

CASE STUDY

Ensuring Adequate Medicaid Reimbursement: The Michigan Experience

The Issue

Michigan physicians had been chronically underpaid for providing professional services to Medicaid beneficiaries for years, and indeed had not had a raise in fees since 1989. As a result, access to primary care services for Medicaid recipients was compromised, forcing more of them to seek such care in the ED. An increased number of nonurgent Medicaid patients, coupled with insufficient payment levels and cumbersome billing mechanisms, compromised the financial viability of many EDs and forced hospitals to either cut back on services or, in certain cases, to close their doors. Clearly, an updated, unambiguous, fair and accurate means of reimbursement for professional emergency services in Michigan was needed.

ACEP Position

“The American College of Emergency Physicians believes that ... (p)hysician services (including medically necessary post-stabilization care) ... should be compensated in a fair and equitable manner.” [from the ACEP policy, “Hospital, Medical Staff and Payer Responsibility for Emergency Department Patients,” approved, 1989 and revised, 1999]

Background

According to federal law, a state that participates in the Medicaid program is required to adopt reimbursement measures and procedures that are sufficient to enlist enough providers so that Medicaid recipients have at least the same access to health care services as the insured population. However, anecdotal evidence suggested that Medicare patients had problems with access to traditional primary care providers. Internists, family physicians and pediatricians who were not well paid (in a way that covered their costs) were not likely to accept Medicaid beneficiaries in their practices, therefore forcing these individuals to use the ED. The EDs in turn were required to see all patients, urgent as well as non-urgent, including those on Medicaid, as a result of the unfunded EMTALA mandate.

In the meantime, emergency physicians were faced with the constant specter of either having claims downcoded on the often-questionable basis that the bills submitted were for levels of care not justified, or being denied payment all together for claims that Medicaid deemed not to be “clean.” Since the reimbursement levels were so low to begin with, in many cases insufficient to cover the fixed costs of billing, it made no economic sense for emergency physician billing companies to re-bill Medicaid if the initial claim was rejected. And at the state level, there was considerable administrative deadweight involved in processing and re-processing claims for emergency services, therefore reducing the portion of the Medicaid budget devoted to clinical services. It should also be noted that the low reimbursement levels occurred against the backdrop of a booming economy, with record low levels of unemployment and a state budget surplus.

Legislative History in Michigan

By 1999, the state was well aware of the problem, through the constant complaints of emergency physicians, billers and hospital administrators. In the spring of that year, the state Senate Health Committee created the Medicaid Workgroup, which was made operational by legislative passage of Public Act 114. The Medicaid Workgroup consisted of representatives from the Michigan College of Emergency Physicians (MCEP), the state medical society, the state hospital association, the Michigan Association of Health Plans, and the Medical Services Administration, the state agency in charge of administering the Medicaid program in Michigan. The charge to the workgroup was twofold: (1) to recommend reasonable reimbursement rates and (2) to develop educational materials for physicians, hospitals and billers. Meetings commenced in the fall of 1999 and were generally held once a month. A sense of collegiality led to the sharing of billing and coding data.

Our chapter was represented by the chair of its Health Finance Committee and the chapter lobbyist. We came to the workgroup meetings well prepared, with actual claims data to document downcoding and non-payment for legitimate services. It was at one of these meetings that the concept of paying physicians on the basis of the patient's ED *disposition*, rather than the diagnosis or level of service, was introduced. Two separate payment levels were proposed: a single fixed payment for patients who were treated and released from the ED, and a separate, higher payment for patients who were treated and admitted (or observed or transferred). It was an approach to reimbursement that was notable for being simple, straightforward, practical and applicable to all EDs in the state.

At the same time, the state medical society was conducting an extensive lobbying effort for a global increase in physician payments, which culminated in Medicaid Access Day in February 2000. Physicians from all over the state, including leaders from MCEP, went to Lansing to lobby for expanded access to health services on behalf of Medicaid patients, which, as everyone noted, was contingent on adequate physician compensation. The Medicaid Workgroup did in fact recommend an 11 percent increase in payments for all physician professional services in FY 2000-2001. For the average Michigan emergency physician, this represented an additional \$10-12,000 collected in his or her name.

At an early stage, MCEP recognized that it had an important ally in the Chairman of the House Appropriations Committee. Several MCEP leaders met privately with the Chairman over lunch on Medicaid Access Day. It was at this meeting that the two-tiered reimbursement methodology was formally presented. It is important to note that, long before this meeting took place, the groundwork had been laid by our state chapter lobbyist, whose persistence and dedication was instrumental in ensuring that our voice was heard. It took many more meetings and numerous phone calls before the details of the two-tiered case rate reimbursement were worked out. It became operational on January 1, 2001 and is scheduled to be reevaluated in July, 2001.

One very important piece of this legislative success story cannot be neglected. At its annual Emergency Medicine Scientific Assembly held in July, 2000, MCEP provided chapter members with an important opportunity to greet and thank the House Appropriations Committee Chairman and to wish him success in his upcoming "retirement," which we hope will be short-lived and followed by a successful election to the state Senate next year.

Arguments in Favor of This Position

Reducing time to payment of physician claims and cutting administrative waste for both the state and the emergency physician billing companies are powerful arguments in favor of a simplified, two-tiered case rate reimbursement methodology. Furthermore, compiling a significant amount of data, having an effective chapter lobbyist, and building coalitions with other like-minded professional groups are all key to a successful legislative outcome.

Arguments Against This Position

Increasing physician reimbursement has never been a popular voter issue. It may have helped that the Chairman of the House Appropriations Committee, a state representative with considerable influence over fiscal policy, was term-limited and therefore not eligible for re-election under Michigan's term limits law.

Legislative History in Other States

California pays for a portion of its emergency physician reimbursement through a statewide EMS fund administered at the county level. The income to this fund comes from surcharges applied to traffic fines and other misdemeanors.

Potential Proponent Organizations

State medical society
state hospital association
state nurses association

Potential Opponent Organizations

Managed care organizations, other third-party payers.

Although MCEP successfully lead the effort to simplify and raise the level of emergency physician reimbursement, our work is not finished. The staff and chapter lobbyist have monitored and will continue to monitor the situation as the implementation process goes forward. This would become particularly relevant should the state encounter future revenues below previous projections, which would jeopardize the Medicaid budget.

Submitted by: James C. Mitchiner, MD, MPH, FACEP (jmitch@umich.edu)

For more information on this issue, please contact one of the following:
Ken King, CAE, ACEP State Legislative Office (800/798-1822, ext. 3236; kking@acep.org)
Diane Kay Bollman, Executive Director, MCEP (517/327-5700; dbollman@mcep.org)

Michigan ACEP was successful in getting significant changes in Medicaid reimbursement. As a prelude to the summary material in this handout, we addressed select Questions and Answers that will assist you in understanding the submitted information.

#1 In Dr. Mitchiner's presentation, the new payment rates were listed along with the two-tiered approach. What were the payment rates prior to this change?

1. The Michigan Medicaid program contracted with several QHP's (Qualified Health Plans) to provide medical services to Medicaid recipients. The problems that Michigan ACEP had were with the QHP's methods of claim adjudication. Claims submitted to the regular state Medicaid program were paid at the Medicaid Fee Schedule that ranged from \$12.61 for 99281 to \$82.07 for 99285. QHP's routinely rejected claims as "not authorized" and ultimately did not pay at all. When it was brought to their attention that emergency services were to be paid, many began paying \$12.61 for a "screening exam" regardless of the service provided.

#2 The enclosed MSA (Medical Services Administrative Bulletin) has a paragraph that may have created problems. On page 3 of 3, "Claims for beneficiaries with other insurance and/or Medicare must be submitted to the other carrier(s) prior to submission to the health plan or MSA.... The emergency room case rate will be reduced by the amount paid by the other carriers." Medicare, PIP insurance, and Workers Compensation would be the payers that would probably be mostly involved here. Since this new methodology instituted in January, 2001, what has been the experience related to this delay in claim submission? What is the timely filing limit for Medicaid in Michigan? Has this increased the denial rates from the Medicaid carrier?

