

SUBJECT TO RESOLUTION COMMITTEE REVIEW

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(JUN-21)

Introduced by: New York

Subject: Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits

Referred to: Reference Committee A

1 Whereas, According to the AMA Council on Medical Service (CMS), employers and insurance
2 companies are increasingly implementing programs (i.e., Financial Incentive Programs or FIPs)
3 that offer patients financial incentives when they use shopping tools to compare prices on health
4 care items and services and choose lower-cost options; and
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6 Whereas, According to the CMS, empowering patients to pursue health care can minimize
7 financial burden and reduce societal health care costs; and
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9 Whereas, According to the CMS, while considering these potential benefits of FIPs, it is critical
10 to ensure that patients are empowered to make fully informed decisions about their health care,
11 that they are never coerced into accepting lower-cost care if it could jeopardize their health, and
12 that programs that influence patient decision-making should be transparent about quality and
13 cost; and
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15 Whereas, Multiple studies have shown that, on average, Medicaid recipients use emergency
16 rooms (ERs) more often than those with private insurance for non-urgent conditions; and
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18 Whereas, Some states have implicated a copay system in an attempt to deter the overutilization
19 of ERs, but there is concern that such costs have been shown to cause people, especially those
20 within low-income and vulnerable populations, to forgo necessary care; and
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22 Whereas, One multistate study found that charging higher copayments did not reduce ER use
23 by Medicaid recipients and reasons postulated for this finding include that copays are hard to
24 enforce, since ERs are legally obligated to examine anyone who walks through the doors,
25 whether or not they can pay; and
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27 Whereas, One concept that has been implemented in a few states provides Medicaid recipients
28 with a prepaid card to cover a certain number of copays for ER visits and that any unutilized
29 amount on that copay card could be converted to a financial reward at the end of the year; and
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31 Whereas, Some states have set up a 24-hour hotline staffed by nurses who can advise people
32 about whether they are having a true medical emergency; and
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34 Whereas, There is also a compelling need to be very cautious regarding the creation of
35 disincentives for patients who are in need of care; therefore be it

1 RESOLVED, That our American Medical Association study and report on the positive and
2 negative experiences of programs in various states that provide Medicaid beneficiaries with
3 incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or
4 condition instead of hospital emergency departments. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 03/31/21

AUTHOR'S STATEMENT OF PRIORITY

Physicians and other health care professionals understand that Emergency Rooms should be used for true emergency care. The COVID pandemic amply demonstrated that healthcare for patients with non-emergent issues needs to be addressed by alternative health care sites. Physicians and other emergency room personnel need to be able to focus on the life and death situations that present themselves at emergency rooms. Information on what have been successful alternatives for providing care to Medicaid beneficiaries and what incentives have worked to induce Medicaid beneficiaries to use those alternatives will arm health care networks around the country with information to provide better healthcare to that population. By adapting to what works well for the Medicaid population, use of emergency rooms for their intended purpose will improve as will the work environment of physicians and healthcare personnel who work there. Such a report has the power to improve the healthcare for so many.

RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
 - a. Collaborate with the physician community in the development and implementation of patient incentives.
 - b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
 - c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
 - d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
 - e. Provide referring and/or primary care physicians with the full record of the service encounter.
 - f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
 - g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
 - a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
 - b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
 - c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
 - d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
 - e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
 - f. Provide meaningful transparency of prices and vendors.
 - g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
 - h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to

undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.

- i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
 - a. Patient outcomes/the quality of care provided with shopped services;
 - b. Patient utilization of shopped services;
 - c. Patient satisfaction with care for shopped services;
 - d. Patient choice of health care provider;
 - e. Impact on physician administrative burden; and
 - f. Overall/systemic impact on health care costs and care fragmentation.

Citation: CMS Rep. 2, I-19

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care,

assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19

Affordable Care Act Medicaid Expansion H-290.965

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20