Emergency Department EDPMA Practice Management Association

November 20, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9930-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: File code CMS-9930-P: Proposed Notice of Benefit and Payment Parameters for Plan Year 2019

Dear Administrator Verma:

I am writing on behalf of the Emergency Department Practice Management Association (EDPMA) to express our concerns with some of the proposals in the Notice of Benefit and Payment Parameters for 2019 (the Notice). 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 141 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 understand that the increased flexibility in the Notice is intended to encourage innovative solutions and reduced costs. The emergency department will play a key role in reaching this goal. The emergency department is often the most appropriate and cost-effective location to receive care. In 2013, the RAND Corporation released a study entitled *"The Evolving Role of Emergency Departments in the United States,"* which found that emergency department physicians are the major decision makers in over half of an average hospital's admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to the ability to pay (i.e., EMTALA). Also, primary care physicians increasingly rely on the emergency department to evaluate complex patients with potentially serious health

conditions, while providing overflow and after-hours primary care. Additionally, emergency physicians are increasingly a viable resource as means to finding alternatives to costly hospitalization stays.

Unfortunately, the emergency department often is not seen as a cost-effective health care resource and key stabilization and decision point for patient disposition. Yet, the RAND report found that "an average inpatient admission costs ten times more than an average emergency department (ED) visit." In many cases, a visit to the emergency department is not only appropriate, but the least costly alternative. Emergency departments can provide a high-level of care in a timely manner avoiding unnecessary and substantial downstream costs.

EDPMA is very concerned that the Notice could jeopardize access to emergency care. It provides states with greater flexibility when choosing a benchmark plan to cover essential health benefits (EHBs) and allows plans to make more substitutions between EHB categories. Depending on the choices made by each state, consumers could lose coverage for emergency care. Alternatively, as recognized by CMS in its proposal, consumers could lose coverage for other essential health benefits making those consumers more dependent on the emergency department where, due to the Emergency Medical Treatment & Labor Act (EMTALA), patients receive care no matter the ability to pay.

Emergency physicians provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients even though they are only 4% of physicians. Under the Notice, they would likely provide even more uncompensated and undercompensated care. If the amount of uncompensated and undercompensated care in the emergency department grows due to inadequate private insurance coverage, the health safety net will be severely jeopardized. Fewer physicians would be attracted to the emergency medicine specialty, wait times in the emergency department would grow, and emergency departments, especially in rural areas, would face closure jeopardizing everyone's access to emergency care.

In order to limit the negative impact on access to emergency care, we ask you to add a few important patient protections to the Notice, including:

1) Requiring QHPs to fully cover emergency care, including providing for a minimum benefit standard for out-of-network emergency care at "usual, customary and reasonable" (UCR) charges (with UCR defined as Congress directed earlier in 2017),
2) Prohibiting states and QHPs from waiving important patient protections relating to emergency care such as the prudent layperson standard, the greatest-of-three rule, and annual and lifetime limits on essential health benefits, and
3) Exempting emergency care from the charges patients must cover with their deductible for QHPs and Ensuring that Cost-Sharing for Out-of-Network Emergency Medicine Counts Toward the In-Network Annual Limit.

1) **Require QHPs to fully cover emergency care, including providing for a minimum benefit standard for out-of-network emergency care at "usual, customary and reasonable" (UCR) charges (with UCR defined as Congress directed earlier in 2017).**

Emergency care is arguably the most essential of the health benefits. That is why federal law (i.e., EMTALA) provides that everyone entering the emergency department will receive certain emergency care no matter the ability to pay. **If emergency care is so essential that it is mandated, it should be essential enough to be covered.**

The emergency department remains a key component of the healthcare safety net and, unfortunately, continues to assume a disproportionate share of the uncompensated and undercompensated care delivered in this country. Fair payment by private insurers is needed to protect the safety net.
Moreover, an adequate out-of-network benefit for emergency care prevents insurers from foisting the full cost of emergency care on the patient by offering narrow networks and high deductibles. Further**, an appropriate minimum benefit standard closes the surprise gap in insurance which has plagued patients in recent years.**

Thus, the federal government established – through Affordable Care Act regulations implemented in 2010 and reaffirmed in 2015 – a minimum benefit standard for out-of-network emergency care. This standard is commonly referred to as the Greatest-of-Three rule. The Department of Health and Human Services, the Department of Labor, and the Treasury Department stated that "it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to a provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts." **Thus, "a plan or issuer must pay a reasonable amount for emergency services by some objective standard."** The Departments further provided that, at minimum, this reasonable amount is "the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as usual, customary, and reasonable charges)."