2. There was not a delay in paying claims when the two-tiered program started in January, 2001. The timely filing limit for Medicaid claims is one year. There was not an increase in denial rates from Medicaid.

#3 On the letter from Richard Murdok, Director of Comprehensive Health Plan Division, to the Qualified Health Plan CEOs, the final paragraph of the initial page speaks to the "Health Plans were informed of the ER Recommendations as part of the RFP process bid last spring." (Spring 2000). Are you receiving the same reimbursement from the private Medicaid HMOs as compared to the state Medicaid program? Have the number of these payers decreased related to this increase in reimbursement rates? Did the state ultimately enhance their monthly payment amounts to these companies to cover this increased potential company expense?

3. The same rates are received from straight Medicaid as from the Medicaid QHP's unless the ED group has a contract with the QHP and has made other payment arrangements. In the new state contract, it is estimated that the number of QHP's were reduced from 30 to approximately 20 plans. We are uncertain if the rate paid to the QHP's per member, per month has increased. We believe it has.

#4 It is very unusual to get full support from an attorney general as demonstrated by the Opinion # 7036. It may be nice to know some history behind this so other states can integrate this direction as an addition way to guarantee proper payment from Medicaid HMOs.

We believe that support was received from the attorney general because we brought emergency physician issues to the attention of the insurance commissioner. Further information from Dr. Fox is as follows: *MCEP supported the Attorney General from the time she sought the nomination of her party through the general election. We were able to educate her at a time when she had the time and the interest to understand our issues.*

Prior to her election, we were able to pass the "PRUDENT LAYPERSON" law in Michigan, thus providing the basis for the Attorney General to take a strong position. The opinion stated by the Attorney General is nothing more than a reiteration of the Prudent Layperson law.

The key to our success was getting the statues passed and staying active in the political process. (Backing the right "horse" in the political race certainly did not hurt either.)

Medicaid Update 2003

James C. Mitchiner, MD, MPH
ACEP Leadership & Legislative Issues Conference
May 6, 2003

What is Medicaid?

- Joint federal-state health insurance program
- Now the largest insurance payer in U.S. - 47 million Americans
- \$257 billion in expenditures in 2002
- Major budgetary problem for states
- "Loved by few, denigrated by many & misunderstood by most."

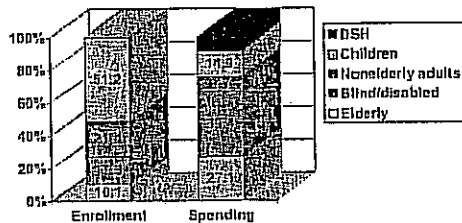
Who & what does Medicaid cover?

- 20% of all children (55% of poor children)
- One-third of all births
- Almost half of all nursing home expenditures
- One-sixth of all drug costs
- Largest payer of medical services for AIDS
- Largest source of public funding for mental health services
- Largest single source of federal grants to states

Medicaid - eligibility

- All poor children < 19
- Kids <6 + pregnant women if < 133% FPL
- Elderly, blind & disabled
- States can be more generous
- SCHIP - extends coverage to children < 200% FPL

Medicaid Enrollment and Spending, By Eligibility Group, 1998



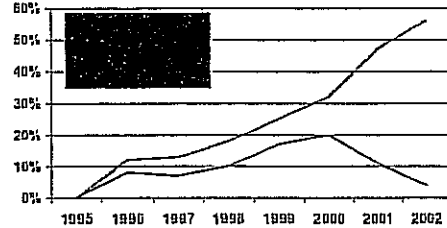
Medicaid - benefits

- Mandated services:
 - inpt/outpt hospital services, physician services, lab tests & X-rays, NH & home health care, family planning, EPSDT
- Optional services:
 - prescriptions, optometry, dental, prosthetics, facilities for mentally retarded
- No premiums, no deductibles, nominal copayments for adults (<\$3)

The Medicaid Crisis, 2003

- Increasing expenditures (11% increase last year)
 - ▾ Expanded enrollment
 - ▾ More benefits
 - ▾ Rx costs (increasing by 20% per year)
 - ▾ Health care inflation
- Decreasing state revenues (~5% increase last year)
 - ▾ Tax cuts from 1990s
 - ▾ Decreased federal share
 - ▾ Poor investment environment

Percent change in Medicaid spending and state revenues, Michigan, FYs 1995-2002



Michigan is not alone

- States facing worst budget crisis since 1940s
- Overall FY 2002 budget shortfalls estimated at 7.8% of state revenue
 - ▾ previous high was 6.5% in 1992
- Mid-year budget cuts in 39 states
- Estimated avg. Medicaid spending growth 12.8% in FY 2002
 - ▾ vs. 2.0% for total state budget

Potential Strategies

- Revising eligibility criteria
- Limiting benefits & covered services
- Administrative streamlining
- Financing & reimbursement
- Structural redesign & innovation

Prescription Drug Control

- Formularies & preferred drug lists
- Expand prior authorization
- Multi-state purchasing cooperatives
- New or higher beneficiary copays
- Require generics
- Limit number of Rx per month
- Pharmacy Plus waivers for seniors

Physician Reimbursement under Medicaid in Michigan

- Access Issues:
 - ▾ Physician payments were stagnant for 11 years
 - ▾ Claims were downcoded or not paid
 - ▾ Medicaid Access Day (MAD) at state capitol
- Michigan Medicaid Workgroup authorized, 1998
 - ▾ Participants: MCEP, MSMS, MHA, MAHP, MDCH
 - ▾ Sharing of billing & coding data
 - ▾ Goal: improve & simplify reimbursement

2-tiered Reimbursement Model

- 2 levels based on ED disposition (not Dx):
 - Treat & release: \$68.49
 - Treat & admit*: \$166.78
- For both FFS Medicaid & MC Medicaid (in absence of pre-existing contract)
- Implemented on January 1, 2001
- Re-evaluated in 12 months

*or transfer or observation

2-tiered Reimbursement Model

Keys to success

- Partner with state medical society
- Formal appeal to state insurance commissioner
- "Bury 'em with data"
- Meet with chair of House Appropriations Committee
- Persistence and patience

2-tiered Reimbursement Model Program Evaluation, 2002

- Costs exceeded projections
 - Reimbursement exceeded Medicare ceiling
 - o RVUs decreased due to practice expense changes
 - Payment for Medicare deductibles
 - o State changed policy on copays for dual eligibles
- Technical problems with claims submission
 - HIPAA non-compliance - ??
- No evidence of excess hospital admissions
- Result: state reinstated payments based on E/M & procedure codes

2-tiered Reimbursement Model

Current status

- Legislature agreed to extend our model
 - Intense lobbying efforts paid off
- But...will the state comply?
- New administration may help



**MICHIGAN COLLEGE OF
EMERGENCY PHYSICIANS**

MCEP

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FILE COPY TO:

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IVE DIRECTOR
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ep.org

December 15, 2000

Dear Doctor:

We are attaching a copy of the final bulletin regarding payment of professional services for Medicaid, which was released from the Medical Services Administration through the Michigan Department of Community Health. Please make sure that this information is disseminated to the individuals responsible for your billing process.

Though the rates are slightly altered from what the Medicaid Workgroup recommended, the overall effect is very positive for emergency physicians across the state.

Beginning with the services provided January 1, 2001, the case rate for Medicaid patients treated and released from the Emergency Department will be \$68.49 and the rate for patients treated and admitted/transferred will be \$166.78. These rates apply only in the absence of a contract with a Medicaid Qualified Health Plan. The rates are global and include all evaluation and management (E/M) and procedural services. Radiology, pathology and other professional services provided by non-emergency physicians on the same date as an emergency encounter will be paid as they would have been prior to the inception of this program.

