

April 6, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD, 21244-8013

CMS-4190-P

Re: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule

Dear Administrator Verma:

On behalf of nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a Centers for Medicare & Medicaid Services (CMS) rule that includes proposed policy and technical changes to the Medicare Advantage (MA) program and the Part D Prescription Drug Benefit program. Our comments are limited to those proposals that affect emergency physicians and the patients we serve.

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Mandatory Drug Management Programs (DMPs)

ACEP strongly supports exempting beneficiaries with sickle cell disease (SCD) from mandatory drug management programs (DMPs) beginning in plan year 2021. Despite efforts from across the Department of Health and Human Services (HHS) to support patients with SCD, we continue to hear stories of individuals with SCD being unable to obtain appropriate medications either because of the stigma associated with the disease or because of current opioid prescribing policies regarding duration and dosage. Exempting SCD patients from mandatory DMPs may help improve their access to potentially life-saving pain medications.

Inappropriate Prescribing of Opioids

In the proposed rule, CMS proposes a definition of inappropriate prescribing of opioids. We appreciate that CMS recognizes “that there are legitimate clinical scenarios that may necessitate a higher level of opioid prescribing based on the clinician’s professional judgement, including, the beneficiary’s clinical indications and characteristics, whether the prescription is for an initial versus a subsequent dose, clinical setting in which the beneficiary is being treated, and various other factors.”¹

¹ Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule, 85 Fed Reg. 9035 (February 18, 2020).

CMS also seeks comment on whether specific populations or diagnoses should be excluded for purposes of this definition, such as cancer, hospice, and/or sickle cell patients.

ACEP believes that it is essential that MA organizations and Part D sponsors take into account both clinical judgement and the clinical setting when determining whether a clinician exhibited an established pattern of fraud, waste, and abuse related to prescribing of opioids. Emergency physicians seeing patients in emergency departments (EDs) are trying to provide the best care possible with limited information. While we do have tools, such as prescription drug monitoring programs (PDMPs), to help us make more informed decisions about prescribing opioids, the use, effectiveness, and accuracy of these tools vary by state and even by hospital. Emergency physicians should not be penalized, or possibly falsely accused of inappropriately prescribing opioids, because of factors that are beyond their control. Further, it is critical that emergency physicians, who are trained in treating patients with acute, undifferentiated conditions (many of patients we treat are in significant pain), be given the leniency and flexibility to make care decisions that are most appropriate in each individual case. Finally, we strongly support CMS' proposal to exempt cases from the definition of inappropriate opioid prescribing that involve the treatment of individuals with conditions that could require a significant amount pain medication, such as cancer patients, patients on hospice, and individuals with SCD.

Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions

CMS is adding the *Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions* measure to the 2023 Star Ratings covering the contract year 2021 Performance Period. CMS had finalized this measure in the 2020 Call Letter. ACEP continues to support this measure, as we believe that patients with multiple chronic conditions are more likely to have complex care needs and that follow-up after an acute event, like an ED visit, can help prevent the development of more severe complications. We believe that this measure will push health plans and outpatient providers to improve access to care for these beneficiaries after an ED discharge.

Emergency and Urgently Needed Services

CMS proposes that MA organizations, starting in the 2022 plan year, will be financially responsible for emergency and urgently needed services with a dollar limit on emergency services including post-stabilization services costs for enrollees that is the lower of--

- A) The cost sharing established by the MA plan if the emergency services were provided through the MA organization; or
- B) A maximum cost sharing limit permitted per visit that corresponds to the MA plan maximum out-of-pocket (MOOP) limit as follows:
 - (1) \$115 for MA plans with a mandatory MOOP limit.
 - (2) \$130 for MA plans with an intermediate MOOP limit.
 - (3) \$150 for MA plans with a lower MOOP limit

ACEP is concerned that CMS has been steadily increasing MOOPs for emergency care and post-stabilization services and **strongly urges CMS to keep these MOOP amounts constant**. The current voluntary maximum out-of-pocket (MOOP) amount is \$120, and the mandatory MOOP amount is \$90. Over the last several years, CMS had increased the voluntary and mandatory MOOP amounts by 60 percent and 20 percent respectively. **CMS is unfairly penalizing Medicare beneficiaries who receive emergency services**. Recent survey results from the Centers for Disease

Control and Prevention (CDC) show that only a small percentage of ED visits are avoidable.² In many cases, Medicare beneficiaries cannot tell whether their condition is life-threatening or not. Regardless of the final diagnosis, if they believe that they have a medical emergency, they are entitled to go to the ED and be treated. Increasing co-payments may have the undesirable outcome of deterring some beneficiaries from going to the ED even when they truly need immediate care.

