

Effective 5/12/2015

26-18-408 Incentives to appropriately use emergency department 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 department 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 the Emergency Medical Treatment and Active Labor Act; and
 - (B) does not mean the medical services provided to a recipient required by the Emergency Medical Treatment and Active Labor Act, including services to conduct a medical screening examination to determine if the recipient has an emergent or nonemergent condition.
 - (iv) "Professional compensation" means payment made for services rendered to a Medicaid recipient by an individual licensed to provide health care services.
 - (v) "Super-utilizer" means a Medicaid recipient who has been identified by the recipient's accountable care organization as a person who uses the emergency department excessively, as defined by the accountable care organization.
- (2)
 - (a) An accountable care organization may, in accordance with Subsections (2)(b) and (c):
 - (i) audit emergency department 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 department.
 - (b)
 - (i) The differential payments under Subsection (2)(a)(ii) do not apply to professional compensation for services rendered in an emergency department.
 - (ii) Except in cases of suspected fraud, waste, and abuse, an accountable care organization's audit of payment under Subsection (2)(a)(i) 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 Subsection (2)(a)(i) is limited to three years after the date on which the medical services were provided to the recipient.
 - (c) The audits and differential payments under Subsections (2)(a) and (b) apply to services provided to a recipient on or after July 1, 2015.
- (3) An accountable care organization shall:
 - (a) 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;
 - (b) provide viable alternatives for increasing primary care provider reimbursement rates to incentivize after hours primary care access for recipients; and

- (c) report to the department on how the accountable care organization complied with this Subsection (3).
- (4) The department shall:
 - (a) through administrative rule adopted by the department, develop quality measurements that evaluate an accountable care organization's delivery of:
 - (i) appropriate emergency department 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) delivery of primary care, urgent care, and after hours care through means other than the emergency department;
 - (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) compare the quality measures developed under Subsection (4)(a) for each accountable care organization and 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) 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:
 - (i) allow the program to charge recipients who are enrolled in an accountable care plan a higher copayment for emergency department services; and
 - (ii) 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); and
 - (d) before July 1, 2015, convene representatives from the accountable care organizations, pre-paid mental health plans, an organization representing hospitals, an organization representing physicians, and a county mental health and substance abuse authority to discuss alternatives to emergency department care, including:
 - (i) creating increased access to primary care services;
 - (ii) alternative care settings for super-utilizers and individuals with behavioral health or substance abuse issues;
 - (iii) primary care medical and health homes that can be created and supported through enhanced federal match rates, a state plan amendment for integrated care models, or other Medicaid waivers;
 - (iv) case management programs that can:
 - (A) schedule prompt visits with primary care providers within 72 to 96 hours of an emergency department visit;
 - (B) help super-utilizers with behavioral health or substance abuse issues to obtain care in appropriate care settings; and
 - (C) assist with transportation to primary care visits if transportation is a barrier to appropriate care for the recipient; and
 - (v) sharing of medical records between health care providers and emergency departments for Medicaid recipients.
- (5) 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.

(6) The department shall report to the Legislature's Health and Human Services Interim Committee on or before October 1, 2016, regarding implementation of this section.

Amended by Chapter 246, 2015 General Session