COMMONWEALTH OF KENTUCKY STATE FISCAL NOTE STATEMENT
LEGISLATIVE RESEARCH COMMISSION
2015 REGULAR SESSION

MEASURE

2015 BR NUMBER **1186** **SENATE** BILL NUMBER **88**

RESOLUTION NUMBER____ AMENDMENT NUMBER ____

SUBJECT/TITLE An ACT relating to emergency departments and declaring an emergency.

SPONSOR Senator Ralph Alvarado

NOTE SUMMARY

FISCAL ANALYSIS**:** ☒ IMPACT ☐ NO IMPACT ☐ INDETERMINABLE IMPACT

LEVEL(S) OF IMPACT: ☒ STATE ☐ LOCAL ☒ FEDERAL

BUDGET UNIT(S) IMPACT: **Department for Medicaid Services**

FUND(S) IMPACT: ☒ GENERAL ☐ ROAD ☒ FEDERAL ☐ RESTRICTED AGENCY ____ ☐ OTHER

FISCAL SUMMARY

FISCAL ESTIMATES	2014-2015	2015-2016	ANNUAL IMPACT AT FULL IMPLEMENTATION
REVENUES			
EXPENDITURES	Indeterminable	Indeterminable	Indeterminable
NET EFFECT	(Indeterminable)	(Indeterminable)	(Indeterminable)

( ) indicates a decrease/negative

MEASURE'S PURPOSE: SB 88 abolishes the current Medicaid system to reduce unnecessary Medicaid hospital emergency room utilization and costs, and requires Medicaid managed care organizations (MMCOs) to pay for all necessary services identified through a hospital emergency room (ER) screening at negotiated rates for hospitals within the MMCO network and at published Medicaid fee-for-service rates for hospitals outside MMCO networks. If a qualified hospital medical professional determines that an emergency condition does not exist, the MMCO would not pay for all services involved in the medical screening examination. SB 88 further requires that the determination on whether a medical emergency exists or not be made solely by the qualified medical professional who performs the medical screening examination in a hospital's emergency department.

PROVISIONS/MECHANICS: SB 88 creates a new section of KRS Chapter 205 to define terms and require MMCOs to cover and pay for medical screening examinations and emergency medical condition care; requires in-network hospital reimbursements at negotiated rates and out-of-network hospital reimbursements at published Medicaid fee-for-service rates; requires that nonemergency

medical condition determinations are made by qualified medical professionals; requires the Department for Medicaid Services to promulgate administrative regulations; amends KRS 205.6334 and 205.6336 to conform; repeals KRS 205.6310; EMERGENCY.

FISCAL EXPLANATION: This fiscal impact is indeterminable because the change in the breakdown of emergency vs. non-emergency hospital ER visits by an MMCO enrollee because of this legislation, and thus change in MMCO reimbursement to hospitals for ER visits, is unknown.

Although this fiscal impact is indeterminable, the Cabinet for Health and Family Services (CHFS) provides the following analysis:

"The legislation contradicts federal laws and regulations as well as the Medicaid State Plan which require the Department for Medicaid Services (DMS), and therefore the MMCOs, to ensure medical necessity and appropriate billing for reimbursement of covered services paid by Medicaid funds. DMS and the MMCOs perform post-payment audits or reviews to determine whether services were medically necessary and billed appropriately, ensuring support documentation is in the patient record. To prohibit an MMCO from conducting a post-payment review of emergency room visits will lead to the potential for significant waste and/or abuse. Data shows that use of the emergency room for non-emergency purposes is high. In addition, the lack of contractual control created by requiring MMCOs to pay regardless of whether or not a condition is a true emergency (for both in-network and out-of-network providers) creates a fiscally irresponsible and untenable situation for the MMCOs and DMS.

With regard to the copayment provision, current federal regulations require deduction of the $8 copay for non-emergency use of the emergency room. DMS would lose the federal match for that amount, requiring this cost to be covered with 100% state funds.

The estimated fiscal impact of this legislation is conservatively estimated to be approximately $10 million. This estimate is based on actual ER data from the Department for Medicaid Services for 2014 with regard to the number of emergency room visits that do not meet “emergency” level based on procedure codes developed by the American Medical Association. Copay costs for those same visits would have to be paid with 100% state funds since failing to deduct the copay would result in the loss of federal fund participation."