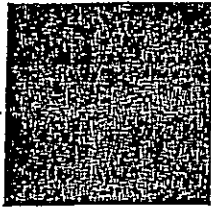
Should you have any questions regarding the program or require further information, please contact the College office.

Sincerely,

Kenneth Whiteside, MD, FACEP
Chair, Health-Finance Committee

James C. Mitchiner, MD, FACEP
President





MSA
MEDICAL
SERVICES
ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hospitals 00-12
Practitioner 00-08
Qualified Health Plans 00-10

Issued: December 1, 2000

Subject: Physician Emergency Room Case Rate

Effective: January 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program

This bulletin provides information and claims submission instructions related to the Physician Emergency Room Case Rate that has been developed in accordance with Section 1690 of PA 114 of 1999 and Section 1690(4) of PA 296 of 2000.

As required by PA 114, a workgroup was convened to recommend reasonable Medicaid reimbursement rates for hospital emergency room services. It was the workgroup's recommendation that an all-inclusive, two-tiered case rate be developed for physician emergency room services, with the level of reimbursement based on whether a patient is treated and released or treated and admitted/transferred.

The emergency room case rates will be effective for services rendered on or after January 1, 2001, for all Medicaid, Children's Special Health Care Services, and State Medical Program beneficiaries whether enrolled in a health plan (qualified health plan or special health plan) or fee for service plan. The case rate fee for a patient that is treated and released will be \$68.49. The case rate for a patient that is treated and admitted/transferred will be \$166.78. The only exception to these rates will be when a health plan has negotiated a contract with providers that specifies different reimbursement rates and procedures for services provided by physicians in a hospital emergency room. This policy is not applicable to Wayne County's Plus-Care program or to the indigent care programs in Ingham and Muskegon counties.

The instructions noted below apply to claims submitted to health plans and to the Medical Services Administration (MSA). As agreed by the workgroup, this policy will be evaluated within twelve months to assess implementation and identify areas for modification.

REPORTING OTHER INSURANCE AND MEDICARE PAYMENTS

Claims for beneficiaries with other insurance and/or Medicare must be submitted to the other carrier(s) prior to submission to the health plan or MSA. All charges and insurance/Medicare payments for services rendered in the emergency room must be reported with the appropriate procedure code. The emergency room case rate will be reduced by the amount paid by the other carriers.

PAYMENT POLICY

Claims for the emergency room case rate submitted for eligible beneficiaries with a date of service on or after January 1, 2001 will be processed for the appropriate rate based on the information provided on the claim.

All claims will be subject to the normal post-payment audit and review processes of the MSA or health plans.

MANUAL MAINTENANCE

Retain this bulletin for future reference.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979. Providers may phone toll free 1-800-292-2550.

APPROVED

James K. Haveman Jr.
Director

Robert M. Smedes
Deputy Director for
Medical Services Administration

STATE OF MICHIGAN



JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH
JAMES K. HAVEMAN, JR. Director
MEDICAL SERVICES ADMINISTRATION

400 SOUTH PINE
PO BOX 30479
LANSING MI 48909-7979

November 13, 2000

Dear Qualified Health Plan CEO:

As you know, there has been much discussion surrounding emergency room (ER) services issues over the past several years. State and Federal actions have resulted in changes in definitions, new access requirements, and most recently the agreement to use a case rate approach for reimbursing professional services in the hospital emergency room. Additionally, we are including the topic of improvements in emergency services utilization in our health plan performance bonus area.

This letter provides an update for you regarding the status of the Professional Services ER Case Rate and other ER claim issues. While I am generally pleased with the progress we have made, the residual claim issues with emergency professionals need to be resolved (paid) in order to draw closure.

The following outlines the decisions that have been made.

1. Professional Emergency Room Claims for Dates of Service January 1, 2001 and Forward

For services provided on and after January 1, 2001, there should be no mistake regarding the reimbursement policy of the State's Fee for Service Program—or the obligation of health plans, in the absence of contracts with providers. In these instances, the case rate established under the Medicaid policy bulletin will be used. The case rate will be:

- \$68.49 for Treat And Release
- \$166.78 for Treat/Admit/Transfer

The case rate amount is based upon appropriations supported for the fee for service program and is consistent with the appropriations boilerplate as not exceeding Medicare rates. Health plans were informed of the ER Recommendations as part of the RFP bid last spring. The final Medicaid policy bulletin on this issue will be released shortly with an effective date of January 1, 2001. The bulletin will describe the operational aspects of the case rate and will provide further definitions regarding hospital emergency room.

Expectations for Health Plan Performance:

Based upon the information contained above and provided to you in various other communications, my office will have the following expectations:

- (1) All claims for services provided before January 1, 2001 for professional services in the hospital emergency room must be paid using either your ER contracted rate or the Medicaid fee for service rates;
- (2) Claims for professional services provided in the emergency room January 1, 2001 and after will be paid using the new case rates established in Medicaid Policy (amounts described above), unless a contract with providers stipulates otherwise; and
- (3) DCH supports an alternative methodology (described above) for claims that continue to be disputed and would recommend that such an alternative be used for claims that are appealed to Arbitration.

Failure to resolve all outstanding emergency services professional claims will result in Contract remedies applied as outlined in Section II-W-2 under the Contract. Because claims may be submitted for up to 12 months after date of service, this issue will be specifically reviewed at each site visit that will take place over the next year to assure that our expectations are met.

I know that we are all prepared to address this issue as described and I thank you for your cooperation on this issue. Please contact my office if you have any questions.

Sincerely,

Richard Murdock, Director
Comprehensive Health Plan Division

cc: Joan Moiles, OFIS, Department of Consumer and Industry
Susan P. Garcia, Michigan Association of Health Plans
Diane Bollman, Michigan College of Emergency Physicians

Section 1690 Emergency Services Workgroup
Emergency Room Services
Reimbursement Report and Recommendations

I. Background

Establishment of the Workgroup

The establishment of the Section 1690 Emergency Services Workgroup was partially intended to resolve the billing issues through the development of both an approach (process) and agreeable, reasonable reimbursement rates.

Under PA 114 of 1999 (Section 1690(4)) the Department of Community Health was directed to *"...convene a workgroup for the purpose of recommending reasonable Medicaid reimbursement rates for hospital emergency room services, which may include differential rates based on emergency room discharge diagnoses."*

According to the legislative language, the Workgroup was intended to include, at minimum, representatives from the Michigan Association of Health Plans, Qualified Health Plans, the Michigan Hospital Association, and the American College of Emergency Physicians. The workgroup members are listed in the appendix of this report and represent the above groups. While not a formal member of the workgroup, it should be noted that the Department of Community Health provided staff through the Divisions of Comprehensive Health Plan, Actuarial Services, and Fee-for-Service.

It is important to note that all parties agree that a provider/health plan contract is the preferable method for addressing the reimbursement and payment issues. Consequently, the recommendations are intended only in those instances where a contract does not exist between the health plan and the provider. Further, to assure consistency, the Medicaid program fee-for-service program will also implement the recommendations.

It is also important to note that the Medicaid reimbursement for emergency providers have not increased since 1989. Further, in order to administer the Medicaid managed care program, the reimbursement provided to health plans is based upon capitation rates that are at or below 100% of the Medicaid fee for service equivalent. Consequently, pressure on this issue for reimbursement is coming from two directions: from providers who have not seen the Medicaid fee screens increased in more than ten years and are seeking increases and from health plans whose capitation is based on the State's fee for service experience.

The Workgroup held their initial meeting on September 10, 1999, and held additional meetings on the following dates:

October 8, 1999
November 10, 1999
January 14, 2000
February 11, 2000
February 25, 2000

Section 1690 Emergency Services Workgroup Report and Recommendations

March 10, 2000 and
March 24, 2000

The workgroup has provided two progress reports to the Senate and House Appropriations Committees. These reports provided copies of the meeting minutes and materials that were distributed during the time frames covered by each report.

