

Rhode Island Global Consumer Choice Compact Waiver
Project Name: Emergency Room Visit Benefit Redesign
Project Number

Category II Change

Date of Request:	August 6, 2009
Proposed Implementation Date: <i>(45 day notice required)</i>	October 1, 2009

Fiscal Impact

	FFY 2010
State:	\$1,012,178.00
Federal: *FMAP calculated @ 63.89%	\$1,790,687.00
Total	\$2,802,865.00

Description of Change:

Attachment A

Fiscal Methodology:

Attachment B

Assurances:

Attachment C

Standard Funding Questions:

Attachment D

Attachment A: Description of Change

New England has the second highest emergency room (ER) utilization rates in the nation, with Rhode Island having one of the highest ER utilization rates.¹ An analysis of ER utilization by Medicaid beneficiaries for State Fiscal Years (SFYs) 2002 through 2007 showed that approximately 30 percent of Medicaid-eligible individuals made an ER visit in any given year. However, the number of visits per 1,000 Medicaid beneficiaries has risen at a rate of eight per cent per year. This rate of increase threatens the fiscal stability of Rhode Island's Medicaid program.

On June 30, 2009, Governor Donald Carcieri signed the Rhode Island 2010 state budget into law. This enacted 2010 State Budget limits Emergency Room visits for all Medicaid populations to no more than 12 visits per year. Emergency Room visits that result in hospitalization do not count against this limit. A Category II change in the amount, scope, and duration of the Medicaid ER benefit will enable the implementation of this State legal mandate, which will apply to both Medicaid Fee-For-Service (FFS) and Medicaid managed care, as is permitted by 42 CFR 438.114. ER visits will be limited to 12 per state fiscal year, with those visits resulting in an inpatient admission not counted towards the limit of 12 visits. At the current time there is no ER visit limit under the approved Medicaid State Plan.

Public Notice Process Prior to Implementation

The ER visit limit was authorized by the Rhode Island General Assembly through the 2010 State Budget. Thus, the public was informed through the State's customary legislative process. The State will also follow their public notice process for changes to the Medical Assistance State Plan, including newspaper advertisement of change and the subsequent scheduling of a public hearing as needed.

The State believes it important to initiate an educational campaign to inform beneficiaries of the change. The Rhode Island Department of Human Services (DHS) will initiate an effort to inform all Medicaid recipients of the new ER benefit limit and to outline all appropriate ER alternatives (e.g., appropriate PCP use, Urgent Care sites, and Nurse Triage Lines).

DHS' implementation plan for the ER visit limit promotes a collaborative working relationship between hospitals, primary care and community behavioral health care providers whose common goal would be focused on linking frequent ER utilizers to more appropriate and cost effective care settings well before they reach the ER limit.

¹ Pitts, S.R. , *et.al.* "National Hospital Ambulatory Medical care Survey: 2006 Emergency Department Summary", *National Health Statistics Reports*, No. 7, August 6, 2008.

Attachment B: Fiscal Methodology

The following methodology was used to project savings that would be realized by establishing a 12-visit limit on emergency room visits, excluding any visits that resulted in a hospital admission.

First, DHS identified the number of beneficiaries in both managed care and fee for service Medicaid who used greater than 12 ER visits in SFY 07. It determined expenditures for the total number of visits incurred as well as what the expenditures would have been if visits had been limited to 12. The difference between these two amounts is the savings that would have been incurred if the Rhode Island Medical Assistance Program had limited its payments in SFY '07 to the first 12 visits.

Because this analysis was conducted based on visits and expenditures made in SFY 07, an annual 8 per cent increase was calculated for each state fiscal year from SFY 07 through SFY 11. The annual eight per cent increase in Medicaid expenditures for ER visits was chosen based on most recent cost reports available.

In order to calculate savings that could be realized in FFY10, 9 months of SFY 10 data and 3 months of SFY11 were combined.

