American Hospital Association

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February 21, 2013

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

RE: CMS 2334-P Medicaid, Children's Health Insurance Program and Exchange: 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; Proposed Rule (Vol. 78, No. 14, January 22, 2013)

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment provisions included in the *Patient Protection and Affordable Care Act* (ACA) and the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA).

The AHA commends CMS for releasing this comprehensive rule to streamline the enrollment process between Medicaid, CHIP and the health insurance exchanges and to implement the "no wrong door approach" to enrollment in preparation for coverage expansions. America's hospitals play a vital role in their communities, providing not only access to needed health care services but also connections to health care coverage. Ensuring a smooth health coverage enrollment process for Medicaid, CHIP and the health insurance exchanges is an important goal, particularly as the ACA's coverage expansions begin in earnest in 2014.

Our detailed comments follow and focus on four areas: presumptive eligibility; certified coverage application assisters; essential health benefits in Medicaid alternative benefit plans; and cost-sharing changes.

PRESUMPTIVE ELIGIBILITY

States have long used presumptive eligibility to temporarily enroll pregnant women and children in Medicaid or CHIP. A presumptive eligibility program allows providers, on behalf of their patients, to begin the enrollment process based on some key pieces of information at the point of service. Thirty-two states have adopted presumptive eligibility for pregnant women, and 17 states have adopted presumptive eligibility for children. The ACA created a new requirement for states to specifically allow hospitals to make presumptive eligibility determinations, even if the state had not previously established a presumptive eligibility program. The proposed rule would implement this requirement by allowing hospitals to self-elect to make presumptive eligibility determinations for all Medicaid eligible populations.

The rule proposes the basic criteria that a hospital must meet to be a qualified hospital authorized to make presumptive eligibility determinations. These criteria include that the hospital: (1) participates as a Medicaid provider; (2) notifies the state Medicaid agency of its decision to make presumptive eligibility determinations; (3) agrees to make determinations consistent with state policies and procedures; (4) assists individuals in completing and submitting the full application, at the state's discretion; and (5) not be disqualified by the agency.

The AHA is pleased that CMS has taken steps to implement this important ACA requirement, but we are concerned that hospitals will not have sufficient information to effectively determine Medicaid eligibility on a presumptive basis. The rule would allow hospitals to make presumptive eligibility determinations as long as the hospitals comply with all of the enrollment and eligibility policies and procedures established by the state Medicaid agency. The rule, however, does not require that states fully cooperate in making such information transparent and available to the hospital. Thus, hospitals will be held to policies and procedures for which they may have no knowledge. This is particularly concerning for states that do not have an existing presumptive eligibility program and no established working relationship with hospitals on making presumptive eligibility determinations. For these hospitals, meeting the requirement that they comply with state enrollment and eligibility policies and procedures without state cooperation could be extremely difficult.

The rule also allows states to go beyond the basic criteria to establish state standards for qualified hospitals. Specifically, CMS proposes "that the agency may establish standards for qualified hospitals making presumptive eligibility determinations related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital that submit a regular application before the end of the presumptive eligibility period and/or are determined eligible for Medicaid based on such application." A hospital's success in meeting these suggested performance standards seems to be largely dependent on whether the state Medicaid agency ultimately determines the presumptive eligible individual qualified for Medicaid – a final decision that is outside the control of the hospital. CMS, in suggesting that states develop performance standards, does not require that the state develop these standards using a public process or stakeholder input. CMS, however, does ask for public comment, in this rule, on whether these performance standards should be federal or state-based.

In addition, the rule requires that a state Medicaid agency take action to disqualify a hospital if it determines that the hospital is not meeting the state-established standards or is not capable of making eligibility determinations in accordance with state policies and procedures. The AHA is concerned that hospitals, eager and willing to help enroll their patients in Medicaid, may be discouraged from even participating in presumptive eligibility determinations because they may lack the necessary information on state eligibility and enrollment policies and procedures and because of the uncertainty over whether they could even meet the yet to be established performance standards.

