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Case Study: The Intersection of Public Policy and Permanente Practice in Emergency Services

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Kaiser Permanente has a long history of innovative approaches to the provision of care for members with urgent or emergent conditions. For example, the Program developed and implemented telephonic nurse advice services long before the term "demand management" was popularized. This case study describes how an innovative Permanente practice has influenced the development of public policy and how, in turn, public policy is affecting our practices in the area of emergency care.

The EPR/CCT Program

In 1989, in order to address rapidly escalating costs for nonplan emergency services and out-of-plan hospital admissions, Southern California Permanente emergency physician Jeff Selevan, MD* designed and piloted the Emergency Prospective Review/Critical Care Transport (EPR/CCT) Program in San Diego, California. Due to the success of the pilot, the program was centralized and expanded to cover the entire Southern California service area; expansion into Northern California is currently being implemented. Variations of the program are also in place in Hawaii and in Colorado. The goal of the program is to bring members back to Kaiser Permanente (or contract) facilities and providers as quickly as possible.

This enhances members' care by repatriating them with their medical home. It also presents an opportunity to reduce costs because unnecessary and/or redundant testing and admissions are avoided.

The core of the program is 24-hour telephone access to a Kaiser Permanente emergency physician staffing the program. When one of our members is treated at an out-of-plan emergency department, the community physician is able to easily and quickly contact the EPRP using an 800 number. The Permanente physician and the community physician review the scope of the needed evaluation and any treatment in the emergency department. The Permanente physician is often able to provide additional medical information by accessing the patient's electronic medical record. Payment for mutually agreed-upon services is conditionally authorized by the Permanente emergency physician. If the patient is stable for transport back to a Kaiser Permanente facility, arrangements—including critical care transport if indicated—are made. If the patient requires out-of-plan admission, case management is initiated. If the patient is discharged, appropriate follow-up arrangements can be facilitated. Kaiser Permanente plans that have implemented the EPR/CCT have realized substantial cost savings, primarily by avoiding unwarranted admissions and redundant testing in the emergency department.

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The Interface of MCOs and Emergency Services

In the last several years, there has been a great deal of adverse publicity surrounding managed care organizations' handling of emergency services. Emergency physicians were reporting adverse outcomes for managed care members because of real or perceived barriers to emergency medical services.[1,2] Most problematic were delays in accessing care because of a requirement to obtain authorization before going to an emergency department and retrospective denial of emergency claims even when initial symptoms could have represented a serious medical condition. A classic example of retrospective denial is the middle-aged man with a history of hypertension who develops chest pain and seeks care in the closest emergency department. After a detailed medical history, ECG, review of the medical record, and consultation with a cardiologist, it is determined the chest pain is not cardiac but rather gastrointestinal in origin. The discharge diagnosis is "heartburn." The claim is denied because heartburn is not an emergency condition. The emergency department is not reimbursed for services rendered, and the patient is caught in the middle of a battle between the hospital and the health plan.

Emergency physicians have a federal mandate, the Emergency Medical Treatment and Active Labor Act[3] (EMTALA), to screen every patient who presents to an emergency department for an emergency medical condition and to provide treatment up to the point of stabilization. This must be done prior to any determination of the patient's ability (or their health plan's willingness) to pay for those services. This creates, in essence, an unfunded federal mandate for hospitals with emergency departments and emergency physicians. Some health plans are reported to have taken advantage of this mandate by refusing prior authorization for emergency services and by later denying reimbursement for the claim. One California HMO is reported to have sent a letter to all of its participating "gatekeeper" physicians advising them not to authorize any emergency department visits because emergency physicians had a legal obligation to evaluate patients anyway.[4]

Crafting a Solution

In response to these concerns, the American College of Emergency Physicians worked with US Representative Ben Cardin (D-MD) to introduce legisla-

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tion addressing some of the most glaring issues, i.e., preauthorization, and retrospective denial. Although this legislation had over 100 cosponsors, it was floundering because of opposition from the managed care industry and big business.

In the spring of 1996, leaders from the American College of Emergency Physicians sat down with emergency physicians and policymakers from Kaiser Permanente. The purpose of this meeting was to determine if there was any common ground in our approaches to emergency services. ACEP leaders described the need to prohibit prior authorization and to eliminate or minimize retrospective denial. They felt that adopting a "prudent layperson" standard for federally mandated emergency services would go a long way toward reducing barriers to appropriate emergency care. This means that health plans would pay claims when patients have symptoms that a prudent or reasonable person would believe could cause a serious impairment to his or her health.

