July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2390–P
P.O. Box 8016
Baltimore, MD 21244–1850

*Re: RIN-0938-AS25; CMS-2390-P; Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability*

Dear Administrator Slavitt:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn. We appreciate CMS' efforts in issuing substantial proposed rules that update the Medicaid managed care program, as well as the opportunity to provide comment on these proposals.

***Medicaid Managed Care Payment Rates***

As you know, more than 3 out of 4 Medicaid recipients will receive services through managed care plans in 2016.[1] Because such a high proportion of Medicaid patients receive medical

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[1] *See* Avalere Health, *Avalere Analysis: Medicaid Managed Care Enrollment Set to Grow by 13.5 Million*, Oct. 23, 2014, http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli.

services in this way, it is important that any finalized rules regulating Medicaid managed care contain provisions that monitor Medicaid payment levels and ensure adequate payment rates for both network and out-of-network providers. Specifically, we recommend that the final rule mandate that Medicaid managed care payments are at least as high as Medicare reimbursement rates (parity). Medicaid reimbursements have dropped significantly as states try to balance their budgets. Because the Supreme Court's recent decision in *Armstrong v. Exceptional Child* prohibits providers from suing states regarding Medicaid payment levels, CMS must take a leading role in ensuring that payment rates support providers' participation in Medicaid. This includes active review of rate certifications submitted by states and supporting state enforcement efforts of Managed Care Organization (MCO) coverage requirements.

Last month, members of the Congressional Committees with jurisdiction over Medicaid sent a letter to CMS noting that "[o]ver the past several years, states have often made drastic and oftentimes, arbitrary, provider payment reductions due to increasing concern over budgetary constraints. Historically, lawsuits by Medicaid providers have helped keep pressure on states to prevent them from arbitrarily reducing provider rates to meet certain budgetary objectives without considering the impact on enrollees' access to care. Unfortunately, on March 15, 2015, the U.S. Supreme Court held that health care providers cannot enforce the Medicaid Act's payment provisions, 42 U.S.C. 1396a(a)(30)(A) against states in federal court. See *Armstrong v. Exceptional Child*, 135 S.Ct. 1378 (2014)."

Members of Congress specifically urged CMS to "provide firm and immediate oversight to ensure that states are setting and maintaining their Medicaid rate structures as Congress intends in section 1902(a)(30)(A) of the Medicaid Act." We applaud this direction and similarly urge CMS to develop an infrastructure that ensures that states are setting Medicaid rates at levels that make health care services equally available to Medicaid enrollees.

There is often significant cost containment pressure for MCOs to deny or lower payment for treatment provided in the emergency department if it is determined that such care was non-emergent. However, possibly due to low payment rates and other challenges, Medicaid and Medicaid MCOs have often been unable to attract an adequate number of primary care physicians to close the access gap. This creates an untenable situation for emergency physicians. We therefore support further measures that continue to promote primary care programs while also providing payment incentives to other physicians - such as emergency physicians – that, as a result of the economic realities of the Medicaid program, regularly furnish necessary primary care services to enrollees of Medicaid MCOs.

We also urge CMS to restate and reinforce the "Prudent Lay Person" (PLP) requirements of the Balanced Budget Act of 1997 (BBA '97) with Medicaid MCOs. The PLP standard mandates coverage of emergency services based on a patient's symptoms upon presentation, not the patient's final diagnosis. We also encourage CMS to develop protective measures that permit provider complaints and CMS enforcement of detected PLP violations.

***MCO Coverage Denials and Arbitrary Coverage Limits in the Emergency Department***

Unfortunately, despite existing regulations that mandate coverage of emergency department services without arbitrary limits, many Medicaid MCOs continue to target emergency departments for payment denials. We support CMS' proposals to ensure that emergency department services are covered regardless of a physician's network status or arbitrary coverage limits MCOs may set. We recommend that CMS specifically prohibit Medicaid MCOs from denying payment or requiring cost-sharing from members based on number of visits or ultimate diagnosis. We remain concerned that CMS will allow MCOs to limit services based on medical necessity, a tactic that has been often used by MCOs in the emergency department. We are also concerned that Medicaid MCOs may repeat the past and refuse to comply with federal and state PLP requirements by instituting diagnosis lists for "approved emergencies"—in direct contravention of the BBA '97 statute. For instance, when a patient presents to the emergency department complaining of chest pain and related symptoms, emergency physicians are required by EMTALA to ensure that the patient is stable prior to making a transfer or discharge decision. This requires a battery of tests and evaluations. If the patient is suffering from a heart attack, those tests and other services may be approved, but if the source of the patient's pain was more benign, such as indigestion, those same tests and services are deemed "not medically necessary." Medicaid MCOs typically apply a retrospective coverage review, despite the fact that the patient's initial clinical presentation clearly warranted the services provided. Thus, EDPMA is concerned that allowing MCOs to continue to deny services for a broad "medical necessity" standard in the emergency department without requiring a particular review standard will continue to lead to coverage denials.

