

State of California—Health and Human Services Agency  
Department of Health Services



California  
Department of  
Health Services

**SANDRA SHEWRY**  
Director



**ARNOLD SCHWARZENEGGER**  
Governor

DATE: MAR 16 2007

MMCD All Plan Letter 07003

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: FEDERAL DEFICIT REDUCTION ACT OF 2005

(REIMBURSEMENT FOR NON-CONTRACTED EMERGENCY  
SERVICES PROVIDERS)

This All Plan Letter (APL) discusses Section 6085 of the Federal Deficit Reduction Act of 2005 (DRA). Additional APLs concerning the DRA may be forthcoming, as more information and guidance is provided by the Centers for Medicare and Medicaid Services (CMS).

DRA Section 6085 created a new section 1932(b) (2) (D), of the Social Security Act. This provision establishes a limit on the amount to be paid to out-of-plan/network providers of emergency services. This provision became effective January 1, 2007.

In California, under Section 6085, any provider of outpatient emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity must accept as payment in full no more than the amount that would have been paid if the outpatient service had been provided under the State's fee-for-service Medicaid program. This applies in any county in California. For out-of-plan/network general acute care hospitals, the applicable payment amount for emergency inpatient services is the average Selective Provider Contracting Program (SPCP) contract rate for general acute care hospitals. For out-of-plan/network tertiary care hospitals, the applicable payment amount for emergency inpatient services is the average SPCP contract rate for tertiary hospitals.

On March 31, 2006, CMS issued SMDL #06-010 clarifying various issues surrounding Section 6085. Additional clarification from CMS was provided by letter to the California Department of Health Services (CDHS) dated November 17, 2006. Copies of the November 17<sup>th</sup> letter and SMDL #06-010 are attached hereto for your convenience.


Notwithstanding the clarification already provided by CMS, additional questions about Section 6085 remain. CDHS has asked for further clarification from CMS. Based on the response from CMS (and it is as yet not clear when that response will be provided), CDHS will develop Section 6085 reimbursement rates. Until that time, for emergency inpatient services rendered on or after January 1, 2007, CDHS encourages managed care plans to reimburse out-of-plan/network hospitals, both SPCP hospitals and non-SPCP hospitals, according to the average SPCP rate for the geographic region referred to as Standard Consolidated Statistical Area (Average Rate) in which the provider is located for the last year reported by the California Medical Assistance Commission (CMAC), as published in the most recent CMAC Annual Report to the Legislature which can be found at [www.cmac.ca.gov](http://www.cmac.ca.gov).

Once the final rates for reimbursement are published, the managed care plans may be required to do a reconciliation process to ensure that all out-of-plan/network providers of emergency services, who were paid on a transition basis the Average Rate, have been reimbursed in accordance with CDHS finalized rates.

If it has not already been provided to you, contract amendment language requiring compliance with Section 6085 will be forwarded to you in the near future.

If you have questions about the DRA implementation process or the information in this letter, please contact your Contract Manager. Thank you for your continued cooperation.

Sincerely,

  
Vanessa M. Baird, MPPA, Chief  
Medi-Cal Managed Care Division

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



**Center for Medicaid and State Operations**

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March 31, 2006

**SMDL #06-010**

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005. On February 8, 2006, President Bush signed into law the Deficit Reduction Act (DRA) of 2005 ( Pub. L. No. 109-171). Section 6085 of the DRA created a new section 1932(b)(2)(D) of the Social Security Act (the Act). This provision establishes a limit on the amount to be paid non-contracting providers of emergency services at the amount that would have been paid if the service had been provided under the State's FFS Medicaid program.

Prior to enactment of this legislation, there was no Federal law or regulation governing the amount of payment for emergency services provided to Medicaid beneficiaries who received these services by a provider who did not have a contract with the beneficiary's Medicaid managed care entity. There were often disputes over the rate at which the provider of emergency services would be paid. This legislation establishes a limit on the amount that emergency service providers who do not have a Medicaid managed care contract can be paid by Medicaid managed care entities.

Under this provision, any provider of services that does not have in effect a contract with a Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), and that provides emergency services to a beneficiary enrolled in that Medicaid managed care entity, must accept as payment in full no more than the amount it would receive if the services were provided under the State's fee-for-service (FFS) Medicaid program.