The Workgroup will continue to meet after the issuance of this report on another charge given by the Legislature in Section 1690 (6). This charge was "...developing educational materials for the purpose of assisting Medicaid recipients in understanding when an emergency room visit may be appropriate and when other alternatives should be used."

Obligation to Serve Persons in a Hospital Emergency Room

The Emergency Medical Treatment and Active Labor Act, EMTALA, 41 USCS 1395 dd(a), requires that hospital emergency department staff provide a medical screening exam and any ancillary services routinely available to the emergency department to determine whether or not an emergency condition exists. Under additional federal and state statutes and rules, this has been interpreted to mean that hospital emergency room providers are obligated to provide necessary emergency services to all persons who present themselves in a hospital emergency room. This obligation continues until the person has been stabilized and may either be discharged or transferred.

The rules of reimbursement have not paralleled the federal and state requirements to provide services through stabilization. That is, reimbursement requirements of various providers were not included in the mandatory service requirements for hospital emergency providers. As a result, emergency providers continue to be placed under financial risk to meet their statutory obligations identified above. In order to sustain the emergency services program it is important for emergency care to be properly reimbursed. Over the last several years different payment responsibilities have been clarified in both federal and state law. While this issue affects all parts of the health care system, this report will address issues that relate to Medicaid payments and services provided to Medicaid Beneficiaries under both the fee for service program as well as the managed care initiative.

Health Plan Responsibility

Qualified Health Plans are responsible, under the State's Medicaid Contract, for payment of all emergency services and medical screening and stabilization services and can not require such services to be prior authorized. This issue was reaffirmed by the passage of PA 136 of 1997 in 1998 (H.B. 4080). However, several key areas continue to present problems related to reimbursement. These are post-stabilization services provided without authorization and confirmation of the level of care provided in the emergency room.

The Department of Community Health has amended Qualified Health Plan Contracts to include the Federal Balanced Budget Act language. This language stipulates that an emergency exists if a "prudent layperson" reasonably believes that the use of a contracting provider will result in a delay that will worsen the condition of the beneficiary. Previously, health plans and other payers typically reimbursed emergency providers based on "discharge diagnoses". The enactment of

Section 1690 Emergency Services Workgroup Report and Recommendations

the emergency provisions under the Federal Balanced Budget Act, changed that process and required payments to be based on “presenting signs and symptoms.”

Since the obligation to cover “emergency services” ceases after stabilization, services rendered after stabilization, that are not authorized, may not be the responsibility of Qualified Health Plans. However, both the Medicaid Contract and provisions under the Federal Balanced Budget Act stipulate a process and timeframe for securing approval from the health plan for authorization of post-stabilization services. If a health plan does not respond within the time frame, the post-stabilization services are “deemed approved.” The issues related to level of care in the emergency room continues to be problematic.

II. Issues and Principles

The Workgroup held preliminary discussions regarding issues that should be addressed and principles that should be applied to whatever reimbursement proposal that might be developed. This included the following:

Issues:

- Reimbursement and procedures for reimbursement are linked—administrative procedures often cause more of an issue than reimbursement;
- Payers must understand the legal responsibility that anyone presenting themselves in a hospital emergency room must be seen and a determination that an emergency no longer exist for the responsibility to end;
- Related to the above, managed care is charged with striving for efficiencies, which would suggest that some emergency room services are more efficiently provided in other settings—yet emergency room providers are legally bound to provide screening and stabilization services; and
- Beneficiaries want convenient care and emergency room care is convenient—even if at times it is an inappropriate setting.

Principles:

- Reimbursement changes should not be undertaken unless they will also result in reducing the administrative cost of processing and paying claims for both the provider and payer;
- Workgroup members recognize resource limitations in terms of limited funds available for reasonable reimbursement, which in turn could potentially limit the access and availability of emergency services;
- Any new reimbursement model must be reviewed at the first 6 and 12 month intervals to assure that it is working toward the principles of reasonable reimbursement rates, and reducing the administrative costs of providers and payers in the processing and payment of emergency services claims; and
- Finally, it was agreed that education and instilling responsibility for beneficiaries is ultimately the key factor for changing inappropriate utilization of emergency room services.

Section 1690 Emergency Services Workgroup Report and Recommendations

III. Methodology

The Workgroup discussed options related to a reimbursement model. It was agreed that a "Case Rate" methodology could eliminate a number of the "gray" areas that currently account for much of the reimbursement issues. These issues include: discrepancies between level of services billed and level of services documented; disputes between plans and providers regarding "stabilization"; disputes between plans and providers regarding authorization processes for post-stabilization services; and disputes between plans and providers regarding the medical necessity of some ER diagnostic procedures. The Workgroup agreed to arrive at conceptual models before costing out such models.

Two case rate models were proposed. One was intended to address professional charges for encounters in the hospital emergency room and the other was intended to address facility related charges for the same encounter. Discussion regarding an overall case rate for both professional and facility charges was raised and rejected as not feasible.

1. Emergency Physician Professional Services Case Rate

The model for Professional Services introduced by the Michigan College of Emergency Physicians which the Workgroup reviewed is referred to as the "disposition model". Essentially, this model describes level of care by treating the patient's disposition as either "treated and released" or "treated, admitted, or transferred". The proponents of this model indicate that it is consistent with the H.B. 4299 requirements and would be usable under the forthcoming Medicare ambulatory payment classifications, (APCs) that will affect all outpatient services.

Because of this uniformity, the proposal would reduce administrative costs. The Workgroup further understood that providers and office staff would use the current level of care coding—so no training would be necessary for operation. The change would be manifested at the payer level upon receipt of various procedure codes coupled with a determination of the "disposition" of the beneficiary..

The Workgroup discussion also reviewed which procedure codes should be allocated to the disposition model as "proxy" for payment of the proposed "disposition" case rate. The recommended case rates assume the following allocation of codes and their associated payments:

Code # for Treat/Release

Code # for Treat/Admit/Transfer

099281
099282
099283
099284

099285
099291
099292

It was agreed that other professional consultative services should be handled separately from the review of the Workgroup and would not be included in any proposed case-rate for professional services.

Section 1690 Emergency Services Workgroup Report and Recommendations

The workgroup also reviewed the alternative of using the same methodology to create an “acuity” model. Under this model, a case-rate reimbursement would be tied to the presentation of procedure codes. Those procedures codes group in a “low acuity” level would be reimbursed under a case rate and procedure codes clustered around the “high acuity” level would be reimbursed under a different and higher case rate. However, the workgroup members were not united in their position that the “acuity” model would totally address the various “gray” areas incumbent with the current reimbursement program. Further, there was lack of agreement relative to the allocation of procedure codes if used as an “acuity” model. In particular, some Workgroup members felt strongly that the inclusion of procedure code 99284 should be included in a lower acuity model. Other members felt equally strong that the code 99284 belongs in the higher acuity model. This difference is not a concern in the disposition model as the reimbursement is tied specifically to the disposition of the beneficiary.

The Workgroup members were supportive of the “disposition” model as the best vehicle to resolve current payment disputes and problems as well as reduce administrative costs of providers and payers in the processing and payment of emergency physician professional claims.

2. Facility Case Rate

Initial Discussions

The Workgroup started discussions for a facility rate by reviewing a model presented by the Qualified Health Plan representatives, referred to as “Fast Tracks”. The emphasis of this model is to direct the triage function within the emergency room and recognize high and low levels of acuity. The Case Rate under this model is inclusive of both facility and ancillary costs.

As the Workgroup proceeded in its discussions there was agreement to classify services in a manner that would be consistent with the classification for the “disposition model” for professional services. Under that classification, only one rate “treat and release” would be necessary, as the reimbursement for the “treat and admit/transfer” would be included in inpatient reimbursement. The Workgroup was presented with cost information that presented data associated with the commonly used facility codes: (99281, 169032, and 169525). However, as noted above, recommendations were made to be consistent with the classification used for the professional services.