Wellcare MMCO estimates that this legislation would have cost an additional $32.6 million in 2014 and will cost an additional $34.6 million in 2015. In addition, Wellcare MMCO states that SB 88 will place significant material hardship on the state by way of rate increases to meet the Centers for Medicare and Medicaid Services' (CMS) demand for actuarially sound MMCO rates.

Coventry MMCO estimates SB 88 will cost taxpayers an additional $27.5 million per year in increased MMCO rates. Coventry also states that SB 88 will result in a need to increase MMCO rates for all MMCOs, not just Wellcare and Coventry.

Passport MMCO indicated no fiscal impact for SB 88 unless it undoes the lock-in regulations. CHFS states that SB 88 will undo lock-in regulations; therefore, there will be an indeterminable impact on Passport MMCO.

Anthem MMCO states that, as a new plan that began January 1, 2014 initially serving Affordable Care Act (ACA) expansion members and then Temporary Assistance for Needy Family (TANF) and

Children's Health Insurance Program (CHIP) members as of July 1, 2014, it elected not to implement either a triage rate and/or payment reduction policy for non-emergent ER services in the first year.

CHFS states that current MMCO payments cost approximately $6 billion annually. Just a 1% increase in MMCO per member per month rates will cost an additional $60 million per year. Approximately 30% of the non-long term care/waiver population is the ACA expansion population; therefore, it is estimated that 70% of the MMCO population additional costs would be under the traditional Medicaid program. Seventy percent (70%) of $60 million would be $42 million; thus, the state share of each one percent (1%) increase in MMCO rates is estimated to equal $12.6 million just for a one percent (1%) increase in MMCO rates. SB 88 will result in the need for more than a 1% increase in MMCO payments.

The Kentucky Hospital Association (KHA) provides the following additional information relating to SB 88:

- The federal EMTALA law, federal regulations on Medicaid cost sharing for non-emergency services received in an emergency department (ED), and the Kentucky State Plan Amendment implementing such cost sharing, all require that hospital personnel performing a medical screening examination decide whether an ED patient has a non-emergency condition. When a patient is determined to have a non-emergency condition, they must be informed of this determination by the hospital staff, and given assistance in obtaining non-emergency care from an alternative site before any copay can be requested by the hospital for receiving non-emergency treatment.
- Federal EMTALA Regulations specify that hospitals must provide an appropriate medical screening examination within the capability of the hospital's ED, including ancillary services, to determine whether or not an emergency medical condition exists, and the examination (and thus the determination) must be conducted by qualified hospital personnel.
- EMTALA required screening examinations are not part of non-emergency services. The $8 co-payment is only applied against care received following the medical screening and determination by the ED physician that a person does not have an emergency condition. [42 USC 1396o-1].
- A Kentucky Medicaid State Plan Amendment (SPA) specifically states that hospital staff conducting the EMTALA screening examination make the determination of whether the patient has a non-emergency condition.
- Federal Medicaid managed care law requires MMCOs to cover "emergency services" which are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition.
- Federal Managed Care Regulations set out additional rules for emergency services. MMCOs may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)].
- The Average hospital payment for an MMCO enrollee ED visit **r**anges from $250-$450.

KHA takes issue with: a) Wellcare and Coventry MMCOs making determinations after the fact that an MMCO enrollee ED visit is non-emergency; and, b) since September 2012 and April 2013 for Wellcare and Coventry, respectively, only $50 has been paid to hospital EDs for MMCO-determined non-

emergency medical screening examinations.

KHA notes the following excerpt from a December 14, 2014 editorial article in the Lexington Herald Leader:

"...According to Citi Research, "taxpayers spent almost $275 million more on purchasing Medicaid services (in Kentucky) over the first nine months of 2014 than was necessary.

Citi's calculation of the insurers' excessive profits is subject to some complicated caveats. Also, the companies will be required to refund most of their windfall once all the numbers are in for 2014. And the state will renegotiate their rates and contracts next year...."

CHFS notes that most of these "profits" were from the Medicaid ACA expansion, and, therefore, mostly 100% Federal Funds of which any "excesses" will have to be paid back to CMS.

CHFS further notes that MMCOs are allowed approximately a 3% profit margin and 10% for administrative costs by CMS and per contractual allowances.

DATA SOURCE(S): **Cabinet for Health and Family Services; Wellcare, Coventry, Passport and Anthem MMCOs; Kentucky Hospital Association**
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