Minnesota Department of **Human Services**

January 8, 2015

Senator Lourey
G-12 Capitol
St. Paul, MN 55155-1606

Senator Benson
115 State Office Building
St. Paul, MN 55155-1206

Representative Mack
545 State Office Building
St. Paul, MN 55155-1206

Senator Rosen
139 State Office Building
St. Paul, MN 55155-1206

Representative Dean
401 State Office Building
St. Paul, MN 55155-1206

Representative Mullery
303 State Office Building
St. Paul, MN 55155-1206

Senator Sheran
G-12 Capitol
St. Paul, MN 55155-1606

Representative Liebling
357 State Office Building
St. Paul, MN 55155-1206

Representative Loeffler
337 State Office Building
St. Paul, MN 55155-1206

Dear Chairs and Leads of the HHS Committee:

The federal Social Security Act requires state Medicaid programs to pay providers for emergency services rendered to individuals eligible for Emergency Medical Assistance (EMA). State Medicaid programs can only receive federal funding for services necessary to treat an emergency medical condition and are not allowed to use federal funding to pay for preventative or chronic condition treatment rendered to individuals in Emergency Medical Assistance. In recognition that providing medical care only in emergency situations doesn't lead to optimal health outcomes or patient experience, the Department, at the request of the legislature, produced a study in January of 2014 (attached for reference) outlining various options for delivering and funding additional services for this population. Recognizing funding limitations within the state budget, the legislature requested the Department complete a report on the EMA program. The goal of this report was to identify any additional services which, if added to the current EMA benefits package could "produce credible savings to the cost of federally funded services."

The Department held several internal meetings regarding this study and also hosted two public stakeholder meetings. During the stakeholder meetings, various individuals and organizations reiterated concerns that the current program does not lead to optimal health outcomes. No dispute exists between DHS, legislators, and stakeholders about those concerns. However, the goal of this study was to develop recommendations on additional services or program changes likely to reduce the use of more costly services, including emergency and inpatient hospital services. Since federal Medicaid regulations only allow payment for services rendered for acute emergencies, any services to prevent or delay an emergency would not be eligible for federal financial participation without an amendment to the federal Social Security Act section 1903. Therefore, any additional services added to the current EMA program would need to be paid solely with state dollars.

DHS staff shared detailed EMA utilization and payment data with the stakeholder group. The data showed that the bulk of current EMA expenditures go toward ER visits for acute symptoms, chemotherapy for cancer, dialysis and end stage renal disease treatment, treatment related to accident-based injuries, as well as inpatient treatment for acute GI, cardiac, and mental health exacerbations. Although there are still a small number of enrollees receiving coverage of services under appeals, the majority of the services currently covered include federal funding. The stakeholders and DHS reviewed and discussed the data, looking for patterns of diagnoses related to frequent and/or high cost ER visits and inpatient admissions that may identify a set of primary care services, drug therapy or other non-emergency services that if covered, could produce enough savings in federal funding to offset the costs of covering the typically non-covered services. No identifiable patterns emerged, and unfortunately much of the high cost treatment appeared to be for conditions that were more unpredictable and some even unavoidable.

Unfortunately, given the narrow parameters of the federal regulations and the lack of a direct link between preventative services and current major categories of EMA expenditures, DHS staff and stakeholders were not able to develop any recommendations that would reliably reduce the cost of the federally funded emergency services paid for by the EMA program.

Sincerely,

Nathan Moracco
Assistant Commissioner