academy of Pediatricians
American Heart Association
National Committee to Preserve Social Security and Medicare

American College of Emergency Physicians®

MEDIA OFFICE
1111 19th Street, NW
Suite 650
Washington, DC 20036
(202) 728-0610, ext 3007
FAX (202) 728-0617
1-800-320-0610, ext 3007

NEWS

CONTACT: (202)728-0610, ext. 3008
Jane Howell (703)527-3642 (home)
or Michele Kamber (703)352-0446 (home)

FOR IMMEDIATE RELEASE
November 17, 1995

EMERGENCY PHYSICIANS SAY GOP REFORM BILL POSES SERIOUS RISK TO SENIORS SEEKING EMERGENCY CARE

EDITOR'S NOTE: Following is the text of a statement sent by the American College of Emergency Physicians to House conferees in response to the passage today of the balanced budget act. The underlined emphasis has been added for your reference.

The Honorable Newt Gingrich
Speaker of the House
H-232 Capitol Building
Washington, D.C. 20515

Dear Mr. Speaker:

I am writing to you on behalf of the 18,000 members of the American College of Emergency Physicians to express our supreme disappointment that the "prudent layperson" definition of emergency was dropped from the final reconciliation conference report after being adopted by the United States Senate.

It is difficult to understand how the Conference Committee could adopt the House provision which simply codifies the current flawed definition of emergency services. The fact that the definition is flawed was established by an independent study, conducted by the Network Design Group, for the Health Care Financing Administration. That study revealed that 60 percent of disputed claims in the current Medicare HMO program involved emergency services. The study clearly established that HCFA's current regulatory definition was the root cause of the disproportionate percentage of disputes over emergency services. The authors recommended that the definition of emergency be amended so that a "reasonable or prudent layperson" could determine whether emergency services would be covered versus denied.

Regrettably, the conferees have decided to take no action to remedy this problem. The College

brought this issue to the Congress and has tried to persuade the Congress of the need for action on this issue. The prudent layperson definition is supported by the entire emergency medical services community, public health organizations, and consumer advocacy and seniors organizations, as well as lawmakers from both parties. Both the House Commerce Committee and the United States Senate adopted the prudent layperson definition of emergency. The only opposition to this provision is the managed care industry, an industry which has a strong financial incentive to deny emergency care for seniors. It is regrettable that the conference report so clearly represents the interests of the managed care industry and offers little comfort for seniors seeking emergency medical care.

As a result of the conferees' action, the College has no choice but to recommend to seniors who are considering Medicare managed care plans that their access to and coverage of emergency services may be seriously jeopardized in these plans. The College plans a major public education campaign to inform seniors about the deficiencies in coverage and protection. Time and again the College has heard Members of the Congress state that the entire basis for moving Medicare beneficiaries into managed care plans is predicated upon their reputation as prudent consumers. In contrast to this, the House language, on its face, assumes that the Medicare population cannot be trusted to make prudent decisions regarding emergency care, and will "over-utilize" the emergency department. This is the message despite the fact that not one bit of evidence has been presented to indicate that senior citizens use the emergency department for non-urgent reasons.

I want to emphasize that the College is not opposed to reforming Medicare. The College is not opposed to providing seniors with additional choices, including managed care. I wish that we could support this reform package. As physicians, however, our first obligation is to our patients, and as the bill is currently written, we have no choice but to inform our patients that they choose the managed care option at their own risk. Unfortunately, this may drive down the number of senior citizens who choose the managed care option.

Let me just conclude by saying that the inclusion of the House language in the reconciliation conference report is gross mistake. In fact, contrary to what its authors contend, it will make access to quality and assured emergency care more difficult for Medicare beneficiaries.

Sincerely,

Gregory L. Henry, MD, FACEP
President