Emergency Department EDPMA Practice Management Association

March 7, 2017

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: RIN 0938-AT14; CMS-9928-P; Patient Protection and Affordable Care Act: Market Stabilization

Dear Administrator Conway:

We are writing on behalf of The Emergency Department Practice Management Association (EDPMA) to express our concerns with the proposed network adequacy provisions in the proposal on Patient Protection and Affordable Care Act; Market Stabilization. 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.

1) **<u>The Proposals Threaten to Significantly Increase Costs to the Consumer for "Covered" Emergency Care</u>**

EDPMA is very concerned that CMS' network adequacy proposals are moving in the wrong direction, to the detriment of insured patients nationwide.

We have continually expressed concerns that the rise in "narrow networks" is contributing to an epidemic of "medical homelessness,"[1] leaving the emergency department (ED) as the only option for many insured patients to receive care. However, because insurers remain unwilling to negotiate *sustainable* reimbursement rates that reflect the true cost of providing Emergency Medical Treatment and Labor Act (EMTALA)-mandated care, some patients visiting the ED will be treated by an out-of-network emergency physician and be financially responsible for a large portion of those charges. Further exacerbating this

[1] http://sanfrancisco.cbslocal.com/2014/04/18/consumerwatch-some-covered-california-patients-say-they-cant-see-a-doctor/

issue, is a lack of enforcement on the federal minimum payment standard (i.e., "Greatest of Three") for when a patient is seen by an out-of-network provider (see section 4 below).

EDPMA contends that federal minimum standards for network adequacy, together with appropriate reimbursement for in-network services, is required to address appropriate patient care in the right setting, and appropriate reimbursement for that care.

Inadequate network adequacy standards coupled with a lack of market based reimbursement standards drives higher out of pocket costs for emergency care for insured patients.

2) The Proposal Inappropriately Relies on States and Accrediting Organizations to Ensure Network Adequacy

EDPMA is deeply concerned with CMS' proposal to rely on States and accrediting organizations to ensure adequate provider networks.

To date, states have been significantly challenged with ensuring adequate provider networks despite having some legislation or regulation in place to address the issue. Given concerns raised by consumers and policymakers, the National Association of Insurance Commissioners (NAIC) updated its decades old Health Benefit Plan Network Access and Adequacy Model Act (MDL-074) (formerly the Managed Care Plan Network Adequacy Model Act), which was finalized in October 2015. According to NAIC, only a few states have had an opportunity to consider the revised model during their legislative sessions. In 2016, Maryland and Delaware adopted components of Model #74. This year, some states will consider Model #74, while others states are awaiting the outcome of ACA repeal and replace efforts before taking action.

The proposal also relies heavily on accrediting organizations. While accreditors play an important role in helping to establish network adequacy standards, they do not have enforcement capabilities. The most an accreditation organization can do when an insurer does not meet its network adequacy standards is downgrade or remove its accreditation status. As such, they are not an appropriate surrogate for a regulatory agency.

Neither the states nor applicable accreditation organizations can effectively address and enforce appropriate network adequacy standards in the same manner and in accordance with the same uniform standards that a federal regulatory agency can.

3) The Proposal Could Discourage Patients From Accessing Needed Care

In addition to our concern that the proposal will perpetuate the out-of-network cycle, we are also concerned that the proposal will have the unintended effect of discouraging patients from seeking timely, appropriate care in the emergency department. If patients are concerned that the cost of emergency care will be foisted on them due to the gaps in their insurance coverage, they may choose not to go to an emergency department when such care is needed. We believe the long-term effects are counter to the "triple aim" of population health, as patients' health will suffer, leading toward greater propensity for complications and morbidity, and ultimately, greater costs to the system.

Failure to enforce federal network standards and fair minimum benefit reimbursement standards, pursuant to the Greater of Three has the unintended consequence of patients choosing to forego much needed emergency care.

4) SOLUTIONS

A) Federal Network Adequacy Standards

We strongly encourage you to address this serious problem by establishing **federal** minimum network adequacy standards. We already know that individual states are not adequately addressing this issue. That is why, in recent years, there has been a boom in the number of articles reporting that insured patients have been surprised by a huge gap in their insurance and are required to pay their out-of-network deductible and other out-of-network contributions when receiving "covered" care.

B) Clarify that the Greatest of Three Rule Requires a Minimum Payment of the "Usual, Customary, and Reasonable" Charge Based on an Independent Transparent Database

In tandem with network adequacy, there must be an enforceable payment standard for emergency care. 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. Thus, ensuring fair payment by private insurers is imperative to protecting the safety net.

In order to protect access to emergency care, the federal government established – through regulations implemented in 2010 and reaffirmed in 2015 - minimum standards for out-of-network payments from private insurers to providers of emergency care. This standard is commonly referred to as the Greatest-of-Three rule which was implemented as part of the ACA. 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 has been unenforceable because insurers do not calculate their reimbursement rates in a consistent and transparent manner. The House and Senate Appropriations Committees of the U.S. Congress understand this problem. Both committees recently passed versions of the 2017 Labor HHS Appropriations bill that include report language asking the Center for Consumer Information and Insurance Oversight (CCIIO) to provide guidance clarifying the meaning of usual, customary and reasonable (UCR) rates.

The House version of the language further states 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."**

Therefore, in tandem with requiring an adequate network of emergency physicians, we urge you to **include in the final rule provisions that clarify that QHPs must reimburse for out-of-network emergency care, at minimum, at a UCR rate and that rate must be based on an independent transparent charge database.**

As an example of legislative language that provides for such payments, see the state of Connecticut's recently passed healthcare legislation that sets such out-of-network reimbursement for emergency services at the 80th percentile of a transparent database (PA 15-146 – https://www.cga.ct.gov/2015/SUM/2015SUM00146-R03SB-00811-SUM.htm.).

We urge you to adopt this same approach.

5) Conclusion

In conclusion, EDPMA is concerned that the proposal would:

- significantly increase the cost to the consumer of "covered" emergency care,
- further encourage insurance companies to offer unfairly low reimbursement rates for emergency care, and
- discourage patients from accessing needed care.

Therefore, we encourage CMS to establish federal standards that:

- ensure network adequacy for the patients covered by QHPs, and
- clarify that insurers must reimburse for out-of-network emergency care, at minimum, at a usual and customary rate and that rate must be based on an independent transparent charge database.

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,

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