Workgroup members representing hospitals felt strongly that the proposed case rate should not include ancillary costs (e.g. lab and x-ray), as those costs are not under the direct control of facilities. Other workgroup members indicated that unless a case rate is all inclusive, many of the “gray” areas will remain outstanding and will not create the administrative relief for both plans and providers.

Workgroup Hospital Representatives’ Proposal

On behalf of Michigan’s 147 hospitals and health systems, the hospital contingent of the Public Act 114 of 1999 – Section 1690 emergency room services workgroup is formally recommending a methodology for developing a reasonable facility case rate reimbursement.

Section 1690 Emergency Services Workgroup Report and Recommendations

Assumptions:

- Establishing “low acuity” and “high acuity” payment levels would differentiate facility case rates.
- Reimbursement for ancillary procedures (e.g., laboratory, radiology, other professional emergency services) is made separately and is not included in the facility case rate.
- Adequate inflationary increases must be applied to facility case rate payments to recognize reimbursement appropriate to 1999.

Facility costs far exceed current reimbursement levels, even with appropriate inflation adjustment. If the charge of the Public Act 114 of 1999 – Section 1690 Emergency Room Services Workgroup is to recommend “reasonable Medicaid reimbursement rates for hospital emergency room services,” then the cost of providing care must be recognized in any recommendation. Government purchasing of outpatient health care services is significantly below the actual cost of providing those services. A preliminary study of Medicaid reimbursement for all outpatient services for a six-month period in 1998 indicates payment levels at less than 44 percent of costs.

The hospital contingent representatives agree that a case rate methodology may allow for the principles of reasonable reimbursement rates, and reducing administrative costs for providers and payers in the processing and payment of emergency services claims, to be attained. Hospitals would support further analysis of data to develop reasonable payment rates that cover the cost of providing emergency care for the facility component – either at hospital-specific or regional rates. Michigan hospitals support the continuance of existing payment methodologies where reimbursement of ancillary procedures is separate from the facility component, and that those rates must be adjusted for inflation.

Workgroup Recommendation

After consideration of the recommendation of the hospital Workgroup members, the Workgroup arrived at consensus that a facility case rate methodology under the following set of considerations might be feasible:

- The desirable outcome and objective was to arrive at a Case Rate methodology consistent with the Emergency Physician “Disposition Model”;
- A facility case rate should incorporate the cost of care variation among hospitals relative to case-mix;
- To accommodate the case-mix issue, the final recommendation may need to be regional or hospital specific;
- Further analysis is necessary and the Workgroup members are in agreement to continue to address the development of a facility case rate as described above in continued Workgroup meetings; and
- Recommendations from the Workgroup will be forwarded to the Legislature at such time as this recommendation is completed. Until the recommendation is completed, continuation of existing payment methodologies should continue, in accordance with existing Medicaid policies.

Section 1690 Emergency Services Workgroup Report and Recommendations

3. Department of Community Health Analysis.

Based upon the discussion regarding models, the Department of Community Health provided various cost analysis using 1998 calendar year fee for service data. This time frame was used because rates have not changed from that time and 1998 is considered the last full year of data that could be used for this purpose as after 1998 full "outstate" implementation of managed care would have limited the fee for service data.

The Department initially provided data that was intended to define the "universe" of emergency room encounters. However, after presentation to the Workgroup members, an alternative methodology was suggested that would match the procedure codes used by emergency room physicians. Based on these codes, DCH staff would combine beneficiary ID and date of service in order to arrive at all emergency room encounters in CY 1998. Following presentation to the Workgroup this data was fine-tuned to review certain codes that may have been excluded.

The report recommendations for the emergency physician Case Rate methodology are based, in part, on the final data analysis prepared by the Department of Community Health and reviewed by the Workgroup members.

4. Other Considerations

The Workgroup members also suggested that part of the recommendations be based on the savings that might be realized in the processing of medical claims. Through the use of a Case-Rate, or other methodology, that would minimize the number of appeals and re-submissions, both payers and providers will realize administrative savings. Studies that were shared with the Workgroup indicated that it costs up to \$26/claim to prepare and process; up to \$8 dollars in a physician's office and up to \$18 by the insurer (payer). It was therefore in everyone's interest to limit the number of times a claim should be processed and reviewed.

IV. Professional Services (Emergency Physician) Recommendations

(1) Recommendation – Case Rate.

The Workgroup recommends the establishment of a two-tier case rate that would accommodate all emergency physician professional charges. The case rates should be implemented as discussed below:

- The "treat and release" Case Rate would be paid at a rate of \$72.22*. The payment would take place based on submission of a claim with modifier that indicates "treat/release".
- The second tier, or "treat/admit/transfer", would be paid at a rate of \$165.51*. The payment would take place based on submission of a claim with modifier that indicates "treat and admit/transfer".

*The Case Rate amounts are based on the following factors:

- A starting point used in the RBRVS, (conversion factor) of \$19.40 as described in Medicaid Hospital and Practitioner Bulletin 92-06;
- Updating the \$19.40 for inflation to current value using the CPI-Medical Component;

Section 1690 Emergency Services Workgroup Report and Recommendations

- Applying against the “updated conversion factor” current Relative Value Units of 2.23 RVUs for “treat and release” and 5.11 RVUs for “treat and admit/transfer”; and
- The Case Rate was based on the code mix from physicians rather than the code mix received from Medicaid fee for service in 1998.

(2) Recommendation – Technical Workgroup

The Workgroup also made the following recommendation to assure standardization of claims coding:

In order to implement the “disposition model” case rates, the MDCH should immediately convene a subgroup of the associations represented by the Workgroup to meet with the MDCH in order to establish acceptable standardization of coding modifiers necessary to identify the hospital admission status of a beneficiary. The coding must be consistent with the national Medicare coding that will be used for all claims paid by Medicaid and by Medicaid Contracted Health Plans.

(3) Recommendation – Health Plan Payments

The Workgroup members were also in agreement that the Health Plans would pay the Case Rate provided the appropriations for Qualified Health Plans included the funding necessary to support the recommendation.

Department of Community Health Position:

The Workgroup members were informed that the Department of Community Health would only implement recommendations for the fee for service program and Contracts with Health Plans that are supported by enacted appropriations and that the Department cannot comment on recommendations that are not supported by current appropriations.

The Department’s data analysis of the 1998 fee for service data, provided for the Workgroup’s review, was used to illustrate how the “disposition” model would work. This analysis, described in Section III-1 of this report, created the “proxy” for payment using the procedure codes that were determined to be more likely to be associated with “treat and release” and those procedure codes more likely to be associated with “treat and admit/transfer”. The “proxy” costs associated with those codes were \$33.04 for “treat and release” and \$87.45 for “treat and admit/transfer”. This data did not include the increases of physician fees in the FY 2000 budget or those included in the FY 01 Executive Budget. Applying the fee increases contained in both the current budget and the Executive Budget recommendation, would increase the “proxy” amounts to \$35.68 and \$94.45 respectively. Because the Department’s analysis did not relate procedure codes with actual patient “disposition”, the use of this data to draw a comparison of the “disposition” model is limited.

FY 01 Fiscal Impact of the Recommendation:

While it is not possible to precisely estimate the total impact of the proposed Case Rate for health plans, the fee for service program data may be used for illustration purposes. Applying the Case Rate values and the same number of encounters as that in 1998 would require a funding increase of \$3.3 million dollars in total gross Medicaid funding for the current fiscal year fee for service program (or an increase of \$1.6 million in general fund dollars). Because health plan

Section 1690 Emergency Services Workgroup Report and Recommendations

enrollment is now about 2/3 of total Medicaid eligibles, the total impact of this recommendation would require about \$8.5 million in total gross Medicaid funding (or \$4 million general fund)—if the assumption is used that no health plan has an existing contract with emergency providers.

