Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

February 13, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G
Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-2334-P

RE: Medicaid, Children's Health Insurance Programs, and Exchanges: 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

Dear Ms. Tavenner:

The Catholic Health Association of the United States (CHA), the national leadership organization of the Catholic health ministry representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations, is pleased to provide comments on the referenced Notice of Proposed Rulemaking (NPRM) on Medicaid, Children's Health Insurance Programs, and Exchanges under the Patient Protection and Affordable Care Act (ACA).

CHA strongly supports HHS' efforts to create a simplified, streamlined application and eligibility process that ensures low-income individuals eligible for Medicaid and the Children's Health Insurance Program (CHIP) will get the coverage to which they are entitled. We are pleased to offer the following comments to help achieve that goal.

Certified Application Counselors

CMS proposes to give states the option of certifying staff and volunteers of state-designated organizations to act as application assisters. The states would establish standards for certification, which must include training in eligibility and benefit rules and regulations

governing all insurance affordability programs in the state, as well as in the safeguarding and confidentially of information. Certified assisters would be available to help individuals, for example, by providing information, assisting with the completion and submission of applications, gathering and submitting documentation, interacting with the agency and managing their case.

CHA supports the idea of allowing states to create a cadre of certified application assistants with specific training to help people trying to navigate the application process. However, we request that CMS clarify that this is not intended to prevent individuals and organizations that have not gone through the certification process to assist in the application process. The agency should continue to allow applicants and beneficiaries to choose who will assist in them the application process, whether or not they choose a certified application assistant.

Presumptive Eligibility

Pregnant women: CMS proposes to limit pregnant women to one presumptive eligibility period per pregnancy. If a pregnant woman with presumptive eligibility does not submit an application to determine Medicaid eligibility her temporary coverage ends on the last day of the month following the month in which presumptive eligibility was established. While in most cases it is reasonable to assume that the presumptively eligible pregnant woman would follow through with a Medicaid application, that may not always happen. Perhaps the woman does not understand the requirement, or hesitates because she is unsure if she will qualify. Even if she simply is negligent in failing to submit the application in a timely manner the person whose health and well-being is put at risk is the baby, who cannot be held responsible for the actions of her mother. Access to regular prenatal care is critical throughout the entire pregnancy. CHA opposes the proposal to limit presumptive eligibility to one period during a pregnancy and strongly urges CMS not to finalize it.

Determination by hospitals: CMS proposes to implement the ACA provision allowing "qualified hospitals" to elect to determine Medicaid presumptive eligibility, even in a state that does not elect to cover presumptive eligibility for children, pregnant woman or other individuals. CMS would give states the option of requiring that a qualified hospital must also assist the individual in completing and submitting the full application and in understanding documentation requirements. However, hospitals may not always be able to render this assistance. For example, the person may be unwilling to complete a full application or may leave the hospital following treatment and not return. A hospital cannot force a patient whom it has found presumptively eligible to complete a full application. This requirement puts an unnecessary obstacle in the way of providing potentially eligible Medicaid recipients the health care they need in a timely manner. CHA urges CMS not to allow states to require hospitals to assist in submitting the full application as a condition of determining presumptive eligibility.

CHA also objects to the proposal to allow states to establish standards to disqualify hospitals from making presumptive eligibility determinations based on what percentage of the people they find presumptively eligible who go on to submit a Medicaid application or are found eligible for Medicaid. As noted above, the hospital cannot control whether the presumptively eligible individual follows through and submits an application. A hospital should not be disqualified from helping future patients gain presumptive eligibility because some number of those it helped in the past failed to apply to Medicaid. Nor should a hospital be disqualified based on what percentage of those it finds presumptively eligible who go on to qualify for Medicaid. It is appropriate to hold a hospital accountable for making presumptive eligibility determinations in accordance with applicable federal requirements and state policies and procedures. However, hospitals that make eligibility determinations in compliance with all applicable rules have fulfilled their obligations and their determination should be honored. (While perhaps not a likely scenario, it is worth noting that a state that has not elected to do presumptive eligibility could use the proposed standard to limit the availability of hospitals-determined presumptively eligibility, which would seem to contradict the intent of the ACA.) Neither federal nor state regulations should impose such a requirement and CHA urges CMS not include this state option in the final rule.

