Association of
American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 F 202 828 1125
www.aamc.org

Via Electronic Submission (www.regulations.gov)

February 13, 2013

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS-2334-P
P.O. Boxes 8016
Baltimore, MD 21244-8010

Re: Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, File Code CMS-2334-P

Dear Ms. Tavenner:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Center for Medicare and Medicaid Services' (CMS' or the Agency's) Proposed Rule entitled *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing*, 78 Fed. Reg. 4594 (Jan. 22, 2012). The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

The AAMC recognizes the extraordinary efforts and coordination needed to implement the Affordable Care Act's (ACA's) health insurance marketplace reform provisions. AAMC commends CMS on many aspects of the proposed rule that will increase coverage, coordinate

eligibility and enrollment processes across insurance affordability programs, and streamline applications and appeals. Consistent with our support for the ACA, the Association strongly supports expanded coverage that will eliminate barriers to access to needed health care services. We look forward to working with CMS to protect patient access to necessary health care services and to address several concerns with the proposed rule.

Presumptive Eligibility Determined by Hospitals (§ 435.1110)

As required by the ACA, CMS proposes to allow hospitals to determine presumptive eligibility as of January 1, 2014. Presumptive eligibility allows certain Medicaid-eligible populations to get immediate temporary Medicaid coverage rather than waiting until a full eligibility determination is made, or going without care. Previously, presumptive eligibility in Medicaid was a state option to improve timely access to care.

Under the proposed rule, starting in January 2014, qualified hospitals can elect to make presumptive eligibility determinations for Medicaid-eligible populations, even if the state is not using presumptive eligibility in any other setting. The state would be required to provide Medicaid coverage during a presumptive eligibility period determined by a qualified hospital on the basis of preliminary information in accordance with requirements generally applicable to the particular Medicaid-eligible population. The state could elect to limit determinations of presumptive eligibility by hospitals to determinations based on income for children, pregnant women, parents, and caretaker relatives, or the state could extend this authority to other bases for eligibility under the state plan or a section 1115 demonstration. CMS also proposes that the state may establish standards for a qualified hospital related to the proportion of individuals the hospital determines presumptively eligible for Medicaid who submit regular applications before the end of the presumptive eligibility period, or the proportion that are determined eligible by the Medicaid agency based on such applications.

The AAMC strongly supports this expansion of hospitals' authority to make presumptive eligibility determinations, which will allow more Medicaid eligible individuals timely access to health care services. The Association urges CMS to ensure that standards for qualified hospitals to make presumptive eligibility determinations allow some degree of state flexibility. At the same time, federal guidance will be essential to ensure consistency among states and to enable hospitals to treat out-of-state patients. Through either regulations or guidance, hospitals should be provided with a way to work with Medicaid agencies in other states to facilitate presumptive eligibility for those patients who may be Medicaid eligible in another state. Federal guidance would reduce the administrative burden resulting from incongruent state standards and also would prove helpful to states that have not previously allowed hospitals to make presumptive eligibility determinations.

Alternative Benefit Plans (§ 440.345(d), § 440.386)

The AAMC commends CMS for the Agency's proposal to codify the requirement that Medicaid benchmark and benchmark-equivalent plans, now referred to as "Alternative Benefit Plans,"

provide essential health benefits (EHBs) and include all subsequent modifications to the definition of EHB made by the Secretary. The Agency proposes to modify public notice requirements regarding alternative benefit plans to provide more flexibility. Public notice would be required before implementing a state plan amendment (SPA) when the new Alternative Benefit Plan: (1) provides individuals with a benefit package equal to or more extensive than the state's approved plan or (2) adds services to an existing Alternative Benefit Plan. AAMC supports CMS' decision to retain the requirement to publish public notice prior to submitting a SPA that establishes an Alternative Benefit Plan which provides less benefits than the state's approved state plan, which includes or increases cost sharing of any type, or which amends an approved Alternative Benefit Plan by adding cost sharing or reducing benefits.

Cost-sharing (§ 447.52) Nominal Amounts

The AAMC is concerned that even seemingly marginal increases in cost-sharing will have a significant effect on access to care, particularly for the nation's most vulnerable patients. CMS proposes several modifications to the maximum allowable cost sharing for individuals with incomes below the federal poverty level (FPL). The proposed limits would change the maximum for outpatient services for those with income below 100 percent of the FPL. Currently, there is a $3.90 nominal limit, indexed annually to the Consumer Price Index (CPI). CMS proposes a new $4 nominal dollar limit that would take effect beginning in FY 2014 and would be updated annually by the Consumer Price Index for All Urban Consumers (CPI-U) beginning in October 2015.