The Permanente physicians at the meeting were concerned that applying this standard could lead to an increase in out-of-plan services provided to our members. They wanted greater coordination between Kaiser Permanente and out-of-plan emergency departments. And they wanted to be able to direct patients who go to nonplan emergency departments with minor conditions to more appropriate settings such as their own doctors' offices. They noted that there was little communication between community emergency physicians and the patients' medical home—their health plans. This often resulted in unnecessary or redundant testing in the emergency department and even unwarranted hospital admissions. The lack of coordination was frustrating for patients as well as the clinicians and added to the costs of care without giving any health benefits to the members. Permanente emergency physicians at this meeting were familiar with the EPR/CCT and suggested it could serve as a model of how to best solve the vexing problems related to emergency care.

The result of the discussions between ACEP and Kaiser Permanente was an historic joint statement of principles for supporting federal legislative requirements for health plan coverage of emergency medical services (Table 1). This statement was released to the public on August 19, 1996. Since that time, Kaiser Permanente and ACEP have worked together with Congressman Ben Cardin to capture the principles in legislative language.

Table 1. Key Principles of the Joint Statement

- Patients would not be required to obtain preauthorization for medically necessary emergency services.
- Health plans would cover emergency services provided to a patient in an emergency department if the patient presents with a condition that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect to result in serious impairment to the patient's health. This is the "prudent layperson" standard.
- Health plans would not be required to reimburse for services, including screening, provided to patients who do not meet the "prudent layperson" standard.
- Health plans could establish a system allowing patients to obtain advice from a health professional, over the telephone or otherwise, as to whether a visit to an emergency department or other setting is appropriate.
- Emergency physicians would provide the emergency medical services necessary to stabilize a patient without being required to obtain preauthorization from a health plan.
- An emergency department would be required to notify the health plan within 30 minutes after the patient is stabilized to obtain authorization for any medical services needed subsequent to stabilization. The health plan must respond to the request for authorization for any recommended services within 30 minutes.
- If the emergency department does not call the health plan, the health plan would not be responsible for payment of any services provided subsequent to stabilization of the patient.
- If the emergency physician and the health plan cannot agree on a course of post-stabilization treatment, the health plan must immediately arrange for an alternate plan of treatment for the patient. The health plan would not be responsible to pay for any unauthorized, nonemergency medical services provided after stabilization of the patient.
- Health plans would be allowed to impose different cost-sharing arrangements when a patient chooses an emergency setting over a nonemergency setting, or an out-of-plan emergency setting over an in-plan emergency setting.
- Health plans would be required to educate their members about the location of participating medical facilities and cost-sharing provisions for emergency and other medical services, as well as the appropriate use of emergency medical services, so that the members can determine the appropriate treatment setting for the medical condition experienced.
- The principles would apply uniformly to all health plans that offer coverage for emergency care, whether licensed or self-insured.

The Access to Emergency Medical Services Act of 1997

The bill (Table 2) was introduced into the US House of Representatives as the Access to Emergency Medical Services Act of 1997 (HR 815) by Reps. Ben Cardin (D-MD) and Marge Roukema (R-NJ) on February 25, 1997. Senators Bob Graham (D-FL), John Chafee (R-RI), Tim Hutchinson (R-AR), and Barbara Mikulski (D-MD) introduced it in the US Senate as S356 on the same day. John Pappas, MD, a Colorado Permanente physician, ably represented Kaiser Permanente at a Washington, DC press conference heralding the introduction.

If enacted without modification, the bill (known as the prudent layperson legislation) will provide substantial protections to patients who experience symp-

Table 2. Short Summary of Access to Emergency Medical Services Act of 1997

The bill would amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and Titles XVIII and XIX of the Social Security Act. If enacted, this bill would guarantee that consumers are covered for legitimate emergency department visits. For health plans that offer coverage for emergency services, including the Medicare and Medicaid programs, the bill would require payment for emergency services consistent with the "prudent layperson" standard. Patients would not be required to obtain prior authorization for emergency services. Health plans would be required to cover and pay for emergency care based upon the patient's initial symptoms, rather than the final diagnosis. The bill also establishes a process in which the emergency department and health plan work together to assure that the patient receives appropriate follow-up care.