Unfortunately, this standard is vague and unenforceable because insurers do not calculate their reimbursement rates in a consistent and transparent manner. Therefore, in May, in the 2017 appropriations bill, Congress directed the Center for Consumer Information and Insurance Oversight (CCIIO) to provide guidance clarifying the meaning of usual, customary and reasonable (UCR) charges in this rule. Congress specified that the guidance may come in the form of Frequently Asked Questions, ***"clarifying what constitutes the UCR amount using a transparent and fair standard, such as an independent unbiased charge database."***

We urge you to address this Congressional directive in the final Notice of Benefit and Payment Parameters. In order to address the fact that the standard is vague and unenforceable, the final Notice should state that QHPs must reimburse for out-of-network emergency care, at minimum, at a UCR rate and that UCR rate must be based on an independent transparent charge database. As an example of statutory language that provides

for such a benefit standard, see the state of Connecticut's statute which requires, at minimum, out-of-network reimbursement for emergency services at the 80th percentile of a transparent database (https://www.cga.ct.gov/2015/SUM/2015SUM00146-R03SB-00811-SUM.htm.). We urge you to adopt this same approach.

2) **Prohibit States from Waiving Important Patient Protections relating to Emergency Care such as the Greatest-of-Three Rule, the Prudent Layperson and Annual and Lifetime Limits on Essential Health Benefits.**

We urge you to reiterate the importance of patient protections relating to emergency care and to clearly state that these protections cannot be waived. As discussed above, the greatest-of-three patient protections are vague and unenforceable and need to be clarified. Otherwise, patients and providers will continue to be unable to identify and address violations of that rule. Violations of the prudent layperson (PLP) standard are easier to identify. Yet, recently, a number of private insurers have established policies that violate this important patient protection.

The PLP standard provides that it is appropriate to seek care in the emergency department when there is a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part" (81 FR 27749 (May 16, 2016) (Final 2016 Medicaid Managed Care Rule).

CMS already concluded that diagnosis lists should not be used to determine when it is appropriate to seek care in the emergency department. For instance, in the Final 2016 Medicaid Managed Care Rule, CMS stated:

> *Regarding the PLP requirements of the BBA of 1997 and the use of approved lists of emergency diagnosis codes, we remind commenters that consistent with our discussion in the 2002 managed care final rule at 67 FR 41028–41031, we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. … While this [PLP] standard encompasses clinical emergencies, it also clearly requires managed care plans and states to base coverage decisions for emergency services on the apparent severity of the symptoms at the time of presentation, and to cover examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable*

administrative burdens
(emphasis added) (81 FR 27749 (May 16, 2016)).

Yet private insurers are establishing policies where they use diagnosis lists to determine what payment, if any, will be made. It may be acceptable to deny coverage retroactively **if the PLP standard is not met**. But, as discussed above, a diagnosis list should not be used to determine whether the PLP standard is met.

The PLP standard is the gold standard in emergency medicine. The Balanced Budget Act of 1997 required by statute all Medicare programs and Medicaid MCEs to comply with and certify their compliance with PLP standards. In the case of Medicaid MCEs, the PLP certification is a requirement of their contract with CMS. CMS also applies the standard to Medicare-participating hospitals under 42 CFR s.489.24.7, the Medicare Advantage program under 42 CFR s.422.113,8 and the Programs of All Inclusive Care for the Elderly under 42 CRF s.460.100.9.

3) Exempt Emergency Services from the Charges Patients Must Cover with their Deductibles for QHPs and Ensure that Cost-Sharing for Out-of-Network Emergency Care Counts Toward the In-Network Annual Limit

The vast majority of patient complaints about their financial liability for emergency care are not addressed by the proposed rule. When an insured patient is liable for a high proportion of a bill for emergency care, it is usually a reflection of the patient's high deductible or copayment. Yet, the proposed rule – which should specifically address the adequacy of the insurance coverage – does nothing to address these high deductibles for emergency care.

The Notice should exempt emergency care from the care the patient is responsible for under the deductible. At minimum, it should exempt Emergency Medical Treatment & Labor Act EMTALA-required care from the patient's deductible. EDPMA and other organizations believe that this is consistent with not only the prudent layperson standard, but also the purpose and intent of the ACA.

Similar to provisions previously finalized by the agency[1], we also believe that cost sharing for out-of-network emergency room services – which is an essential health benefit – should count toward an enrollee's in-network annual limit on cost sharing. Specifically, we urge CMS to require that each QHP that uses a provider network to count cost sharing paid by an enrollee for emergency services provided by an out-of-network emergency physician in an in-network setting towards the enrollee's annual limitation on cost sharing.

[1] § 45 CFR 156.230(e)(1)

4) <u>Conclusion</u>

In summary, EDPMA urges CMS to:

1) Require QHPs to fully cover emergency care, including providing a minimum benefit standard for out-of-network emergency care at "usual, customary and reasonable" (UCR) charges (with UCR defined as Congress directed earlier this year),
2) Prohibit states/QHPs from waiving important patient protections relating to emergency care such as the prudent layperson standard, the greatest-of-three rule, and annual and lifetime limits on essential health benefits, and
3) Exclude emergency care from the deductible and ensure that out-of-network emergency care counts toward the in-network annual limit.

Thank you for your consideration. Please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Andrea Brault, MD, FACEP, MMM, Chair of the Board
Emergency Department Practice Management Association (EDPMA)