American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 24, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-8013

CMS-4192-P

Re: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a rule that proposes changes to the Medicare Advantage (MA) and Medicare Prescription Drug (Part D) programs. Specifically, we would like to address a few policies proposed in the rule that have a significant impact on emergency physicians and the patients we serve.

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment for Special Needs Plans (SNPs)

ACEP strongly supports the Centers for Medicare & Medicaid Services' (CMS') proposal to require that all SNPs include one or more standardized questions on the topics of housing stability, food security, and access to transportation as part of their health risk assessments (HRAs). Like the rule notes, many dual eligible individuals deal with multiple social risk factors, and it is extremely important to identify these among this patient information and collect information that may help address issues pertaining to food insecurity, homelessness, lack of access to transportation, and low levels of health literacy.

As emergency physicians, we see patients from all social statuses, and both by law and by oath, we treat all patients that come through our doors. We intersect with many different types of clinicians across the health care sector, including primary care clinicians, behavioral health specialists, hospitalists and other specialists, social workers, and community workers—and routinely consult with these colleagues for the sake of our patients. Although ACEP supports the proposal, and notes that it applies to SNPs specifically, we would like to provide some comments on efforts to address social risk factors in the emergency department (ED) setting.

Many interventions help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other clinicians who are involved

with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[1]

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.[2] Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.[3]

ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models. We have developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently recommended to the HHS Secretary for full implementation. The AUCM provides incentives to participants to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. Under the model, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socio-economic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed. ACEP is excited about the infinite possibility this model has in terms of improving care for Medicare beneficiaries and is eager to work with HHS on implementation.

Special Requirements during a Disaster or Emergency

In the rule, CMS is proposing to make a number of refinements to MA organizations' responsibilities when health care services are affected by disasters or emergencies, including public health emergencies (PHEs). ACEP supports these changes as a way to ensure that MA beneficiaries continue to have access to affordable coverage during these periods. We especially think it is vital that MA organizations cover basic and supplemental benefits furnished at non-contracted facilities, waive, in full, requirements for gatekeeper referrals, and provide in-network cost sharing even if the enrollee uses out-of-network providers. Without such changes, there is a chance that some enrollees could delay necessary care and wind up in the ED after their conditions have exacerbated. Finally, we support CMS' proposal to

[1] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/
[2] For more information on the Maryland Mobile Integrated Health Care Programs, please go to https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964
[3] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

create a 30-day transitional period, where MA plans would still need to follow these special requirements as a disaster or emergency winds down. We agree that such a transitional period would protect MA enrollees from experiencing any sudden increases in costs if they had relied on care from a non-contracted provider during the disaster or emergency and needed time to connect with a contracted provider.

Network Adequacy

CMS is proposing to add an additional requirement to ensure greater compliance with MA network adequacy requirements. Specifically, CMS is requiring that, as part of as part of an application for a new or expanding service area, MA organization applicants must demonstrate that they meet CMS network requirements. The proposal explicitly authorizes CMS to deny an application on the basis of an evaluation of the applicant's network for the new or expanding service area. However, in order to provide flexibility to organizations as they build their provider networks, CMS is providing a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for the contracted network in the pending service area, at the time of application and for the duration of the application review.

While ACEP appreciates this effort to monitor and enforce network adequacy requirements, we do not believe the proposal goes far enough to truly ensure that MA organizations are abiding by them. We have long advocated for CMS to enforce strong network adequacy standards across both Medicare and Medicaid as a way to ensure that all Medicare beneficiaries and Medicaid enrollees have access a full range of health care services. Although CMS notes in the rule that the agency has identified a "pattern" that MA organizations continue to have failures in their networks even after their contracts are operational, CMS chooses to only partially address the issue by limiting any kind of enhanced enforcement strategy only to applicants for new or expanding service areas. This approach seems extremely limited given the importance of ensuring strong network adequacy requirements. We therefore strongly recommend that CMS expand its enforcement proposal and require *all* MA organizations to routinely demonstrate to CMS that they meet CMS network requirements.

ACEP is also disappointed that CMS did not choose to propose a similar policy that it did in the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule" to add emergency physicians to the provider specialty list for time and distance standards.[4] In previous years, we have specifically requested to CMS that emergency medicine be added to provider specialty list for MA plans. We believe that it is essential for all beneficiaries enrolled in MA to know from their MA health plan in advance of an emergency if the emergency physician treating them is in-network (NOT during or after an emergency has occurred). The very nature of 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. While we were happy to see CMS propose to add emergency physicians to the provider specialty list for time and distance standards for federally facilitated exchange (FFE) qualified health plans (QHPs), we believe it is extremely important to also add emergency physicians to the MA list.

[4] 87 FR. 681. (January 5, 2022).

Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data

Currently, MA organizations and Part D sponsors are required to report their medical loss ratios (MLRs) and are subject to financial and other sanctions for failure to meet the statutory requirement that they have an MLR of at least 85 percent. CMS has created a standardized template for MA plans to report this information, and in the past few years simplified the reporting requirements—reducing the amount of information that plans have to provide. As such, CMS has not been collecting the information needed to verify that a plan's MLR has been calculated accurately, except in the small number of cases that it can audit each year. Therefore, CMS is now proposing to re-instate more robust reporting requirements, including that MA organizations and Part D sponsors report the underlying cost and revenue information needed to calculate and verify the MLR percentage and remittance amount.

ACEP believes that it is extremely important that CMS ensure that all health plans, including MA plans, are calculating the MLR correctly. In some cases, health plans are purposefully inflating the amount that they count as "medical services" in order to avoid paying out rebates to their enrollees. CMS itself provides one specific example of such a practice in the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule." In the rule, CMS identifies a pattern of health plans paying out extremely large incentives or bonuses to providers (which in most of cases are owned by the issuers) in situations where the plans may otherwise not meet their MLR requirement.[5] Given this proclivity for health plans to attempt to circumvent the MLR requirements, we strongly support the proposal for MA plans to report additional information that will enable CMS to determine whether the MA plans are in fact calculating their MLRs correctly—and we urge the agency to finalize the proposal.

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

Sincerely,

Gillian Schmitz, MD, FACEP

Gillian R. Schmitz, MD, FACEP

ACEP President

[5] 87 FR. 691. (January 5, 2022).