Key provisions of the bill:

- Establishes a uniform definition of emergency based upon the "prudent layperson" standard. Health plans would be required to cover emergency services if the patient has symptoms that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect to result in serious impairment to the patient's health. Health plans would not be required to reimburse for services that do not meet the "prudent layperson" standard.
- Plans would be prohibited from requiring, as a condition for coverage, that patients obtain prior authorization from the health plan before seeking emergency care.
- Establishes coverage standards for out-of-plan emergency care to protect patients who, under reasonable circumstances, seek care in an out-of-plan emergency department.
- Allows health plans to establish reasonable cost-sharing differentials for emergency care when a patient chooses an emergency setting over a nonemergency setting, or an out-of-plan emergency setting over an in-plan emergency setting.
- Provides a process for coordination of post-stabilization care. Treating emergency physicians and health plans would be required to make timely communications concerning any medically necessary post-stabilization care identified as a result of a federally required screening examination. Plans, in conjunction with the treating physician, may arrange for an alternative treatment plan that allows the health plan to assume care of the patient after stabilization.
- Health plans would be required to educate their members on emergency care coverage and the appropriate use of emergency medical services, including the use of the 911 system.
- There would be no preemption of state law as long as the state law does not prevent the application of the federal law.
- In general, requirements of the bill would be enforced in the same manner as the requirements of the "Health Insurance Portability and Accountability Act of 1997."
- Applies to all health plans that offer coverage for emergency care, whether licensed or self-insured, including the Medicare and Medicaid programs. Effective for plan years beginning on or 18 months after the date of enactment.

toms suggestive of an emergency medical condition. Patients would not have to obtain prior authorization from their health plan before seeking emergency medical services. Furthermore, plans would be required to educate members about coverage of emergency services and the process for obtaining emergency services. Health plans that cover emergency services would be required to cover emergency services up to the point of stabilization if the patient has symptoms that a prudent or reasonable person would believe could seriously impair his or her health (the "prudent layperson" standard). Coverage is not required if the person fails to meet the prudent layperson standard. Taken together, these provisions assure that members have access to information they need to make appropriate decisions about when and where to seek care without placing a barrier to care if the patient reasonably believes he or she is experiencing an emergency medical condition. Because plans are not required to pay for any service if the prudent layperson standard is not met, members would have an incentive to use emergency departments appropriately.

In order to ensure that medical care for nonemergency conditions identified during screening and stabilization is provided in a coordinated and appropriate manner, the prudent layperson legislation requires emergency departments to contact patients' health plans within 30 minutes after the EMTALA requirements for screening and stabilization are met. This contact between the health plan and the emergency physician will help assure that the health plan, which is the primary source of the patient's health care services, is involved in the provision of follow-up care. There is also a requirement that the health plan either deny or approve the request for further testing and treatment within 30 minutes of the time of the emergency department's phone call. Although there is no requirement that the phone calls be made or received by physicians, only plan physicians can deny disputed requests. These provisions make possible the type of communication essential to optimal management and care of health plan patients in need of emergency services.

Complying With the Requirements

Kaiser Permanente Divisions with EPR/CCT programs in place will meet the requirements of the legislation. However, it is important to understand that there are a variety of ways in which to comply with the proposed standards. For example, in the Mid-Atlantic Region of the Central East Division, a nurse responds to calls from community emergency physicians when our members go to their departments. After assessing the situation, the nurse can put the community physicians in touch with the appropriate on-call Permanente physician or

can dispatch a physician from a contract group to the emergency department. This group of physicians has admitting privileges at many of the area's hospitals and is very familiar with Kaiser Permanente procedures and resources. After assessing our member in the emergency department, the contract physician can admit the patient, repatriate the patient to a plan hospital, or arrange appropriate outpatient care and follow-up. Community Health Plan, a member of the Kaiser Permanente family in the Northeast Division, provides medical care in a largely rural environment. It will be able to comply with the requirements of the Access to Emergency Services Act of 1997 by having its on-call primary care physicians be responsible for responding to calls from community emergency physicians.

Benefits of Federal Standards

By proposing federal standards for coverage of emergency services, Kaiser Permanente and ACEP have taken the first step in alleviating the public's concern about access to and coverage for these critical services. The legislation and programs like the EPR/CCT are win-win for all involved, especially our members. Patients and community physicians benefit by having access to information that expedites, improves, and coordinates care. Patients also benefit by having their proposed treatment discussed with a physician from their health plan who frequently has access to their records and by the assurance that the care provided will be covered. The plan benefits by ensuring that post-stabilization care is appropriate and not unnecessarily intrusive, and by avoiding costs associated with unnecessary testing and unwarranted admissions.

What Happens Next?