Table 2 shows a total of \$2,802,765 in savings in Medical Assistance expenditures that could be realized in FFY 2010 by capping payment of ER visits at 12 per year (with visits resulting in a hospital admission not included). At a Federal Medical Assistance Percentage (FMAP) of 63.89 percent, the projected Federal share savings is \$1,790,687 and State share savings is \$1,012,078 (State share of 36.11 percent).

Table 2

Projected FFY 2010 Savings Due to the ER Visit Limit

	FFY 2010
State Share of Savings	\$1,012,178.00
Federal Share of Savings	\$1,790,687.00
Total Savings	\$2,802,865.00

Attachment C: Assurances

The State assures the following:

- ***This change is consistent with the protections to health and welfare as appropriate to title XIX of the Social Security Act (the Act)***

This Category II planned change is consistent with protections to health and welfare under Title XIX of the Social Security Act (the Act).

With respect to access to ERs, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). EMTALA, implemented under Sections 1866 and 1867 of the Act, was intended to address two related problems:

- Some hospitals' refusal to treat patients who were unable to pay for services
- Some hospitals' practice of transferring patients who could not pay before their life-threatening conditions had been stabilized

EMTALA requires all participating hospitals that have ERs to provide an "appropriate medical screening examination" to anyone who comes to the ER and requests treatment. The screening examination determines whether or not an emergency medical condition exists. If an emergency medical condition applies, the hospital must either stabilize or transfer the patient. A transfer may only be made if the patient, or the patient's surrogate, requests a transfer after being informed of the patient's EMTALA rights or if a physician certifies that the benefits of the transfer outweigh the associated risks.

Medicaid beneficiaries will continue to have these EMTALA protections, irrespective of the ER visit limit.

- ***The change results in appropriate efficient and effective operation of the program, Including Justification and Response to Funding Questions***

An analysis of Medicaid utilization data for SFY 07 shows that 468 of a total of 184,995 beneficiaries had more than 12 emergency room visits in that fiscal year. Thus it is apparent that the vast majority (99.997 per cent of total Medicaid enrollees) would not be affected by an annual limit of 12 emergency department visits (with visits resulting in a hospital admission excluded). The State believes,

therefore, that the planned change will result in appropriate and efficient operation of the Rhode Island Medicaid Program.

For response to “Standard Funding Questions” see Attachment D.

- ***This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902, 1903, 1905, and 1906, Current Federal Regulations, and CMS Policy.***

Section 1902 of the Act requires the establishment of a Medicaid State Plan. The Act is clear that: “Within broad national guidelines established by Federal statutes, regulations, and policies, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; sets the rate of payment for services; and (4) administers its own program.”² Medicaid eligibility groups classified as categorically needy are entitled to certain mandatory services, including ER services. It is within the State’s authority under Sections 1902 and 1905 of the Act to set the amount, duration, and scope of ER services. The planned ER visit limit results in a sufficient level of services to reasonably achieve the purpose of the benefit. The planned limit on the ER benefit does not discriminate among Medicaid beneficiaries based on medical diagnosis or condition. These are the statutory requirements that must be met in establishing benefit limits, as required by 42 CFR 440.230.

Sections 1903 and 1906 do not apply to this Category II change.

It should be noted that the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) requirements do not affect this Category II planned change because the EPSDT requirement to provide other necessary health care is “to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.”³ “Screening service” in this instance refers to EPSDT screening services, which are not rendered by hospital ER departments.

² http://www.cms/hhs.gov/MedicaidGenInfo/03_Technical_Summary.asp

³ *State Medicaid Manual*, 5122 EPSDT Service requirements.

Attachment D: Standard Funding Questions

1. Section 1903(a)(I) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Response: Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources

will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations)

Response: The State share of reimbursement comes directly from General Revenue appropriations to the State Medicaid agency.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: No supplemental or enhanced payments are made for ER services.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or

operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: This Waiver Change does not impact rate setting for clinic and hospital services.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response: No governmental providers are eligible to provide this service.