V. Facility Recommendations

The Workgroup members agreed to defer the final recommendations for a proposed facility reimbursement rate pending further Workgroup analysis and deliberation. (See the discussion under item III-2 above.)

VI. Implementation Steps and Timelines

The implementation of the Workgroup recommendations would take place in two phases. The first phase would be through a Contract modification provision between the State and all contracting health plans. The Contract modification language would then be effective in all instances where a provider/health plan contract is not in place. The effective date of this Contract modification would be October 1, 2000, consistent with the effective date of new Contracts issued under the current Request for Proposal.

The second phase of implementation would address services provided and reimbursed through the State's fee for service program. The implementation would be established through the usual Medicaid policy bulletin consultation process and would be effective based upon dates contained in the bulletin.

As noted in the Workgroup recommendations, an implementation subgroup will be formed to assure that the necessary billing code modifications will be made consistent with the movement to standardize coding.

Per request of the Workgroup members, the Workgroup will be reconvened at both a 6-month and 12 month intervals following the initial implementation of the recommendations. This would take place during April and October of 2001. The Workgroup members indicated that a review at this time would look at both progress in the implementation and areas for modification if necessary. Further, the Workgroup was willing to review the feasibility of a single professional case rate after adequate experience with the two-tier rates.

VII. Consensus Statement

The following Workgroup members have consented to have their names listed under the following Statement of Agreement:

Statement of Agreement:

As a Workgroup member, I agree that the recommendations contained in this report represent a consensus of the Workgroup:

Tina Barnikow (Michigan Association of Health Plans)
Diane K. Bollman (Michigan College of Emergency Physicians)
Millard Doster, M.D., (Michigan College of Emergency Physicians)

Section 1690 Emergency Services Workgroup Report and Recommendations

James M. Fox, M.D., (Michigan College of Emergency Physicians)
Susan P. Garcia, (Michigan Association of Health Plans)
Erik Harris, (Michigan Health and Hospital Association)
Charles E. Jessup, D.O., (Michigan College of Emergency Physicians)
Marc Keshishian, M.D., (Michigan Association of Health Plans)
Michael Kobernick, M.D., (St. John/Macomb Hospital and Interested Party)
Jeff LaFave, (Michigan Health and Hospital Association)
Kathy Madden, (Michigan Association of Health Plans)
Sheldon P. Mandelbaum, (Michigan Health and Hospital Association)
Michael A. Pelc, (Michigan Health and Hospital Association)
John W. Walker, M.D., (Michigan College of Emergency Physicians)
Nancy Wanchik, (Michigan Association of Health Plans)
Doug Welday, (Michigan Health and Hospital Association)

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Act No. 296
 Public Acts of 2000
 Approved by the Governor*
 July 19, 2000
 Filed with the Secretary of State
 July 21, 2000
 EFFECTIVE DATE: July 21, 2000

*Item Veto

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Sec. 1022.

Entire Section. (Page 20)

STATE OF MICHIGAN
 90TH LEGISLATURE
 REGULAR SESSION OF 2000

Introduced by Senators Gougeon, Schwarz, Johnson and A. Smith

ENROLLED SENATE BILL No. 964

AN ACT to make appropriations for the department of community health and certain state purposes related to mental health, public health, and medical services for the fiscal year ending September 30, 2001; to provide for the expenditure of those appropriations; to create funds; to require and provide for reports; to prescribe the powers and duties of certain local and state agencies and departments; to provide for disposition of fees and other income received by the various state agencies; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS - FISCAL YEAR 2000-2001

Sec. 101. Subject to the conditions set forth in this act, the amounts listed in this part are appropriated for the department of community health for the fiscal year ending September 30, 2001, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH

Full-time equated unclassified positions	6.0	
Full-time equated classified positions	6,258.1	
Average population	1,528.0	
GROSS APPROPRIATION		\$ 8,564,877,900
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		\$ 72,087,300
ADJUSTED GROSS APPROPRIATION		\$ 8,492,290,600
Federal revenues:		
Total federal revenues		4,461,470,600
Special revenue funds:		
Total local revenues		910,969,100
Total private revenues		49,649,800
Tobacco settlement revenue		86,021,400
Total other state restricted revenues		297,189,000
State general fund/general purpose		\$ 2,686,991,200

Sec. 1690. (1) Reimbursement for medical services to screen and stabilize a Medicaid recipient in a hospital emergency room shall not be made contingent on obtaining prior authorization from the recipient's qualified health plan. If the recipient is discharged from the emergency room, the hospital shall notify the recipient's qualified health plan within 24 hours of the diagnosis and treatment received.

(2) If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's qualified health plan prior to admitting the recipient.

(3) Subsections (1) and (2) shall not be construed as a requirement to alter an existing agreement between a qualified health plan and their contracting hospitals nor as a requirement that a qualified health plan must reimburse for services that are not considered to be medically necessary.

(4) Effective October 1, 2000, the department shall implement a 2-tier case rate, not to exceed the corresponding Medicare rates, for all emergency physician professional charges as recommended by the emergency services workgroup authorized in section 1690 of 1999 PA 114. The case rate shall be determined based upon the final disposition of the patient. Those patients who are treated and sent back to their residence shall form 1 group (treat and release). The second group shall be comprised of those patients who are treated and either transferred to another health facility or kept in the hospital as admitted or observed patients (treat and admit/transfer).

Sec. 1691. (1) It is the intent of the legislature that a uniform Medicaid billing form be developed by the department in consultation with affected Medicaid providers. Every 2 months, the department shall provide reports to members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the progress of this initiative.

(2) Until such time as a uniform billing form is developed and implemented, or unless otherwise provided in state law, the following shall apply to Medicaid qualified health plans:

(a) If a billing form is received by a qualified health plan with a noncorrectable error, the qualified health plan shall return the form within 10 business days to the billing provider with plain language instructions as to what items need to be corrected.

(b) If a qualified health plan fails to provide reimbursement for at least 90% of its clean claims within 30 days of receipt, the qualified health plans shall be subject to an interest charge based on the value of the unpaid claims. Interest shall be paid at the rate specified in section 3902(a) of title 31 of the United States Code, 31 U.S.C. 3902. As used in this subdivision, "clean claim" means a claim that has no defect or impropriety, including lack of required substantiating documentation for noncontracting providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

(c) If a qualified health plan has followed the procedure specified in subdivision (a), the required time for reimbursement does not begin until a corrected billing form has been received.

(d) A Medicaid provider that submits a duplicate of a claim that has been denied or returned with notice that it is complete or incorrect shall be subject to a service charge for each duplicate claim, in an amount determined by the department, if the duplicate claim is submitted without completion, correction, or further information that addresses the denial or return.

(3) The department shall hold regular Medicaid billing seminars targeted to both qualified health plans and Medicaid providers. The number and locations of these seminars should be sufficient to provide reasonable access to qualified health plans and Medicaid providers throughout the state. The department shall provide quarterly reports to the members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the number of seminars, their content and location, and the number of persons attending these seminars.

Sec. 1692. (1) The department shall do or demonstrate that it has accomplished all of the following concerning the provision of early and periodic screening, diagnosis, and treatment (EPSDT) and maternal and infant support services (MSS/ISS):

(a) Explore the feasibility of developing a uniform encounter form for EPSDT services, MSS/ISS referral, and MSS/ISS screening and services.

(b) Require each qualified health plan to evaluate 100% of pregnant Medicaid enrollees for possible MSS/ISS screening referral during the initial pregnancy services visit, using uniform screening and referral criteria.

(c) Require each qualified health plan to notify the department and the appropriate local health department of all MSS/ISS screening referrals, and require all MSS/ISS screening and service providers to notify the department and the appropriate local health department of Medicaid clients who fail to keep MSS/ISS appointments.