Currently, the bill has 119 sponsors in the US House of Representatives and 17 in the Senate. It is garnering significant bipartisan support and has strong support from numerous organizations (Table 3). Our Washington representatives, Dr. Don Parsons (Associate Medical Director for Government Relations) and Richard Froh (Vice President, Government Relations) are meeting with key legislators on a regular basis to educate them about the need for federal standards for coverage of emergency services.

Currently, the American Association of Health Plans has not endorsed the bill. They have, however, developed voluntary standards addressing coverage of emergency services and have said they would remove from membership any plan which failed to meet those standards. Business leaders support the concepts in the legislation but have major reservations about supporting the bill for two reasons: 1) they don't like the idea of legislating a solution to the problem, and 2) this bill would amend ERISA, a long-standing Federal statute that exempts self-funded plans from state regu-

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Table 3. Organizations Supporting H.R. 815/S.356 "Access to Emergency Medical Services Act"

American College of Emergency Physicians	American Academy of Pediatrics
Kaiser Permanente	American Society of Internal Medicine
American Medical Association	American College of Surgeons
American Hospital Association	American Association of Neurological Surgeons
Federation of American Health Systems	Congress of Neurological Surgeons
National Association of Public Hospitals & Health Systems	American Association for the Surgery of Trauma
Catholic Health Association	Eastern Association for the Surgery of Trauma
Association of American Medical Colleges	American Society of Anesthesiologists
VHA Inc.	Emergency Nurses Association
National Association of State EMS Directors	Association of Operating Room Nurses
Center for Patient Advocacy	Internal Association of Fire Fighters
Families USA	American Ambulance Association
Public Citizen's Health Research Group	Association of Air Medical Services
Citizen Action	American Osteopathic Association
National Council of Senior Citizens	American Public Health Association
National Committee to Preserve Social Security & Medicare	Brain Injury Association
Coalition for American Trauma Care	AO North American
American Red Cross	Orthopedic Trauma Association
American Health Association	American Burn Association
American College of Cardiology	Journal of Trauma

"No longer will emergency departments have bills denied because a final diagnosis was deemed non-emergency even though the presenting symptoms clearly signaled an emergency to the patient."

lation. Any change in the ERISA protections is being viewed as "the camel's nose under the tent" and could lead to more regulation of plans with resultant increase in cost.

Conclusion

Kaiser Permanente and the American College of Emergency Physicians are working hard to ensure passage of this legislation. It is the next logical step in managed care and is critical to the future of emergency care. What began as an historic agreement in 1996 is leading the way for America to protect the quality of health care for patients as well as to manage costs. If HR 815/S 356 becomes law, no longer will health plan members be put in the position of having to make their own diagnosis before going to the emergency department. No longer will emergency departments be denied reimbursement because a final diagnosis was deemed nonemergency even though the initial symptoms clearly signaled an emergency to the patient. No longer will health plans be faced with bills for services which reasonably could have been provided in other settings. The Access to Emergency Medical Services Act of 1997 is sound public policy and good managed medical care. ❖

References:

1. Pear R. "Congress weighs more regulation on managed care." *The New York Times,* Monday, March 10, 1997, pgs. A1 and A16.
2. Dickinson E, Verdile V. Managed care organizations: A link in the chain of survival? *Ann Emerg Med* 1996;28:719-21.
3. Public Law 99-272 of COBRA 1985 amended Section 1867 of the Social Security Act.
4. Personal Communication, California Chapter of the American College of Emergency Physicians.

Show Your Support and Make a Difference

Kaiser Permanente's agreement with the American College of Emergency Physicians is just one example of Permanente physicians becoming involved in the legislative arena to protect and advance the interests of health care consumers and Kaiser Permanente. Other opportunities for physician and provider involvement include our legislative efforts to expand health care coverage for uninsured children, protect Medicare for our Medicare members, and support activities related to women's health issues.

Legislators need to hear from you, their constituents, regarding how Kaiser Permanente is making a difference in the communities they represent. We know you are busy, so the level of your involvement is up to you. You can help by calling or writing your legislator to request support for Kaiser Permanente positions, by participating in a legislator tour of your medical facilities, by meeting with your legislator to discuss Kaiser Permanente, by offering to serve as a health care expert resource to your legislator, or by testifying on our behalf at legislative hearings.

Show your support for Kaiser Permanente by becoming involved. It is fun, and together we can make a difference! To join Kaiser Permanente's grassroots network formed to support Kaiser Permanente's legislative efforts, contact Darrcy Loveland, Counsel in the Program Offices Government Relations Department (510-271-6867 or by e-mail at darrcy.loveland@kp.org).