Effective 5/3/2023

26B-3-204 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 Section 26B-3-902.

(b) As used in this section:

(i) "Managed care organization" means a comprehensive full risk managed care delivery system that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through a managed care plan.

(ii) "Managed care plan" means a risk-based delivery service model authorized by Section 26B-3-202 and administered by a managed care organization.

(iii) "Non-emergent care":

(A) means use of the emergency department to receive health care that is non-emergent 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 an individual 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 non-emergent 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 managed care organization as a person who uses the emergency department excessively, as defined by the managed care organization.

(2)

(a) A managed care organization may, in accordance with Subsections (2)(b) and (c):

(i) audit emergency department services provided to a recipient enrolled in the managed care plan to determine if non-emergent care was provided to the recipient; and

(ii) establish differential payment for emergent and non-emergent 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, a managed 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 managed 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) A managed care organization shall:

(a) use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all Medicaid or CHIP recipients enrolled in the managed 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 managed care organization complied with this Subsection (3).

(4) The department may:

(a) through administrative rule adopted by the department, develop quality measurements that evaluate a managed care organization's delivery of:

(i) appropriate emergency department services to recipients enrolled in the managed care plan;

(ii) expanded primary care and urgent care for recipients enrolled in the managed care plan, with consideration of the managed 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 managed care plan members;

(b) compare the quality measures developed under Subsection (4)(a) for each managed care organization; and

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

Renumbered and Amended by Chapter 306, 2023 General Session