The AAMC strongly opposes any increased cost-sharing for either outpatient or inpatient services for Medicaid patients, because even minimal increases to cost-sharing are likely to have a considerable impact on access to care. Even the smallest increases in out-of-pocket cost sharing may prevent these individuals from seeking critical health care services before their medical needs become more complex and costly to treat. The AAMC also opposes any changes that will increase cost-sharing for very low income patients, as the burden of attempting to collect these additional amounts will fall on the hospitals where they seek care.

Modification to Maximum Allowable Cost Sharing for Non-Emergency Use of Emergency Department (ED) (§447.54)

The AAMC strongly opposes CMS' proposals to modify cost sharing for non-emergency use of the ED. The proposed rule would allow for increases in nominal cost sharing for non-emergency uses of the ED and create more requirements for hospitals before this cost sharing could be imposed. Under current law, nominal cost sharing limits apply to individuals with incomes at or below the federal poverty level. For individuals with incomes above 150 percent of the FPL, no cost-sharing limit applies. States may impose cost sharing for non-emergency use of the ED for individuals otherwise exempt from cost sharing requirements, as long as this cost-sharing remains within the nominal cost-sharing limit.

Under the proposed rule, cost-sharing of up to $8 would be permitted without a waiver for individuals with family incomes up to 150 percent of the FPL. As under current law, no cost sharing limits would apply to higher-income individuals. This proposal would allow substantial increases to the nominal limit (from $3.90 to $8.00 for individuals with family incomes below 100 percent of FPL, and from $7.80 to $8.00 for individuals from 101 percent – 150 percent of FPL) without a waiver. The maximum limit would also apply to individuals who are otherwise exempt from cost-sharing requirements. AAMC strongly opposes these proposed increases to the nominal limits. Allowing state agencies to impose higher cost sharing for non-emergency care will place a high burden on very low income patients, which is likely to result in individuals avoiding care when they have to make tough decisions about whether their condition requires emergency attention.

CMS acknowledges in the proposed rule that it is difficult to determine when services should be characterized as non-emergency. While providers are making progress in redesigning care to direct non-emergency patients away from EDs, it is premature to consider imposing this type of penalty when alternatives to care in the emergency department still are unavailable. Additionally, it is unreasonable to punish individuals who have a long history of considering an emergency department as the one place where they can obtain care. The AAMC encourages CMS to look into other policy solutions to reduce non-emergency use of the ED that would not prevent low income individuals from obtaining care they need. AAMC supports efforts to better coordinate care and to reform payment and delivery models in ways that will reduce use of the ED. The Association urges CMS to look into proposals that complement these efforts.

The AAMC opposes CMS' proposed revisions to 44 CFR § 447.80(b)(2) to require a hospital to "ensure that the alternative provider can provide services in a timely manner with the imposition of a lesser cost-sharing amount or no cost-sharing if the individual is otherwise exempt from cost-sharing." CMS' proposed revision would require a hospital to "ensure" something that is beyond that hospital's control. It is unclear how this requirement could be implemented in medically underserved communities that do not have viable alternative treatment services for timely provision of non-emergency care.

CMS also proposes that the treating hospital would not only have to provide the referral, but also coordinate scheduling. This requirement is not only burdensome but would take away time and resources that should be devoted to patient care.

Finally, under existing law a provider "was not prohibited from choosing to reduce or waive cost-sharing on a case by case basis." The proposed revisions would eliminate this flexibility. AAMC strongly opposes these revisions and encourages CMS to continue to allow hospitals to choose to reduce or waive cost sharing on a case by case basis.

****

The AAMC appreciates this opportunity to provide comments on this proposed rule. If you have questions, please contact me at ibaer@aamc.org or Allison Cohen, Senior Policy and Regulatory Specialist at acohen@aamc.org. We both also may be reached at 202-828-0490.

Sincerely,

/s/

Ivy Baer, J.D., M.P.H.
Senior Director and Regulatory Counsel
Regulatory and Policy Group

cc: Allison Cohen, J.D., L.L.M., AAMC
Jane Eilbacher, AAMC