



**American Hospital
Association**

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November 25, 2013

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

***RE: CMS 2380-P Basic Health Program; Proposed Rule (Vol. 78, No. 186,
September 25, 2013)***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the *Patient Protection and Affordable Care Act* (ACA) option for states to establish a Basic Health Program (BHP). The BHP is a health benefits program for certain low-income individuals with incomes between 133 percent of the Federal Poverty Limit (FPL) and 200 percent FPL that serves as an alternative to coverage provided through the new Health Insurance Marketplaces. The proposed rule sets the basic program parameters and processes for state BHPs building on the existing federal regulations for the marketplaces and the Medicaid program.

The AHA wishes to address three concerns with regard to the BHP program parameters:

- 1. the application of marketplace rules pertaining to Qualified Health Plan (QHP) payment for services during the 90-day grace period for non-payment of premiums;**
- 2. the absence of any reference to presumptive eligibility determinations for the BHP and, in particular, the absence of any reference to hospitals' role in making such determinations; and**
- 3. the absence of a process for assuring that provider rates are adequate to ensure access to care.**

Our detailed comments follow.



PAYMENT FOR SERVICES DURING 90-DAY GRACE PERIOD FOR NON-PAYMENT OF PREMIUMS

The AHA strongly urges CMS to revise its policy regarding the payment for services provided during the 90-day grace period when an individual purchases coverage through the marketplace and fails to pay his/her premium. States, when establishing a BHP, choose between the application of existing federal marketplace regulations and the Medicaid program regulations. If the state chooses to apply existing marketplace regulations with regard to termination of coverage for non-payment of insurance premiums, the proposed rule stipulates that states must align their BHP premium payment standards with the exchange standards found at 45 CFR 156.270(d).

CMS's current exchange premium payment standards permit QHP issuers to terminate coverage after 30 days of non-payment of premiums for enrollees receiving tax-subsidized premiums. Specifically, QHP issuers would be required to pay all appropriate claims for services provided during the first month of the grace period, and could suspend claims for services furnished during the second and third months. If a consumer does not pay his/her outstanding premiums by the end of the three-month grace period, the QHP issuer may deny all pending claims for services rendered during the second and third months.

The effect of this policy is to allow QHP issuers to retroactively terminate coverage for the second two months of the grace period. This shifts the burden related to Congress's intent to protect patients and maintain continuity of coverage during most of the grace period from QHP issuers to health care providers. It unfairly burdens providers who treat these patients because they will not get paid by the QHP issuer for covered services and will have to wait to try to obtain direct payment from the patient. The reality is that it will be extremely difficult to collect payment from low-income patients who already are having trouble paying their QHP premiums. **As stated in our Aug. 15 letter, the AHA believes CMS must revise section 45 C.F.R. 156.270(d) to reflect the ACA-mandated minimum three-month grace period, and require QHPs issuers to pay for all services rendered during that time period. This flawed policy should not be allowed to apply to BHP.**

PRESUMPTIVE ELIGIBILITY DETERMINATIONS

The AHA recommends that CMS permit presumptive eligibility determinations to be made for the BHP that include hospital-based determinations. The AHA further recommends that hospital-based presumptive eligibility determinations permit the delegation of authority to another entity, such as eligibility service vendors. The proposed rule recommends states to look for ways to provide individuals with application and enrollment assistance. Specifically, the proposed rule cites the certified application counselor programs allowed in the marketplaces, as well as the Medicaid program.

It is clear that CMS wants states to employ eligibility and enrollment tools that go beyond eligibility determinations conducted by the state agencies. Allowing presumptive eligibility determination to be made by providers, such as hospitals, is that kind of tool. Eligibility determinations can be made based on a few pieces of information, such as income and family size, while allowing the individual to enter into the health system and access services beyond the hospital emergency department while their application is pending. CMS could further the promotion of insurance coverage for these low-income individuals in the BHP by allowing hospitals to conduct presumptive eligibility determinations. The ACA already provides for hospital-based presumptive eligibility determinations for the Medicaid program. Unfortunately, CMS's implementing rule for Medicaid hospital-based presumptive eligibility stipulates that hospitals cannot delegate the authority for making presumptive eligibility determinations. This policy has created confusion in the hospital field with regard to a hospital's use of non-hospital staff, such as eligibility service vendors, to conduct determinations.

Eligibility services vendors provide hospitals with needed expertise in state Medicaid eligibility rules as well as allow hospitals to more efficiently and effectively staff these functions all the while getting patients connected to coverage. CMS has an opportunity to correct this oversight by revising 45 CFR 435.1102 to allow hospitals conducting presumptive eligibility determinations to delegate to another entity, such as eligibility service vendors. **The AHA recommends that these revisions to Medicaid eligibility determination regulations also apply to the BHP.**

PROCESS FOR ENSURING THAT PROVIDER RATES ARE ADEQUATE TO ENSURE ACCESS TO CARE

States have an option to establish a Basic Health Plan as an alternative for individuals and families between 133 percent and 200 percent FPL. Provider participation is vital to the success of the BHP in any state that chooses to offer it, yet there are no provisions to ensure adequate payment to potential providers. **We urge the agency to consider adding the payment and access requirements delineated in its Medicaid Equal Access Proposed Rule (CMS 2328-P: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services) to the BHP program requirements.** While not finalized, the Equal Access Rule represents a good first step toward holding states more accountable for ensuring appropriate provider payment, including a process to monitor rate changes and their impact on access to care.

Ms. Marilyn Tavenner

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Thank you for your consideration of our comments. We look forward to working with you and your staff on the further implementation of the ACA BHP. If you have any questions, please contact me, Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org, or Ellen Pryga, director of policy, at (202) 626-2667 or epryga@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President