The AHA recommends that: (1) CMS provide guidance to all states, including those states with no previous experience with presumptive eligibility programs, on how the states must work with hospitals that elect to make presumptive eligibility determinations; and (2) the performance standards for qualified hospitals that elect to make eligibility determinations should be federally established (not state-based) standards. In developing the federal standards, the AHA recommends that CMS consult with hospitals and examine successful hospital-based presumptive eligibility programs. A federal standard would provide consistency across states. This is particularly important for hospitals that serve Medicaid patients from multiple states.

The AHA also believes that CMS has narrowed the scope of the ACA hospital presumptive eligibility statutory provision by allowing states to limit the populations for which a hospital can make presumptive eligibility determinations. The rule allows states to restrict the populations for which a hospital can make a presumptive eligibility determination. Prior to the ACA, hospitals were limited to making presumptive eligibility determinations (in states with presumptive eligibility programs) to pregnant women and children. The ACA provision, however, not only grants hospitals the ability to make presumptive eligibility determination, but does not limit the scope of the populations for which hospitals can make such determinations. The AHA recommends that CMS drop the option in the rule that would allow state Medicaid programs to restrict the populations for which hospitals make eligibility determinations. Hospital should be allowed to make eligibility determinations for all the patient populations they serve that may be eligible for the Medicaid program, including the new expansion population.

CERTIFIED COVERAGE APPLICATION ASSISTERS AND TRANSLATION ASSISTANCE

The proposed rule recognizes that many state Medicaid programs have established relationships with providers, such as hospitals, to assist individuals seeking health coverage. In this capacity, many hospitals have served as "application assisters," promoting health coverage enrollment for low-income populations and often providing much-needed language translation assistance.

The AHA is pleased that the proposed rule recognizes the services of community-based providers and hospitals in providing application assistance through a certification process that will provide the training and skills needed to access confidential data and meet confidentiality requirements. In addition, we urge CMS to continue its work to promote a streamlined application process that includes a single application in multiple languages beyond

English and Spanish. We also encourage CMS to create translation glossaries so that hospitals engaged in outreach and enrollment activities can more effectively help those potentially eligible for Medicaid while easing the translation services burden on hospitals.

ESSENTIAL HEALTH BENEFITS IN THE MEDICAID ALTERNATIVE BENEFIT PLANS

The ACA requires that the Medicaid Alternative Benefit Plan in current law be modified to include the new eligibility group of low-income adults, also known as the expansion population. The ACA further requires that the Alternative Benefit Plan be modified to include the essential health benefit (EHB) requirements identified by the Department of Health and Human Services (HHS), including mental health and prescription drug coverage.

The proposed rule includes the two-step process outlined in the Nov. 20, 2012, State Medicaid Directors letter regarding EHB requirements. That process first requires a state to determine whether the Alternative Benefit Plan meets the criteria for a benchmark option for EHB, as set by the HHS Secretary. If so, the standards for both the Alternative Benefit Plan and EHB will be met. If these standards are not met, the state will proceed to the second stage – identifying one of the EHB base-benchmark options and supplementing the Alternative Benefit Pan until all EHB requirements are met.

The state Medicaid agency has the responsibility to ensure that the Alternative Benefit Plan for the expansion population meets the ACA's EHB requirements. This role becomes particularly important with respect to the definition of the EHB-required habilitative benefit. Habilitative services help individuals attain, retain or improve their skills and functioning. For children and young adults, a clearly defined habilitative service is critically important for lifelong developmental and health care needs.