While an unintended consequence to be sure, we are concerned that the upcoming implementation of ICD-10 may provide Medicaid MCOs with a smoke screen of confusion that might allow them to deny emergency services. In particular, as has been emergency physicians' past experience, expanded code sets enable MCOs to establish "approved" or "not approved" emergencies, which are in contravention to federal PLP law. The number of potential codes applicable to the emergency department will increase exponentially as a result of the ICD-10 transition and, with the prospect of such increase, Medicaid MCOs may use these additional codes to limit access to the emergency department and coverage of emergency services. We encourage CMS to consider the effect of ICD-10 transition in its final rule to ensure that Medicaid MCOs are not using the potential confusion caused by this transition as a guise for payment denials.

***Request for Temporary Relief During the First Year of ICD-10 Implementation***

On July 6, 2015, the CMS and the American Medical Association (AMA) issued a joint media release (the "Media Release") headed "CMS and AMA Announce Efforts Providers Get Ready for ICD-10". In general terms, the Media Release announced collaborative efforts by both CMS and AMA to continue to help physicians get ready for ICD-10 implementation ahead of the October 1, 2015 deadline. More specifically, CMS adopted several policies to ease the transition to ICD-10 in response to physicians' concerns that inadvertent coding errors or system glitches

during the transition from ICD-9 to ICD-10 may result in audits, claims denials under various Medicare reporting programs.

The Media Release went further to state that "for 12 months after ICD-10 implementation, Medicare review contractors **will not deny** physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical review based solely on the *specificity* (emphasis added) of the ICD-10 diagnosis code [so] long as the physician/practitioner use[s] a valid code from the right family." CMS and the AMA advise that this policy will be adopted by the Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs) and the Supplemental Medical Review Contractors (SMRCs) too and extends to quality reporting applicable to PQRS, VBM and MU by not subjecting physicians to penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code when the physician uses a code from the correct family of codes.

EDPMA members are most appreciative of CMS' and the AMA's joint actions as we think adoption of a proactive policy extending a twelve month 'hold-harmless" period effectively responds to the requests from the provider community to allow for flexibility in claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.

Given however, ICD-10's broader implementation on October 1 beyond Medicare and its application to state Medicaid programs under both traditional Medicaid fee-for-service and Medicaid MCOs models, EDPMA specifically requests CMS authorize the adoption of this sound policy to the states and their contractors as well. We believe that a global hold-harmless policy which extends the same transitional benefits to the Medicaid programs, free of impunity from state audit review contractors in the same manner extended from federal review contractors, also for a twelve month period, and also on the basis of requiring a valid code from the correct coding family, provides sufficient support to physicians to ease the ICD-10 transition and proactively address concerns and potential problems our membership anticipates.

***Network Adequacy Standards***

EDPMA applauds the provisions of the Proposed Rule that require improvements in Medicaid MCO network adequacy standards, as well as require enhanced oversight by states for such standards. In the final rule, we recommend that CMS include additional provisions that establish CMS oversight over states' monitoring efforts. Given the considerable variation in how each state operates its Medicaid managed care program, we believe that consistent, national standards in monitoring and enforcing network adequacy will greatly benefit Medicaid recipients. Well-defined, stringent regulations on network development will support access for Medicaid recipients who have traditionally faced hardship in establishing and maintaining long-lasting physician-patient relationships. These regulations should include clear and significant penalties when MCOs fail to meet the required network adequacy standards.

***Medical Loss Ratio***

We support CMS' proposed implementation of an 85% Medical Loss Ratio (MLR) in Medicaid managed care programs. As CMS notes, nearly a quarter of the Medicaid MCOs have current MLRs below 83%. The imposition of an 85% MLR may help ensure the payment adequacy necessary to keep high quality medical professionals in Medicaid networks as well as properly reimburse out of network physicians providing essential care.

***Other Comments to the Proposed Rule***

Currently, Medicaid MCOs, PIHPs, PAHPs, and PCCMs are required to provide their enrollees with handbooks that detail how to receive emergency services and how such services are covered. MCOs, PIHPs, and PAHPs may not deny coverage and payment for treatment of emergency medical conditions. We support these requirements and recommend that CMS continue to actively monitor (or require states to monitor) Medicaid MCOs to ensure that such requirements are being fully met.

Finally, EDPMA supports CMS' efforts to promote innovative tools, such as data-mining, to deter fraud in Medicaid managed care programs. However, we caution that such tools should be deployed only in a manner that does not impact beneficiary access to needed services and is not administratively burdensome for health care providers.

As noted above, 76% of Medicaid beneficiaries will receive benefits through managed care plans in 2016. Therefore, this proposed rule -- the first major update to Medicaid managed care regulations in more than a decade -- must include provisions to ensure that rates offered by Medicaid managed care are sufficient to ensure equal access to care and provisions to ensure that CMS will monitor and enforce those provisions.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors