American Hospital Association

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March 20, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS-2244-P) Medicaid Program; Premiums and Cost Sharing (Vol. 73, No. 36), February 22, 2007

Dear Mr. Weems:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed changes to Medicaid policy regarding cost-sharing requirements for non-emergency care furnished in hospital emergency departments (EDs).

PROVISION OF THE PROPOSED REGULATIONS

The *Deficit Reduction Act of 2005* (DRA) (Section 1916 (e)) created an option for state Medicaid programs to allow hospitals to impose cost-sharing for non-emergency services provided to Medicaid patients. Under this provision, hospitals must first apply the appropriate medical screening required under the *Emergency Medical Treatment and Labor Act* to determine if the individual has an emergency condition. If the hospital determines that the individual does not have an emergency condition, it must inform the individual that there is a health care provider available and accessible that can provide the non-emergency service without a co-payment requirement and that the hospital can coordinate referral to that health care provider. After providing the individual with this notification, the hospital can then require payment of the cost-sharing amount before providing service to that individual.

ED visits in the United States have increased over the past decade, with many visits being used for primary care. A study supported in part by the Agency for Healthcare Research and Quality concluded that greater primary care access and scope of services may reduce hospital ED use. The congressional sponsors of this DRA provision intended that this non-emergency cost-sharing option would deter individuals from using hospital EDs for services that can be provided in lower-cost settings. However, the sponsors failed to understand that a growing number of physicians do not take Medicaid patients because of inadequate payment, and the hospital ED often is the only source of primary medical care for Medicaid beneficiaries.

We oppose this cost-sharing option because it does not address the real problem – that many Medicaid patients have no access to primary care services except through the ED. This option also places a significant coordination burden on hospitals. After determining that the care requested is not emergent, a hospital would have to work with the patient to find available alternative care and to secure referrals. In addition, many Medicaid patients cannot afford a co-payment. As a result, hospitals will be placed in the untenable situation of pursuing patients for small, unpaid amounts. States may lower their payments to hospitals assuming that hospitals can and will be forced to collect the co-payment. However, hospitals ultimately will be forced to write off these uncollected co-payments as bad debt.

At the time that the DRA was being considered by Congress, the Congressional Budget Office analysis noted that co-payments will cause fewer individuals to seek care. Without the ability to discern what is "non-urgent," many Medicaid patients may avoid or delay going to the ED altogether. Putting up barriers to primary and urgent care in the ED will lead to poorer health and higher costs for many Medicaid beneficiaries in terms of more costly ED visits or avoidable hospitalizations.

The DRA provision that permits states the option to require hospitals to impose cost-sharing amounts for non-emergency services provided in the ED is a flawed policy. The AHA opposes this approach and will continue to support efforts to broaden health care coverage and access to needed services.

If you have any questions, please feel free to contact me or Molly Collins Offner, director of policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President