(d) Prohibit qualified health plans from requiring prior authorization for their contracted providers for any EPSDT screening and diagnostic service, for MSS/ISS screening referral, or for up to 3 MSS/ISS service visits.

SECTIONS 1690 & 1692 OF SB 964 – DEPARTMENT OF COMMUNITY HEALTH BUDGET

Sec. 1690. (1) Reimbursement for medical services to screen and stabilize a Medicaid recipient in a hospital emergency room shall not be made contingent on obtaining prior authorization from the recipient's qualified health plan. If the recipient is discharged from the emergency room, the hospital shall notify the recipient's qualified health plan within 24 hours of the diagnosis and treatment received.

(2) If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's qualified health plan prior to admitting the recipient.

(3) Subsections (1) and (2) shall not be construed as a requirement to alter an existing agreement between a qualified health plan and their contracting hospitals nor as a requirement that a qualified health plan must reimburse for services that are not considered to be medically necessary.

(4) Effective October 1, 2000, the department shall implement a 2-tier case rate, not to exceed the corresponding Medicare rates, for all emergency physician professional charges as recommended by the emergency services workgroup authorized in section 1690 of 1999 PA 114. The case rate shall be determined based upon the final disposition of the patient. Those patients who are treated and sent back to their residence shall form 1 group (treat and release). The second group shall be comprised of those patients who are treated and either transferred to another health facility or kept in the hospital as admitted or observed patients (treat and admit/transfer).

Sec. 1691. (1) It is the intent of the legislature that a uniform Medicaid billing form be developed by the department in consultation with affected Medicaid providers. Every 2 months, the department shall provide reports to members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the progress of this initiative.

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(3) The department shall hold regular Medicaid billing seminars targeted to both qualified health plans and Medicaid providers. The number and locations of these seminars should be sufficient to provide reasonable access to qualified health plans and Medicaid providers throughout the state. The department shall provide quarterly reports to the members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the number of seminars, their content and location, and the number of persons attending these seminars. §

MCEP SUCCESSFUL IN INCREASING MEDICAID FUNDING

The Michigan College of Emergency Physicians has scored a tremendous victory in their lobbying efforts in Lansing this year. Commencing in September of 1999 with their involvement in a State legislated Medicaid Workgroup, members of the Health Finance Committee worked diligently in collecting and processing claims data from across the State. Their efforts culminated in the passage of the FY 2000-2001 Department of Community Health budget which contains language that endorses a funding increase for professional emergency medicine services for Medicaid.

Led by James M. Fox, MD, FACEP, the workgroup was able to increase funding by 67 %. This 8.5 million-dollar increase is the first increase in Medicaid funding for professional emergency services since 1989. The new funding levels are tied to a two-tiered payment system that determines payment based on the final disposition of the patient. The so-called "Disposition Model" was developed by Dr. Fox to help eliminate the ongoing disputes between providers and third party payers. The rates of \$72.22 for treat/release and \$165.51 for treat/admit (observe)/transfer will be inclusive of both E/M and procedure services. This system will be in place and enforced by the Department of Community Health on October 1, 2000 for both fee-for-service Medicaid and HMO/QHP Medicaid.

Please note that the payment arrangement as well as the levels of payment will be enforced for all Medicaid services in the absence of a contract. What this means is that every provider of emergency services in the State should immediately review their current contracts with Medicaid third party payers and determine if these contracts should be maintained or amended. Most contracts have a 60 to 90 day termination clause; therefore, it would behoove everyone to do this review immediately so that they might take advantage of the new rates on October 1.

Heartfelt thanks are extended to everyone who helped bring this to fruition: Vanderveen & Associates; the MCEP Staff; Charlie Jessup, DO; John Walker, MD; Millard Dosster, MD; Tanya Potter; Steve Rivera, DO and the members of the Health Finance Committee.

Additionally, special thanks and recognition to Sandy Steele, Billing and Coding Manager for Romain Management, without whom this success could not have been achieved. Sandy and Romain Management were tireless in providing and accumulating the data necessary to reach this victory.

If you have any questions, please contact the MCEP office at 517-327-5700 or Dr. Fox at 313-343-7808. *(See related story on page XXX)*§

STATE OF MICHIGAN

JENNIFER M. GRANHOLM, ATTORNEY GENERAL

HEALTH MAINTENANCE ORGANIZATIONS:

Reimbursement for emergency health services provided to Medicaid patients

HOSPITALS:

PHYSICIANS AND SURGEONS:

PUBLIC HEALTH:

Under the Public Health Code and the Medicaid managed care program, where the requirements of these statutes are otherwise satisfied, a health maintenance organization must reimburse physicians for emergency health services provided to Medicaid patients, including instances when the physician has not obtained prior authorization from the patient's health maintenance organization.

Opinion No. 7036

October 18, 1999

Honorable Michael D. Bishop
State Representative
The Capitol
Lansing, Michigan

You have asked whether health maintenance organizations may deny reimbursement for emergency health services provided to Medicaid patients on grounds that the providing physician failed to obtain prior authorization from the health maintenance organization.

Congress, through adoption of section 4701(a) of the Balanced Budget Act of 1997, Pub. L. 105-33, gave to the states the option of utilizing managed care organizations as a method of providing Medicaid funded health care services. The State of Michigan chose this option and entered into contracts with managed care

organizations establishing qualified health plans. These plans utilize health maintenance organizations (HMOs), which are required to provide care to Michigan Medicaid recipients pursuant to 42 USC 1396u-2. Subsection (b)(2) of this statute, which requires the provision of emergency services without prior authorization, states:

(A) In general

Each contract with a medicaid managed care organization under section 1396b(m) of this title and each contract with a primary care case manager under section 1396d(t)(3) of this title shall require the organization or manager —

(i) to provide coverage for emergency services (as defined in subparagraph (B) without regard to prior authorization or the emergency care provider's

contractual relationship with the organization or manager

(Emphasis added.)

Subsection (b)(2) of the federal statute defines "emergency services" as follows:

(B) "Emergency services" defined

In subparagraph (A)(i), the term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that —

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) "Emergency medical condition defined"

In subparagraph (B)(ii), the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in --

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.

Moreover, HMOs doing business in Michigan are governed by the Public Health Code (Code), 1978 PA 368, MCL 333.1101 *et seq*; MSA 14.15(1101) *et seq*, which is "AN ACT to protect and promote the public health; . . . to regulate health maintenance organizations and certain third party administrators and insurers."

Section 21005(2) of the Code defines "health maintenance organization" as a health facility or agency that:

- (a) Delivers health maintenance services which are medically indicated to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.
- (b) Is responsible for the availability, accessibility, and quality of the health maintenance services provided.

Section 21004 of the Code defines "emergency health services" as follows:

- (1) "Emergency health services" means *medically necessary services* provided to an enrollee for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious

jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. *A health maintenance organization shall not deny payment for emergency health services up to the point of stabilization provided to an enrollee under this subsection because of either of the following:*

(a) The final diagnosis.

(b) *Prior authorization was not given by the health maintenance organization before emergency health services were provided.*

(2) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.

(3) "Stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

(Emphasis added.)

Similarly, section 21077(2) of the Code requires that:

In case of an emergency episode of illness or injury which requires immediate treatment before it can be secured through the health maintenance organization, or for an out-of-area service specifically authorized by the health maintenance organization, an enrollee may utilize a provider within or without this state not normally engaged by the health maintenance organization to render service to its enrollees. The organization shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case.'

(Emphasis added.)

¹ Michigan's Legislature has adopted essentially identical provisions with regard to emergency health services in section 418 of the Nonprofit Health Care Corporation Reform Act, 1980 PA 350, MCL 550.1101 *et seq*; MSA 24.660(101) *et seq*, which provides, *inter alia*, for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance, and in section 3406k of the Insurance Code of 1956, 1956 PA 218, MCL 500.100 *et seq*; MSA 24.1100 *et seq*, which revises and consolidates the laws relating to the insurance and surety business.