MA and Cost Plan Network Adequacy

CMS is proposing to codify many existing network adequacy standards, including the list of provider and facility specialty types (27 specialty and 14 facility types) that have been subject to CMS network adequacy standards in the past. Further, CMS is making some modifications to existing policies, including reducing the current 90 percent threshold requirement (90 percent of beneficiaries must have access to at least one provider/facility of each specialty type within the published maximum time and distance standards) to 85 percent in certain areas and giving MA plans a 10-percentage point credit towards that threshold for certain provider specialty types when the plan contracts with telehealth providers.

Overall, ACEP is concerned about any changes to network adequacy requirements that could potentially impact patients' access to care. We have long advocated for CMS to enforce strong network adequacy standards across both Medicare and Medicaid. We strongly believe that all Medicare beneficiaries must have access a full range of health care services. People who do not have access to care are more likely to defer seeking more routine care or visiting a primary care physician or specialist for more minor conditions or symptoms. Such deferral or delay will often result in their condition or symptoms becoming exacerbated, and eventually, result in a trip to the ED. At this point, due to the progression of their condition, their care in the ED will be much costlier and more complex than if they had earlier access to more routine care in a physician's office. Therefore, we request that if CMS does finalize their modifications to existing network adequacy requirements, the agency should carefully monitor the impact the changes have on access to care and be prepared to revert back to the current standards if access is in any way diminished.

We also note that emergency medicine is not one of the specialty types that CMS proposes to establish as permanently subject to CMS network adequacy standards. We believe that it is essential for all beneficiaries enrolled in MA to know from their MA plan in advance of an emergency (NOT during or after an emergency has occurred) if the physician treating them is in-network. The very nature of emergency conditions and ED care, more than any other type of specialty care, precludes the opportunity for patients to preferentially go to facilities with in-network emergency physicians. **Therefore, we recommend that CMS consider adding emergency physicians and other safety net providers in the list of specialty types that are subject to CMS network adequacy standards.**

Finally, we do want to voice our support for CMS' effort to reward MA plans that promote alternative delivery models such as telehealth to help reach people in certain areas. Although not mentioned in the rule, we believe there is a lot of value in promoting emergency telehealth services (especially now as we deal with the COVID-19 national emergency). We believe that CMS should reward MA plans that choose to contract with telehealth providers who specialize in emergency medicine. There are established examples of high quality, cost-effective telehealth programs in the ED setting that allow greater access to an emergency physician in the inner city or rural EDs that would not normally be able to economically support that level of provider. Studies have shown that access to physicians via telehealth after discharge from acute care settings, such as the ED, helps to prevent short term returns to the ED and

² Centers for Disease Control and Prevention National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables, available at: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf.

readmissions for patients with chronic health conditions. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment and the time patients are boarding in the ED. As more and more small and rural hospitals close, EDs close too, leaving a gap in unscheduled acute care in a region. To fill these gaps, emergency physicians housed in what may be a state's only large or teaching hospital to provide telemedicine services to patients and providers in smaller rural or community hospitals that are staffed by RNs and Advance Practice Nurses (APNs). These valuable services provide clinical expertise in real time to stabilize patients who may need to be transferred long distances or may be observed at timely intervals over several hours by the emergency physician team at the academic medical center before a decision is made to transfer, admit locally, or release the patients. In all, ACEP continues to support the coverage of emergency telehealth services that would benefit patient care both in and out of the ED.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs, at jdavis@acep.org.

Sincerely,

A handwritten signature in black ink that reads "William P. Jaquis". The signature is written in a cursive, flowing style.

William P. Jaquis, MD, MSHQS, FACEP

ACEP President