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₵ 02-13-13 10:30 AM ₵

H.B. 141

MEDICAID EMERGENCY ROOM AND PRIMARY CARE AMENDMENTS

2013 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Michael S. Kennedy

Senate Sponsor: Margaret Dayton

LONG TITLE

General Description:

This bill amends the state Medicaid program and the state Children's Health Insurance Program to establish incentives for the appropriate use of emergency room services.

Highlighted Provisions:

This bill:

- defines terms;
- clarifies the authority of an accountable care organization that administers a plan for Medicaid or the Children's Health Insurance Program to audit a provider for delivering nonemergent care in an emergency room;
- permits an accountable care organization to establish a differential payment for nonemergent care delivered in an emergency room;
- requires the accountable care organization to use savings from reductions of inappropriate emergency room use to improve enrollee's access to primary care and urgent care;
- requires the Department of Health to develop quality measures for the appropriate use of emergency rooms and access to primary care, and to compare the accountable care organizations based on the quality measures; and
- directs the Department of Health to apply for waivers to the Medicaid program and the Children's Health Insurance Program to:

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- impose higher copayments on a recipient who seeks nonemergent care in an emergency room; and
- allow the Medicaid program and the Children's Health Insurance Program to development an algorithm to determine assignment of new recipients to the accountable care organization plans that have the better quality measure ratings.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-40-110 (Effective 05/01/13), as last amended by Laws of Utah 2012, Chapter 347

ENACTS:

26-18-408, Utah Code Annotated 1953

26-40-116, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-18-408** is enacted to read:

26-18-408. Incentives to appropriately use emergency room services.

(1) (a) This section applies to the Medicaid program and to the Utah Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.

(b) For purposes of this section:

(i) "Accountable care organization" means a Medicaid or Children's Health Insurance Program administrator that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through an accountable care plan.

(ii) "Accountable care plan" means a risk based delivery service model authorized by Section 26-18-405 and administered by an accountable care organization.

(iii) "Nonemergent care":

(A) means use of the emergency room to receive health care that is nonemergent as defined by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(B) does not mean the medical services provided to a recipient to conduct a medical screening examination to determine if the recipient has an emergent or nonemergent condition.

(2) (a) An accountable care organization may, in accordance with Subsection (2)(b):

(i) audit emergency room services provided to a recipient enrolled in the accountable care plan to determine if nonemergent care was provided to the recipient; and

(ii) establish differential payment for emergent and nonemergent care provided in an emergency room.

(b) (i) The audits and differential payments under Subsections (2)(a) and (b) apply to services provided to a recipient on or after January 1, 2014.

(ii) Except in cases of suspected fraud, waste, and abuse, an accountable care organization's audit of payment under Subsections (2)(a) and (b) is limited to the 18-month period of time after the date on which the medical services were provided to the recipient. If fraud, waste, or abuse is alleged, the accountable care organization's audit of payment under Subsections (2)(a) and (b) is limited to five years after the date on which the medical services were provided to the recipient.

(3) An accountable care organization shall use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all of the recipients enrolled in the accountable care plan.

(4) (a) The department shall, through administrative rule adopted by the department, develop quality measurements that evaluate an accountable care organization's delivery of:

(i) appropriate emergency room services to recipients enrolled in the accountable care plan;

(ii) expanded primary care and urgent care for recipients enrolled in the accountable care plan, with consideration of the accountable care organization's:

(A) emergency room diversion plans;

(B) recipient access to primary care providers and community health centers including evening and weekend access; and

(C) other innovations for expanding access to primary care; and

(iii) quality of care for the accountable care plan members.

(b) The department shall:

(i) compare the quality measures developed under Subsection (4)(a) for each

accountable care organization; and

(ii) share the data and quality measures developed under Subsection (4)(a) with the Health Data Committee created in Chapter 33a, Utah Health Data Authority Act.

(c) The Health Data Committee may publish data in accordance with Chapter 33a, Utah Health Data Authority Act which compares the quality measures for the accountable care plans.

(5) The department shall apply for a Medicaid waiver and a Children's Health Insurance Program waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services, to:

(a) allow the program to charge recipients who are enrolled in an accountable care plan a higher copayment for emergency room services; and

(b) develop, by administrative rule, an algorithm to determine assignment of new, unassigned recipients to specific accountable care plans based on the plan's performance in relation to the quality measures developed pursuant to Subsection (4)(a).

Section 2. Section **26-40-110 (Effective 05/01/13)** is amended to read:

26-40-110 (Effective 05/01/13). Managed care -- Contracting for services.

(1) Program benefits provided to enrollees under the program, as described in Section 26-40-106, shall be delivered in a managed care system if the department determines that adequate services are available where the enrollee lives or resides.

(2) (a) The department shall use the following criteria to evaluate bids from health plans:

(i) ability to manage medical expenses, including mental health costs;

(ii) proven ability to handle accident and health insurance;

(iii) efficiency of claim paying procedures;

(iv) proven ability for managed care and quality assurance;

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) an estimate of total charges for administering the pool;

(viii) ability to administer the pool in a cost-efficient manner;

(ix) the ability to provide adequate providers and services in the state; [~~and~~]

(x) for contracts entered into or renewed on or after January 1, 2014, the ability to meet

quality measures for emergency room use and access to primary care established by the department under Subsection 26-18-408(4); and

[~~(x)~~] (xi) other criteria established by the department.

(b) The dental benefits required by Section 26-40-106 may be bid out separately from other program benefits.

(c) Except for dental benefits, the department shall request bids for the program's benefits in 2008. The department shall request bids for the program's dental benefits in 2009. The department shall request bids for the program's benefits at least once every five years thereafter.

(d) The department's contract with health plans for the program's benefits shall include risk sharing provisions in which the health plan shall accept at least 75% of the risk for any difference between the department's premium payments per client and actual medical expenditures.

(3) The executive director shall report to and seek recommendations from the Health Advisory Council created in Section 26-1-7.5:

(a) if the division receives less than two bids or proposals under this section that are acceptable to the division or responsive to the bid; and

(b) before awarding a contract to a managed care system.

(4) (a) The department shall award contracts to responsive bidders if the department determines that a bid is acceptable and meets the criteria of Subsections (2)(a) and (d).

(b) The department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1) if:

(i) the executive director seeks the recommendation of the Health Advisory Council under Subsection (3); and

(ii) the executive director determines that the bids were not acceptable to the department.

(c) In accordance with Section 49-20-201, a contract awarded under Subsection (4)(b) is not subject to the risk sharing required by Subsection (2)(d).

(5) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.

Section 3. Section **26-40-116** is enacted to read:

26-40-116. Program to encourage appropriate emergency room use -- Application

for waivers.

The program is subject to the provisions of Section 26-18-408 and shall apply for waivers in accordance with Subsection 26-18-408(5).

Legislative Review Note
as of 2-8-13 12:26 PM

Office of Legislative Research and General Counsel