This rule applies whether the non-contracting provider is within the State or outside of the State in which the managed care entity has a contract. This rule does not apply to payments made by the State on behalf of enrollees in a State's primary care case management system. This letter contains initial guidance on this new legislative authority, which is effective on January 1, 2007.

States must amend any existing MCO, PIHP, and PAHP contracts that have provisions governing payment for emergency services at non-contracting providers that are inconsistent with the requirements of new section 1932(b)(2)(D) (i.e. which would require payment of an amount in excess of State FFS rates) before January 1, 2007. As of that date, all of these entities which cover emergency services outside of their contracting network must limit the amount to be paid non-contracting providers for services, which meet the definition of emergency in section 1932(b)(2)(B) of the Act, to no more than the amount that would have been paid if the service had been provided under the State's FFS Medicaid program. For services provided by non-contracting hospitals, this amount

must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in FFS payments. In any State where Medicaid rates paid to hospitals are negotiated and not publicly released, the applicable payment amount would be the average contract rate that would apply for tertiary hospitals.

Should you have any questions regarding this new legislation, or submission of a contract in order to reflect the establishment of this provision, please contact the CMS Regional Office serving your State.

Sincerely,

/s/

Dennis G. Smith  
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
for Medicaid and State Operations

Martha Roherty  
Director, Health Policy Unit  
American Public Human Services Association

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

Matt Salo  
Director of Health Legislation  
National Governors Association

Jacalyn Bryan Carden  
Director of Policy and Programs  
Association of State and Territorial Health Officials  
Page 3 – State Medicaid Director

Christie Raniszewski Herrera  
Director, Health and Human Services Task Force  
American Legislative Exchange Council

Lynne Flynn  
Director for Health Policy  
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DEPARTMENT OF HEALTH & HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
REGION IX

DMCH-SSB-MM

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San Francisco, CA 94105

NOV 17 2006

Stan Rosenstein, Deputy Director  
California Department of Health Services  
Medical Care Services  
MS 4000  
P.O. Box 942732  
Sacramento, CA 94234-7320

Dear Mr. Rosenstein:

This letter is in response to your letter dated April 11, 2006 in which you requested clarification on guidance contained in State Medicaid Director's Letter #06-010. We apologize for the delay in our response. This letter provided information that is specific to Section 6085 of the Deficit Reduction Act (DRA) of 2005 and new limits on Medicaid managed care organization (MCO) payments for emergency services provided by non-contract providers. Please see your original questions below and our responses.

**DHS Question #1:** "Is this provision limited to payments for emergency inpatient services or does it also include emergency outpatient services?"

**CMS Response:** Section 6085 of the DRA applies to "any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan." Therefore, this provision applies to providers of both emergency inpatient and outpatient services.

**DHS Question #2:** "If this provision does apply to emergency outpatient services, is it limited to those services provided in acute care hospitals, or are all Medicaid providers, including clinics, private practice physicians, etc., covered by this provision?"

**CMS Response:** This provision will apply in most instances to services provided in an inpatient hospital or outpatient hospital setting. However, in the unlikely instance where an enrollee in a MCO, PIHP, or PAHP receives covered emergency services as defined in Section 1932(b)(2) of the Social Security Act from a non-contract provider in a setting outside of an acute care hospital, the payment limitation in this provision would still apply.

**DHS Question #3:** "The intent in the drafting of the language for states who contract for hospital services was that there would be two distinct rates, depending on whether a facility provided tertiary or acute care services. However, the letter seems to imply one rate for the tertiary average. Please clarify."

Page 2 – Stan Rosenstein

**CMS Response:** We appreciate the opportunity to clarify the guidance contained in SMD Letter #06-010. Section 1932(b)(2)(D) of the Social Security Act specifies that, “In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.” Thus, the rate paid to a hospital under this circumstance would depend on whether the facility provided tertiary or acute care services. If services were provided by a general acute care hospital, the payment cannot exceed the average contract rate in the State for general acute care hospitals. If the services were provided by a tertiary care hospital, payment cannot exceed the average contract rate in the State for tertiary care hospitals.

If you have any additional questions, please contact Meredith Mayeri at (415) 744-3686.

Sincerely,

A handwritten signature in black ink that reads "Michele P. Walker" followed by a stylized flourish.

Linda Minamoto

Associate Regional Administrator

Division of Medicaid & Children's Health