DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administrat

7500 SECURITY BOULEVAR
BALTIMORE MD 21244-185

FEB 20 1998

Dear State Medicaid Director:

This letter is one in a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA). The BBA contains numerous provisions relating specifically to managed care. In order to provide guidance on these as quickly as possible, we are issuing a number of managed care letters. (List of those already issued is attached). This letter is the twelfth in this managed care series.

The purpose of this letter is to advise you of the changes made by the BBA regarding coverage of emergency services by managed care organizations (MCOs). Section 4704 of the BBA added section 1932(b)(2) to the Social Security Act (the Act) to assure Medicaid managed care beneficiaries have the right to immediately obtain emergency care and services.

Under the new statutory provision, each contract with an MCO must require the organization to provide for coverage of emergency services. (For PCCMs, see Application to PCCMs, below.) We interpret coverage to mean that an MCO must pay for the cost of emergency services obtained by Medicaid enrollees. In addition to establishing an obligation to cover emergency services, the law further stipulates that emergency services must be covered without regard to prior authorization or the emergency care provider's contractual relationship with the organization. These provisions collectively enable a Medicaid enrollee to immediately obtain emergency services at the nearest provider when and where the need arises. The responsibility of MCOs regarding the coverage of emergency services is explained in more detail in the attachment.

Emergency services are defined broadly by the BBA to mean covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard described below. The services must also be furnished by a provider that is qualified to furnish such services under Medicaid. Once the individual's condition is considered stabilized, the MCO may require authorization for hospital admission or follow-up care.

The BBA defines emergency medical condition as 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 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, serious impairment to body functions or serious dysfunction of any bodily organ or part. While this standard encompasses clinical emergencies, it also clearly requires MCOs to base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and to cover examinations where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

In addition to covering medical services that are needed to evaluate or stabilize an emergency medical condition found using a prudent layperson standard, the contract must require the MCO to comply with the guidelines for coordinating post-stabilization care established under Medicare Part C. This particular requirement is effective 30 days after the date Medicare regulations are promulgated.

APPLICATION TO PCCMs

The prudent layperson standard should be applied to determine when Medicaid beneficiaries in a PCCM may immediately seek treatment without having to obtain prior authorization from the PCCM. However, we realize that the financial structure of PCCMs is significantly different from that of MCOs and we do not believe Congress intended to make PCCMs financially responsible for emergency services furnished on a fee-for-service basis. Therefore, HCFA will not require changes to PCCM contracts to provide for payment of emergency services.

SANCTIONS

Medicaid MCOs that fail to cover emergency screening or stabilization services may be subject to intermediate sanctions or termination. Section 1932(e) of the Act authorizes States to use intermediate sanctions if an MCO fails substantially to provide medically necessary items and services that are required (under law or under the organization's contract with the State) to be provided to an enrollee covered under the contract. HCFA may also impose sanctions under 1903(m)(5)(A) of the Act if the failure to cover emergency services as required under 1932(b)(2) of the Act adversely affects (or has a substantial likelihood of adversely affecting) a Medicaid beneficiary. Contract termination may also be imposed for any violation of the requirements in sections 1903(m) and/or 1932 of the Act.

If you have any questions, please contact Rob Weaver at 410-786-5914.

Sincerely,

Sally K. Richardson
Director
Center for Medicaid and State Operations

Attachments

cc:
HCFA Regional Administrators
HCFA Associate Regional Administrators
HCFA Press Office
Jennifer Baxendell, National Governors Association
Lee Partridge, American Public Welfare Association
Joy Wilson, National Conference of State Legislatures

CLARIFICATION OF BENEFICIARY ACCESS AND MCO FINANCIAL RESPONSIBILITIES FOR EMERGENCY SERVICES

MCO Responsibility – Beneficiary Information – MCOs are required to inform beneficiaries of their rights and responsibilities and information on covered items and services. Plans should inform beneficiaries of the following regarding their rights of access to, and coverage of, emergency services, both inside and outside of the plan's network.

Both In-Network and Out-of-Network Emergency Services Are Medicaid-Covered Benefits

Definition of Emergency Services – Emergency services are defined as covered inpatient and outpatient services furnished by a qualified Medicaid provider that are necessary to evaluate or stabilize an emergency medical condition.

Definition of Emergency Medical Condition – Coverage of emergency services by an MCO will be determined under the prudent layperson standard. That standard considers the symptoms (including severe pain) of the presenting beneficiary. MCOs must cover cases where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in (i) placing their health or the health of an unborn child in immediate jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Prohibition on Retrospective Denial for Services Which Appeared to Be Emergencies – MCOs may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard (as defined above), turned out to be non-emergency in nature.

Prohibition on Prior Authorization for Emergency Services–MCOs may not require prior authorization for emergency services This applies to out-of-network as well as to in-network services which a beneficiary seeks in an emergency.

MCO Responsibility–Payment Liability and Coverage of Emergency services – Under the Emergency Medical Treatment and Active Labor Act, also commonly referred to as the anti-dumping statute, Medicare participating hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in unstabilized emergency condition to another facility unless the

medical benefits of the transfer outweigh the risks, and the transfer conforms with all applicable requirements. When emergency services are provided to an enrollee of a MCO, the organizations's liability for payment is determined as follows:

Presence of a Clinical Emergency – If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, MCOs must pay for both the services involved in the screening examination and the services required to stabilize the patient.

Emergency Services Continue Until the Patient Can be Safely Discharged or Transferred – MCOs are required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and an MCO concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the beneficiary at the treating facility prevails and is binding on the MCO. The MCO may establish arrangements with hospitals whereby the MCO may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.

Absence of a Clinical Emergency – If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability should be whether the beneficiary had acute symptoms of sufficient severity at the time of presentation. In these cases, the MCO must review the presenting symptoms of a beneficiary and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. If a Medicaid beneficiary believes that a claim for emergency services has been inappropriately denied by an MCO, the beneficiary may seek recourse through the MCO or State appeal process.

Referrals – When a beneficiary's primary care physician or other plan representative instructs the beneficiary to seek emergency care in-network or out-of-network, the plan is responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the patient meets the prudent layperson standard described above.

BBA MANAGED CARE STATE LETTERS

Section	Subject	Date Issued
	SPA Option for Managed Care	12/17/97
4704(a)	Specification of Benefits	12/17/97
4707(a)	Marketing Restrictions	12/30/97
4704(a) 4704(b) 4706 4707(a) 4707(c) 4708(b) 4708(c) 4708(d)	Miscellaneous Managed Care Provisions	12/30/97
4701 4703 4708(a)	Choice, MCE Definition, Repeal of 75/25, and Approval Threshold	1/14/98
	External Quality Review	1/20/98
4704(a)	Mental Health Parity	1/20/98
4701(a)	Enrollment, Termination, and Default Assignment	1/21/98
	PCCM Services Without Waiver	1/21/98
4707(a)	Sanctions for Noncompliance	2/20/98
4701(a) 4710(a)	Provision of Information & Effective Dates	2/20/98