November 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
445-G Hubert H. Humphrey Building
Department of Health and Human Services
200 Independence Ave S.W.
Washington, DC  21201

RIN: 0938 AR93

Re:  CMS 2380-P; Proposed Rule — Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs.

Dear Administrator Tavenner:

On behalf of the Emergency Department Practice Management Association (EDPMA), the American College of Emergency Physicians (ACEP) 33,000 members, and the American College of Osteopathic Emergency Physicians (ACOEP) 5,000 members; we appreciate the opportunity to provide comments on the Proposed Rule for the Basic Health Program (the “Proposed Rule”), as published September 25, 2013 (78 Fed. Reg. 59122).

EDPMA is one of the nation’s largest professional physician trade associations focused exclusively on the delivery of emergency medical services, with an emphasis on the provision of high-quality, cost-effective care in the emergency department to all Americans. Together, EDPMA’s members deliver (or directly support) health care for over half of the 130 million patients that visit U.S. emergency departments each year. EDPMA’s membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist health care providers in our nation’s emergency departments. We work collectively and collaboratively to deliver essential health care services often unmet elsewhere to an underserved patient population who often has nowhere else to turn.

The American College of Osteopathic Emergency Physicians (ACOEP) represents over 5,000 Emergency Physicians and provides oversight to over 50 Emergency Medicine Residency Programs. ACOEP, founded in 1975, exists to support high quality emergency care, promote and protect the interests of Osteopathic emergency physicians, ensure the highest standards of
postgraduate education, and provide leadership in research through the Foundation for Osteopathic Emergency Medicine, in a distinct unified profession.

The ACA allows states to establish a Basic Health Program (BHP) that provides coverage for individuals with incomes below 200% of the federal poverty level who are not eligible for Medicaid and would otherwise be eligible for subsidized coverage through health insurance exchanges. States could use this approach to help improve continuity of care by mitigating the effects of shifting eligibility between Medicaid and subsidized private coverage, which will be significant.

The importance of assuring continuity of care is clear to emergency physicians. We are often the first point of access for individuals in need of acute care, including millions of indigent individuals, Medicaid, and Medicare beneficiaries. Assuring the ongoing availability of quality emergency services is an important part of maintaining the safety net and assuring continuity of care for all. Our position at the nexus of care provides us with a unique perspective on how benefit design may affect the ability of individuals to receive emergency services – an essential health care benefit.

Standard Health Plan Coverage and Emergency Services

As CMS notes in the Proposed Rule, Section 1331(b) of the Affordable Care Act (ACA) requires that state-offered plans under the BHP must provide, at a minimum, essential health benefits. The ACA includes emergency department services as “essential health benefits” and coverage for emergency department services may not limit coverage for out-of-network providers to be more restrictive than the requirements or limitations that apply to emergency department services received from in-network providers. Finally, the ACA provides that when emergency services are provided out-of-network, the cost-sharing requirement is to be the same that would apply if the emergency services had been provided in-network.

In past rulemaking, HHS (and other agencies implementing the ACA) has promulgated rules and other guidance implementing these provisions. Specifically, CMS has adopted the Interim Final Rule (IFR) applicable to Group Health Plans and the Final Rule for Qualified Health Plans offered through state health exchanges. The IFR established a “greatest of three” approach for payment to providers for emergency services provided out-of-network. The IFR identifies these as: 1) the median in-network rate, 2) the amount the plan ordinarily uses to calculate payment for out-of-network services, and 3) the Medicare rate.

The Proposed Rule would continue this approach for defining how emergency services are to be offered through standard health plans under the BHP. Specifically, proposed section 600.400 sets forth the requirements of the “standard health plan coverage.”

The IFR was intended to implement provisions of the Affordable Care Act to prevent enrollees from being penalized for seeking emergency care from an out-of-network provider. However, we believe that this language has proven to have wide variability in its interpretation by insurers and group health plans. Some insurers are providing benefits at such low amounts as to saddle the patient with unreasonably high out-of-pocket expenses. We do not yet know how this provision
will be implemented for qualified health plans offered through health exchanges. We urge CMS to consider issuing guidance in this area which would address these issues.

