November 22, 2017

VIA EMAIL
KanCare Renewal
c/o Becky Ross
KDHE, Division of Health Care Finance
900 SW Jackson, LSOB –9thFloor
Topeka, Kansas 66612
kdhe.kancarerenewal@ks.gov

RE: KanCare's Proposed 1115 Medicaid Waiver Renewal

Dear Ms. Ross:

We are writing on behalf of the Kansas Chapter of the American College of Emergency Physicians (KACEP), its parent organization, the American College of Emergency Physicians (ACEP), and the Emergency Department Practice Management Association (EDPMA), whose membership includes emergency medicine physician groups, billing, coding and other professional support organizations that assist healthcare providers in our nation's emergency departments.

Let us note as emergency providers, we greatly appreciate the Kansas' Medicaid system (KanCare's) focus on coordinated care on decreasing emergency room visits. As Kansas' 1115 renewal waiver reports, "[d]ecreases in utilization of these services are a positive outcome, reflecting increased access of treatment from the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays." While coordinated care may decrease visits, we want to ensure that a patient's access to the emergency department is not hindered by further erosion of the prudent layperson (PLP) standard found under State law[1]. Our comments focus less on the proposal but more on the process in which KanCare currently operates and requests the Kansas Department of Health and Environment (KDHE) for amendments to the waiver that address emergency providers' concerns related to maintaining the PLP standard.

The PLP standard obligates Medicaid carriers and managed care organizations (MCOs) to reimburse emergency medical providers for the delivery of emergency medical services and care to Medicaid recipients.[2] We have growing concerns that certain Medicaid managed care organizations operating as part of KanCare are not reimbursing emergency physicians in a manner that is consistent with this federal standard. Our concerns particularly relate to retrospective denials by which certain KanCare MCOs have determined, retrospectively, after emergency medical services treatment and care has been rendered to the patient. Those retrospective determinations assert that the conditions by which the patient sought out emergency services did not constitute an emergency medical condition. Consequently, these particular cases are deemed 'non-emergent' and are not reimbursed in

[1] KA Ins. Statute 40-4602
[2] Balanced Budget Act of 1997

accordance with the KanCare promulgated reimbursement rates, resulting in drastically reduced reimbursement at rates as low as $13.00.

In addition to this issue of retrospective reimbursement determinations, we are finding that certain KanCare MCOs have created and implemented lists of symptoms, conditions and diagnosis codes (which remain outdated) but which we have little transparency and no clear sense on the basis for the determination on those codes the MCOs deem non-emergent.

Moreover, we understand that KanCare and the KanCare Medicaid MCOs have an overly burdensome appeals process that can be utilized in these kinds of situations, but we find that working within the appeals process established is needlessly inefficient, expensive, and time consuming, particularly when individual claims need to be appealed for resolution of small dollar amounts (though in the aggregate, the impact to our providers is significant).

CMS already concluded that diagnosis lists should not be used to determine when it is appropriate to seek care in the emergency department. For instance, in the Final 2016 Medicaid Managed Care Rule, CMS stated: "Regarding the PLP requirements of the BBA of 1997 and the use of approved lists of emergency diagnosis codes, we remind commenters that consistent with our discussion in the 2002 managed care final rule at 67 FR 41028–41031, we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. … While this [PLP] standard encompasses clinical emergencies, it also clearly requires managed care plans and states to base coverage decisions for emergency services on the apparent severity of the symptoms at the time of presentation, and to cover examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The final **determination of coverage and payment** must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens." [3]

Emergency departments are the nation's health safety net. Federal law – through the Emergency Medical Treatment & Labor Act (EMTALA)[4] - requires hospitals and physicians to evaluate and stabilize everyone visiting the emergency department, no matter the ability to pay. Even though emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients. Kansas is one of nine states that have uncompensated care (UC) fund pools and benefits by providing UC pool payments to hospitals to defray hospital costs provided to Medicaid-eligible or uninsured individuals. Under the 1115 waiver extension, these funding pools are available to go directly to health care providers, of which Kansas has or is expected

[3] (81 FR 27749 (May 16, 2016))
[4] 42 U.S. Code 1395dd

to budget $80 million[5] for two pools, one for uncompensated care and another for delivery reform incentive payments. The State benefits by renewing UC pools in their waiver because it represents a long-term investment in its healthcare safety net, especially for rural or economically distressed areas. However, consider the alternative. If emergency physicians continue to be undercompensated in Kansas, fewer emergency physicians may choose to practice in the state, lines in Kansas emergency departments will grow, and some emergency departments may even close down.

While we look forward to a continued dialog with the KDHE and other important stakeholders, we acknowledge the process needs to be collaborative to ensure that quality and access to healthcare in Kansas are not compromised. We encourage KanCare to take the opportunity through the current waiver process to reform the states' MCO system. We also encourage state investment in technologies that assist providers in the appeals process that focus more on transparency and accuracy and less on automatic downcoding by illegal diagnosis codes. Finally, we encourage the State to continue its commitment to improving its healthcare safety net by allowing 30 percent of the UC pool to go directly to EMTALA obligated providers. Making these improvements in the renewal process will ensure that KanCare 2.0 remains in compliance with state and federal law, while also creating a model other states can use going forward.

Thank you for considering our comments on improving Kansas' healthcare safety net.

Sincerely,

Andrea M. Brault, MD, MMM, FACEP, Chair of the Board Emergency Department Practice Management Association (EDPMA) 8400 Westpark Drive, 2nd Floor; McLean, VA 22102
Email: andrea@emergencygroupsoffice.com; emundinger@edpma.org

Paul D. Kivela, MD, MBA, FACEP, President, American College of Emergency Physicians (ACEP) 4950 W. Royal Lane; Irving, TX 75063-2524; Email: pkivela@acep.org; hmonroe@acep.org

Jonathan Wilcher, MD, FACEP, President, Kansas Chapter, American College of Emergency Physicians
Email: wilcher.jonathan@gmail.com; dlantz@kmsonline.org

CC: Secretary Susan Mosier, MD, Deputy Secretary for Public Health

[5] October 13, 2017 CMS Letter to Kansas Medicaid granting a 12-month temporary extension.