Thus, both the Congress and the Michigan Legislature have adopted similar legislative provisions requiring HMOs to provide for emergency health services without the necessity of prior authorization. To determine the Legislature's intent in adopting statutes, one must look to their plain meaning. In *Dussia v Monroe County Employee Retirement System*, 386 Mich 244, 249, 191 NW2d 307 (1971), the court stated: "It is a cardinal rule that the Legislature must be held to intend the meaning which it has plainly expressed, and in such cases there is no room for construction, or attempted interpretation to vary such meaning."

Federal Medicaid and Michigan HMO statutory provisions, by their plain language, require that HMOs include emergency medical services within their coverage. That coverage must include medical services for a condition of acute or sudden onset until the condition is stabilized. To qualify for coverage, the insured's condition must be characterized by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could result in: (1) serious jeopardy to the individual's health; (2) serious jeopardy to a pregnancy; (3) serious impairment to a bodily function; or (4) serious dysfunction of any organ or body part. HMOs must make payment for emergency medical services without regard to prior authorization. Indeed, section 21027(1)(a) of the Code provides that the Michigan Department of Community Health, with the concurrence of the Michigan Insurance Bureau, may sanction an HMO for noncompliance with the Code.

It is my opinion, therefore, that under the Public Health Code and the Medicaid managed care program, where the requirements of these statutes are otherwise satisfied, a health maintenance organization must reimburse physicians

for emergency health services provided to Medicaid patients, including instances when the physician has not obtained prior authorization from the patient's health maintenance organization.

JENNIFER M. GRANHOLM
Attorney General

Act No. 136
Public Acts of 1997
Approved by the Governor
November 17, 1997

Filed with the Secretary of State
November 17, 1997

EFFECTIVE DATE: 91st day after adjournment of 1997 Regular Session

**STATE OF MICHIGAN
89TH LEGISLATURE
REGULAR SESSION OF 1997**

Introduced by Reps. Crissman, McBryde and Goschka

Reps. Baade, Baird, Basham, Birkholz, Bogardus, Cassis, Curtis, Dalman, DeHart, Dobb, Dobronski, Freeman, Gagliardi, Gernaat, Gubow, Jelinek, Kukuk, LaForge, Law, Martinez, Middleton, Nye, Oxender, Profit, Quarles, Richner, Rison, Rocca, Schauer, Schroer, Scott, Thomas, Vaughn, Voorhees and Wallace named co-sponsors

ENROLLED HOUSE BILL No. 4080

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," by amending section 21004 (MCL 333.21004), as amended by 1982 PA 354.

The People of the State of Michigan enact:

Sec. 21004. (1) "Emergency health services" means medically necessary services provided to an enrollee for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A health maintenance organization shall not deny payment for emergency health services up to the point of stabilization provided to an enrollee under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the health maintenance organization before emergency health services were provided.

(2) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.

(3) "Stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.

Act No. 124
Public Acts of 1998
Approved by the Governor
June 9, 1998
Filed with the Secretary of State
June 10, 1998
EFFECTIVE DATE: June 10, 1998

STATE OF MICHIGAN
89TH LEGISLATURE
REGULAR SESSION OF 1998

Introduced by Rep. Gubow

ENROLLED HOUSE BILL No. 5076

AN ACT to amend 1980 PA 350; entitled "An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts," (MCL 550.1101 to 550.1704) by adding section 418.

The People of the State of Michigan enact:

Sec. 418. (1) A health care corporation certificate that provides coverage for emergency health services shall provide coverage for medically necessary services provided to a member for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A health care corporation shall not deny payment for emergency health services up to the point of stabilization provided to a member under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the health care corporation before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

This act is ordered to take immediate effect.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.

Act No. 125
Public Acts of 1998
Approved by the Governor
June 9, 1998
Filed with the Secretary of State
June 10, 1998
EFFECTIVE DATE: June 10, 1998

STATE OF MICHIGAN
89TH LEGISLATURE
REGULAR SESSION OF 1998

Introduced by Rep. Crissman

ENROLLED HOUSE BILL No. 5135

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; to repeal certain parts of this act on specific dates; and to provide penalties for the violation of this act," (MCL 500.100 to 500.8302) by adding section 3406k.

The People of the State of Michigan enact:

Sec. 3406k. (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state that provides coverage for emergency health services shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could

reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the insurer before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

This act is ordered to take immediate effect.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.

News & Views



MICHIGAN COLLEGE OF
EMERGENCY PHYSICIANS

Vol. XVIII No. 1 January/February 1999

LIFE AFTER PRUDENT LAYPERSON

P.A. 136 of 1997 became the law of the State of Michigan on April 1, 1998. With much deserved fanfare, the MCEP celebrated this legislative triumph and waited anxiously for the billing discrepancies of the MCO's to come to an end. Well, we are still waiting!!!

While waiting, we have not been resting on our laurels. Representative David Gubow, co-sponsor of P.A. 134, was a keynote speaker at the MCEP Scientific Assembly in July of 1998. At that meeting, he invited MCEP to address the House of Representatives Insurance Committee concerning Managed Care Organization reimbursement issues. The presentation was very well received and MCEP was invited to forward supporting data to Mr. Gubow's office. The next step was to acquire more data and to bring Representative Penny Crissman, the other co-sponsor of P.A. 136, into the loop. While collecting this data, we would periodically notify the Managed Care Organizations of the problems we were experiencing and ask that they reconsider claims. With one MCO, Representative Crissman went so far as to visit the headquarters with MCEP to see if she could facilitate a resolution to the problem. This unfortunately was to no avail.

The next move was again through State Representative's Crissman and Gubow. They pulled together members of the HMO lobby, MCEP, MSMS, as well as Rick Murdock and Carol Issacs of the Department of Community Health. This meeting was full of very frank discussion and problem identification. The end result of this dialogue was a letter dated

December 17, 1998 from Jim Havemen, Jr., Director of the Department of Community Health, stating to the Managed Care Organizations that claims should be resolved by January 22. If outstanding emergency claims are not resolved by that date, the Medical Services Administration was directed to arbitrate these claims.

While the above was ongoing, members of MCEP had the good fortune of meeting and supporting Ms. Jennifer Granholm. She supported our position with regard to payment for appropriate emergency medical services and has publicly stated that the current climate of retrospective denial and prior authorization for emergency services must stop. Fortunately, the majority of the citizens of the State of Michigan agreed with her views and she was elected Attorney General of the state in November of 1998. MCEP is anxiously awaiting her active participation in this ongoing dialogue. We were encouraged to learn that she has accepted our invitation to be the keynote speaker at the 26th Annual Scientific Assembly on Mackinac Island on July 25-28, 1999.

Currently, the discussions continue. What can the membership of MCEP do to help to continue to focus the attention of our legislatures on the problems of the Managed Care Organization industry? Contact your billing company and review charts that are rejected or downcoded for payment. If you feel the claim met the prudent layperson standard, resubmit it. Compile a list of the problems and carriers involved and send a copy to the MCEP office. You may wish to notify your legislator of your concerns as well.



James M. Fox, MD, FACEP

The future will hopefully be brighter. The Attorney General has targeted this as a priority in her administration. However, she will need all of our help in order to be successful (i.e., send your problems to MCEP). Also, we need to consider pursuing a legislative agenda that would put some teeth in the current prudent layperson laws. Currently, there is no incentive for MCO's to play by the rules. That needs to change. Lastly, we need to continue to do what we have always done, provide exemplary emergency medical care to all who seek it. We have been the safety net of the nations' health care system since our inception. Nothing, not even unfair reimbursement, should cause us to alter that course. § (Fox)

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Submissions to the March Newsletter should be received by the Chapter office no later than February 15, 1999.