Under the EHB proposed rule, health plans operating within the exchanges would be allowed to substitute habilitative services as long as the services they substitute are actuarially equivalent. As a result, consumers may not be aware when purchasing health plans within the exchange that the plan may have substituted habilitative services for other services that are actuarially equivalent. The proposed rule asks for public comment on whether the state-defined habilitative services for the exchange should apply to Medicaid or whether states should be allowed to separately define habilitative services for the program. **In commenting on the EHB proposed rule, the AHA recommended a standard for habilitative services to prevent health plans from substituting habilitative services. For this proposed rule, it is our belief that the states have a better understanding of the health care needs of the Medicaid populations they serve. Therefore, we recommend that CMS allow states to separately define habilitative services for purposes of the Medicaid program and the Alternative Benefit Plan.**

COST SHARING

Reducing non-emergency use of hospital emergency departments (EDs) continues to be a challenge for hospitals and state Medicaid agencies. Our recent report, *Prepared to Care: The*

24/7 Standby Role of America's Hospitals, found that, from 2004 to 2009, visits to the ED by Medicaid and uninsured patients grew by 42 percent, compared to a 23 percent increase overall.

Imposing cost-sharing for non-emergency use of EDs is one strategy to reduce this costly service, but it poses challenges for hospitals. The *Emergency Medical Treatment and Active Labor Act* (EMTALA) requires that hospitals provide stabilizing treatment for anyone presenting with an emergency medical condition. The current Medicaid regulation also includes a "prudent layperson standard" for the definition of an emergency medical condition. And, the Medicaid statute requires that once an EMTALA screen has been performed and it is determined that the care being sought is of a non-emergency nature, the hospital must inform the individual that alternative sources of care in the community are available and that, if the patient chooses to proceed with treatment, that a cost-sharing amount would apply. For hospitals, the collection of Medicaid cost-sharing amounts for non-emergency care in ED settings can prove difficult, leading to lack of payment and increases in bad debt.

The proposed rule recognizes the challenges for hospitals in balancing the EMTALA and Medicaid requirements. Specifically, the rule calls for state Medicaid programs to share best practices on ways to discourage non-emergency use of EDs and ease the burdens imposed on hospitals. **The AHA strongly supports CMS's effort to gather best practices on the most effective strategies to limit non-emergency ED use and develop possible standards going forward in consultation with hospitals.**

ADDITIONAL ISSUES

Continuous Medicaid Eligibility. **The AHA is pleased that CMS proposes to implement the option for states to provide up to 12 months of continuous Medicaid eligibility for children.** This will protect children on Medicaid who "age out" of the program during an inpatient hospital stay by maintaining their eligibility for the duration of their hospital stay. And we are pleased the rule would also extend eligibility for pregnant women through the last day of the month in which the post-partum period ends. Continuous eligibility for children and extended eligibility for pregnant women are important strategies to maintain needed health care coverage.

Medicaid "Institutions for Mental Diseases" (IMD) Restrictions. The proposed rule does not address, for the expansion population, whether Medicaid would pay for the cost of inpatient care incurred when treating Medicaid beneficiaries aged 21-64 if they receive treatment in IMDs such as private psychiatric hospitals. These freestanding psychiatric hospitals play a vital role in ensuring access to community-based mental health care for those with serious mental illnesses. The IMD restrictions present an access barrier for the Medicaid expansion population receiving coverage through the Alternative Benefit Plan. The ACA is clear that the Alternative Benefit Plan should include the EHB of hospitalization and mental health services that are included in the exchange-based coverage.

The AHA believes that new Medicaid beneficiaries should have the same access as those who purchase health care coverage through the exchanges to choice, quality and cost-effective

treatment for inpatient psychiatric care as they do for medical/surgical treatment. **We urge CMS to state clearly that the IMD restrictions do not apply to the coverage provided to the Medicaid expansion population through the Alternative Benefit Plan. This policy will bring Medicaid mental health coverage for the expansion population in line with the EHB requirements that apply to coverage offered through the exchanges.**

Thank you for consideration of our comments. We look forward to working with you and your staff on streamlining the enrollment and eligibility process for Medicaid, CHIP and the exchanges. If you have any questions, please feel free to contact me or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President