- 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 Ĥ→ **and the Emergency Medical Treatment and Active Labor Act** ←Ĥ ; 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 Ĥ→ **[~~January~~] July** ←Ĥ 1, Ŝ→ **[~~2014~~] 2015** ←Ŝ .

(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 Ĥ→ **[~~five~~] three** ←Ĥ years after the date on which the medical services were provided to the recipient.

(3) An accountable care organization shall Ĥ→ **:**

(a) ←Ĥ 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 Ĥ→ **; and**

(b) report to the department on how the accountable care organization complied with Subsection (3)(a) ←Ĥ .

(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).

Ĥ→ (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. ←Ĥ

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