**Cost Sharing Requirements for Use of Emergency Department Services**

Earlier this year, CMS adopted an approach in its final Medicaid rule which would allow states to increase cost sharing for individuals who receive care in the nation’s emergency departments in certain circumstances. We are concerned about the potential negative effects of that approach. In this regard, EDPMA, ACEP and ACOEP reference our comments previously filed, and we include these points in this comment.

In short, while EDPMA supports CMS’s underlying intention to encourage the appropriate use of services offered in the emergency department by all, including Medicaid beneficiaries and future BHP enrollees, we oppose using the mechanism of increased cost sharing for non-emergency use of the ED to achieve that goal.

As we have noted in our earlier comments, we believe that the nature of the emergency department setting coupled with the federal EMTALA requirements and the protections of the federal and state prudent layperson laws, make any process for determining in advance which types of services or care provided will be found to be “non-emergency services” inherently flawed.

In order to ensure that access to emergency services – an essential health benefit – is not harmed, CMS should not permit states to set policy which could harm such access. EDPMA members continue to see many problematic attempts by states to define “non-emergencies” including restrictive diagnosis codes, limitations on number of visits, etc. At a minimum, CMS should give greater direction to State Medicaid Plans as well as to states choosing to offer a BHP regarding acceptable processes for distinguishing non-emergency from emergency services.

The growth in health care costs over the past several years has resulted in the imposition of higher levels of cost sharing by public and private payers. The combination of deductibles and co-payments in the private sector, along with the recent recession, has reduced utilization significantly. Co-payments are effective when there is a consequence for non-payment. It is unclear, however, whether or how imposing co-payments on low income (Medicaid) enrollees who come to the emergency department (ED) for “non-emergency” reasons affects their utilization or reduces overall Medicaid program costs. Practically, there is no consequence for non-payment due to the Emergency Medical Treatment and Labor Act (EMTALA) which requires a medical screening for everyone who comes to the ED, regardless of ability to pay.

Further, much of the high use of EDs by Medicaid enrollees is due to lack of access to primary care physicians and we are concerned this will be a larger problem with the 2014 coverage expansion. Therefore, we do not support the proposed co-payment policy for vulnerable, low income populations.

Throughout the Proposed Rule, CMS has requested comments on multiple aspects of the BHP’s future implementation. We have listed our reactions to some of the other areas that could impact emergency medicine below.
Transparency

CMS has proposed public transparency in several areas of the Proposed Rule. EDPMA, ACEP and ACOEP strongly support transparency in state activities in this area. In particular, we would like to support CMS’ proposal to require that states seek public comment on BHP Blueprints, including any significant revisions to same. (See. 78 Fed. Reg. at 59125). Further, we would urge CMS to require states to consider providers, particularly the providers of emergency services, essential “stakeholders” in the process and to notify same before implementing significant changes. As you know, EMTALA requires hospitals to treat all individuals seeking care for potential emergency medical conditions. Emergency physicians are crucial in assisting hospitals to meet EMTALA requirements. Accordingly, if a state chooses to operate a BHP program, providers of emergency services will also be treating these enrollees and the state should be required to have transparency in program operations that affect emergency departments across the United States.

Other comments

Individuals enrolled in the Basic Health Program should be guaranteed these protections, as well as those included in Sec. 1932 (b) (2) of the Social Security Act. That section includes the definition of “emergency medical service” to include “symptoms of sufficient severity 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 serious jeopardy to health …”

We welcome the opportunity to participate in future dialogue regarding state operation under the BHP and/or CMS’ oversight of state plans in this area. We also understand that you will be undergoing additional rulemaking in this area, and we look forward to contributing to that process.

Please feel free to contact Elizabeth Mundinger, EDPMA’s Executive Director, at 703 610-9033 if we can be of any assistance on this topic or in any other area.

Sincerely,

Mark Mitchell, DO, FACEP
President, ACOEP

Alexander Rosenau, DO, FACEP
President, ACEP

James A. Kolka, DO, FACEP
Chair, EDPMA Board of Directors