Limitations on Premiums and Cost Sharing

Proposed Increases in Cost Sharing for Outpatient Services: The proposed regulations for outpatient services replace the current tiered copayments with a single copayment based on the individual's income. HHS proposes to set the copayment for the below poverty population at $4.00—ten cents above the current FY 2013 maximum copayment amount. This is simply too high. Although the 5% aggregate cap does ameliorate the burden for some of beneficiaries, it does not address the burden for others.

HHS should determine the "nominal amount" in relation to the income and health status of the paying population. This is what HHS is doing for Medicare populations living below the federal poverty level (FPL) by limiting Part D copayments to $1.10 for preferred/generic drugs and $3.30 for other medications for individuals with incomes at or below the FPL; and $2.50 and $6.30, respectively, for individuals with incomes over the FPL. (*See https://secure.ssa.gov/poms.nsf/lnx/0603001005.)* We propose these amounts as benchmarks for Medicaid as well.

CHA urges HHS to amend the table at § 447.52(b)(1) by setting the maximum copayment for outpatient services for individuals with family income at or below 100% FPL at $1.10. Should HHS determine this amount is not adequate, we urge HHS to at least lower the Medicaid copayment maximum significantly to $2.10, which is the approximate average of the FY 2013 maximum copayment amounts.

Inpatient Services: The proposed regulations for an inpatient stay copayment for individuals with incomes at or below 100% FPL is 50% of the cost the agency pays for the first day of care. This is unchanged from the current regulations. However, we believe this is problematic. Assuming a per diem inpatient rate of $854.00 (modeled on 2012 Florida rates), the below poverty individual would be responsible for a $427.00 copayment. The monthly income for someone earning at the poverty level is only $930. It is unreasonable to expect that any low-income person can afford this kind of copayment. The individual may have qualified for Medicaid precisely because she does not have sufficient income to meet the expenses of daily living (food, shelter, clothing) and also pay for health care.

In general, people do not admit themselves into the hospital but rather are admitted by doctors and thus there is little or no care reduction incentive to be gained by the inpatient stay copayment. As CMS notes in the preamble to the proposed regulations, the 50% cost sharing for inpatient care is "a relatively high cost for very low income people and not a service that consumers have the ability to avoid or prevent. " 78 Fed. Reg. at 4658.

CHA recommends that HHS determine "nominal" in relation to the income and health status of the below poverty Medicaid populations and amend the table at § 447.52(b)(1) by setting the maximum copayment for an inpatient stay as follows: individuals with incomes at or below 100% FPL: $10.00 (to be adjusted annually by the statutory COLA). This $10.00 copayment should also be the base copayment for individuals with higher incomes whose copayment responsibilities have been set by Congress.

Exemptions from Premiums and/or Cost Sharing*:* Research has shown that higher co-payments are likely to cause low-income people to decrease their use of necessary health care services. Low-income people with chronic health conditions are the most vulnerable to harm from cost-sharing, as they use the most health care services. CMS proposes to expand limits on premiums and/or cost sharing in two important areas. Under current law states may not impose premiums or cost-sharing requirement on individuals who are required to contribute all of their income (except a minimal amount required for personal needs) toward the cost of their care. CMS proposes to give states the option of extending this exemption to individuals who are receiving care in home and community based settings. This is consistent with other provisions of the ACA that expand Medicaid coverage of home- and community-based services. CHA supports efforts to help elders to live independently in their homes and communities for as long as possible, and we support the proposal to allow states to exempt such elders from Medicaid premiums and cost-sharing.

CHA also supports the proposal to revise the current cost-sharing exemption for pregnancy-related services so that all services provided to pregnant woman will be considered pregnancy related and exempt from cost sharing, unless the state plan provides otherwise. The health and well-being of an unborn child and her mother are inextricably linked. Eliminating cost sharing requirements for the mother's health care needs will remove a potential barrier to protecting the health of both mother and child.

Thank you for the opportunity to share CHA's comments on the proposal essential health benefits regulation. We await future proposals on how EHBs will be applied in the context of the Medicaid program and its expansion, and we look forward to continuing to work with you on implementing the ACA to ensure that everyone has affordable access to the care they need.

Sincerely,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy