AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
Executive Vice President, CEO

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org

(p) 312.464.5000
(f) 312.464.4184

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Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Proposed Rule Concerning 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 (CMS-2334-P)

Dear Acting Administrator Tavenner:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to comment on the above-referenced Centers for Medicare & Medicaid Services' (CMS) proposed rule, published in the Federal Register on January 22, 2013. This lengthy and complex proposed rule addresses a number of important implementation issues presented by the intersection of the 2014 transition in the Medicaid, Children's Health Insurance Program (CHIP), exchange premium tax credit, and cost sharing reduction assistance programs (e.g., "insurance affordability programs"). We appreciate the tremendous efforts being made by CMS to prepare for the expansion of Medicaid coverage in 2014 and the creation and operation of health insurance exchanges, including state-based exchanges, partnership exchanges, and federally-facilitated exchanges. We commend CMS for the provisions in the proposed rule to streamline and align the eligibility determination, application, enrollment, and appeals processes across the insurance affordability programs, which we hope will make it easier for individuals to understand, navigate, and access their health insurance options in 2014. At the same time, we are concerned that the provisions in the proposed rule regarding Medicaid premiums and cost sharing could have the opposite effect and impose unnecessary and unwarranted barriers to individuals' ability to access care.

Given the breadth of this proposed rule and the limited comment period, the AMA is providing comments on only a few key areas, as indicated below.

Coordination of Eligibility Determinations, Enrollment, Appeals, and Notices Across Insurance Affordability Programs

The AMA commends CMS' efforts to further streamline eligibility determinations, appeals, and notices across the various insurance affordability programs. CMS has created some important safeguards by proposing new coordination of eligibility and enrollment responsibilities at 42 CFR §435.1200 and achieving alignment with the exchange initial open enrollment period (42 CFR §435.1205). In particular, we support the provision in 42 CFR §435.1205 that would require, beginning October 1, 2013, state Medicaid agencies to accept the single streamlined application used to make determinations for eligibility for enrollment in a qualified health plan (QHP) through the exchanges and all insurance affordability programs, or an alternative application developed by the state and approved by the Secretary, and electronic accounts transferred from an agency administering another insurance affordability program. We also support the proposed requirement at 42 CFR §435.1200 that state Medicaid agencies must enter into agreements with the exchange and agencies administering other insurance affordability programs that clearly delineate the responsibilities of each program to: minimize burdens on individuals seeking to obtain or renew eligibility or appeal a determination of eligibility; ensure compliance; ensure prompt eligibility determinations based on date of application to any insurance affordability program; and provide for a combined eligibility notice to individuals as well as multiple members of the same household to the maximum extent possible.

The proposed rule includes several important provisions with respect to notices and appeals for eligibility determinations regarding insurance affordability programs that are designed to make the process easier for individuals to understand and navigate. For example, in order to maximize coordination of appeals involving different insurance affordability programs and minimize the burden on consumers, the proposed rule would require a state Medicaid agency to treat an appeal of a determination of eligibility for enrollment in a QHP in the exchange and for advance payment of the premium tax credit or cost sharing reductions, as a request for a fair hearing of the denial of Medicaid (42 CFR §221). We support this provision, which is intended to eliminate the need for an individual to request multiple appeals to different agencies and urge CMS not to allow a later effective date for this provision. We also support §431.224 of the proposed rule, which would require a state agency to establish and maintain an expedited review process that can be requested by individuals (or their physicians) with urgent health needs. This expedited appeals process aligns with current managed care rules.

We agree with CMS that an effective notification process is important to a high quality consumer experience and a coordinated eligibility and enrollment system. Thus, we support the goal of providing a single combined notice of eligibility from state Medicaid and CHIP agencies and exchanges after all eligibility determinations based on modified adjusted gross income have been made. We believe this will go a long way towards minimizing or avoiding

confusion for consumers who otherwise could receive multiple, uncoordinated notices about eligibility determinations from the different agencies. In terms of the content for notices, we agree with the proposed provisions that require clear notice of specific adverse determinations and of their basis, which must be more than a simple citation to a regulation, as well as information about alternative bases of eligibility.

Payments for Services—Premiums and Cost Sharing

While not required by the Affordable Care Act (ACA), this rule proposes to update and simplify policies on Medicaid premiums and cost sharing requirements to promote the most effective use of services and to assist states in identifying cost sharing flexibilities. The AMA generally supports the proposed streamlining and simplifying of Medicaid premium and cost sharing provisions, which should make the complicated payment framework a bit easier to understand and navigate. However, while we generally support modest copayments or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals, we are concerned about the possible negative consequences to beneficiaries of some of the changes being proposed by CMS, especially the proposed higher cost sharing charges. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other basic necessities, such as food and rent. This is especially the case for individuals with chronic conditions who may require more frequent medical care, and thus be charged more copayments. While we understand CMS' goal of increasing state flexibility by allowing higher copayments for certain low-income populations, we remain concerned that the proposed cost sharing provisions could pose barriers to Medicaid beneficiaries' ability to timely access medically necessary services, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

We have several specific concerns related to the proposed provisions on increased cost sharing for "non-emergency" visits to hospital emergency departments. As indicated previously, while we support modest copayments for non-emergency care, the proposed cost sharing amounts for non-emergency medical services in the proposed rule are not modest, particularly for those with incomes above 150 percent of the Federal Poverty Level (FPL), for which there is no limit. Even the proposed cost sharing amount up to $8 for those with incomes at or below 150 percent of the FPL is not modest relative to income. In fact, the proposed cost sharing amounts could effectively deter Medicaid patients from seeking life-saving emergency treatment when necessary. We urge CMS to reduce the cost sharing amounts for non-emergency services in the final rule, and base nominal cost on the income of Medicaid beneficiaries.

In addition, imposing cost sharing for non-emergency services fails to address the root causes of non-emergency use of the emergency department. Research indicates that Medicaid beneficiaries often use the emergency room because there are no available and accessible

non-emergency services providers nearby. Moreover, as referenced in the preamble to the proposed rule, there are logistical and clinical challenges to applying cost sharing to non-emergency use of the emergency department. In practice, there is no bright line during an emergency room visit that separates when the screening portion is over and the treatment—subject to cost sharing—begins. In addition, there is no expert clinical consensus on a definition or measure of emergency versus non-emergency use of the emergency department. Emergency room physicians have both legal duties to screen patients under EMTALA and ethical duties to treat such patients, even if the condition turns out to be non-emergent. CMS should make clear in the final rule that distinguishing between emergent and non-emergent conditions must be based on the prudent layperson definition on how the patient presents to the emergency department, not a discharge diagnosis.

Instead of focusing on cost sharing, which we think could result in harm to patients, we would encourage CMS to review the best practices adopted in a partnership among Washington State's Health Care Authority, the American College of Emergency Physicians, the Washington State Hospital Association, the Washington State Medical Association, and the Washington Chapter of the American College of Emergency Physicians. These best practices focus on medically sound ways of reducing unnecessary emergency department visits by Medicaid beneficiaries and include elements such as the electronic exchange of patient information among emergency departments, care coordination policies, patient education about the appropriate use of the emergency department, and adoption of guidelines for prescribing narcotics. While these best practices have only been implemented since July 1, 2012, they have already demonstrated savings and reductions in preventable utilization of emergency departments, while improving the quality of care provided. We encourage CMS to monitor this program and provide it as a guide for other states.

With respect to drugs, the proposed rule would allow states to set higher cost sharing for non-preferred drugs than for preferred drugs. Individuals with incomes at or below 150 percent of FPL could be charged up to $4 copayments for "preferred" drugs and $8 copayments for "non-preferred" drugs. While this may seem like a reasonable tool for states seeking to contain prescription drug costs, research has shown that even low prescription drug copayments can result in very low income patients not filling their prescriptions. The reality is that in many cases Medicaid beneficiaries cannot be incentivized to favor the preferred drug—they may simply choose to go without the non-preferred drug even if it really is necessary and might work better than a non-preferred drug. Instead of this approach, we recommend that CMS consider how copayments are assessed for Medicare populations living below the FPL in the Part D program, and treat Medicaid beneficiaries similarly.

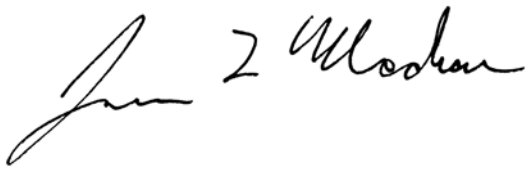
Premium Assistance

We support the provisions in the proposed rule that would allow states to use Medicaid and Children's Health Insurance Program (CHIP) funds to provide assistance to beneficiaries to purchase private insurance in the individual market. Premium assistance programs can serve an important function in coordinating coverage through qualified health plans for families

where some family members are covered in the exchange through premium tax credits and children in the family are eligible for Medicaid or CHIP. This can help to ensure better coordination of access to physicians and other health care providers and help during transitions from public programs to private coverage where income fluctuations change eligibility for insurance affordability programs. In particular, we support the provisions in §435.1015 that would ensure that beneficiaries are provided with wrap-around benefits and do not incur any additional cost sharing charges in excess of amounts that would be imposed in Medicaid or CHIP.

Thank you for your consideration of our comments. If you have any questions, please contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,



James L. Madara, MD