American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 20, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

CMS-2023-0010

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the "Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies."

In general, ACEP is concerned about the increase in revenue MA plans are expected to receive in 2024 due to the provisions included in the Advance Notice—especially given the level of overpayments that have been well documented both by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). As CMS stated in the *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 Final Rule*, "The improper payment measurements conducted each year by CMS that are included in the HHS Agency Financial Report, as well as audits conducted by the HHS-OIG, have demonstrated that the MA program is at high risk of improper payments. In fiscal year (FY) 2021 (based on calendar year 2019 payments), we calculated that CMS made over $15 billion in Part C overpayments, a figure representing nearly 7 percent of total Part C payments. The HHS-OIG has also released several reports over the past few years that demonstrate a high risk of improper payments in the MA program, and for several years has identified the MA program as one of the top management and performance challenges facing HHS due to the high amount of improper payments. The Medicare program, including MA, has also been identified by the Government Accountability Office (GAO) as a high-risk program due to the risk of substantial improper payments."[1]

MA plans should not be receiving increased payments when there has been a documented pattern of overpayments that CMS still needs to address. Further, it is important to note that although MA plans have regularly received payment increases

[1] Fed Reg. Vol. 88. 6660. (February 1, 2023).

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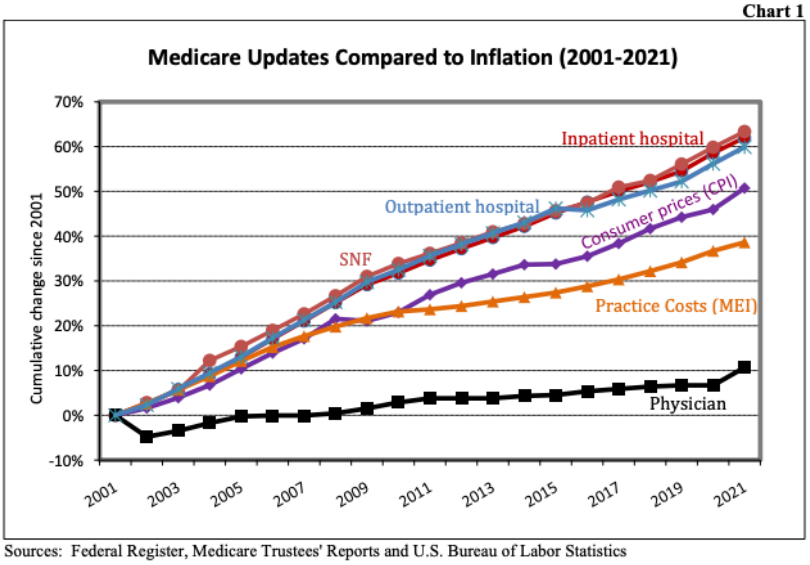
in previous years and are set to receive another one in 2024, physician payments under the Medicare Physician Fee Schedule (PFS) have declined over recent years.

Physicians must continue to deal with annual updates to Medicare payments that do not cover the increased costs due to inflation of providing care. Along with a 2 percent across-the-board reduction to the PFS conversion factor in 2023 and an estimated 1.25 percent cut to the conversion factor in 2024, the 2 percent sequestration reduction continues to apply year after year. In short, Medicare payment to physicians is simply inadequate. An analysis conducted by ACEP found that ***Medicare payments have decreased by 53 percent when comparing Medicare payments to inflation*** between the start of the Resourced-based Relative Value Scale (RBRVS) in 1992 and 2016.[2] As seen in the chart below, over the last 20 years, the payment systems for other Medicare provider types like hospitals and skilled nursing facilities (SNF), as well as actual practice costs that are reflected in the Medicare Economic Index (MEI), have far exceeded Medicare payments under the PFS.

Chart 1



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Even the 2022 Medicare Trustees Report acknowledges that updates for physician reimbursement are not sufficient. The Trustees believe that, absent a change in the delivery system, access to Medicare-participating physicians will become a significant issue in the long term.[3] Given the fact that annual updates to physician payments are already not keeping up with the cost of providing physician services, adding large-scale payment reductions would make it even more difficult for a number of physician specialties including emergency medicine to continue providing care.

CMS should make it a top priority to work with Congress on creating a sustainable payment system for physicians that keeps pace with the increased costs of providing care.

Beyond our general concern about the high payments to MA plans, we have the following comments regarding a couple of the measures included in the Medicare Part C and D Star Ratings.

[2] The ACEP analysis is available at:: https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/state-issues/medicare-versus-inflation.pdf.

[3] The 2022 Medicare Trustees Report is available at: https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C)

In the Advance Notice, CMS discusses its decision to remove emergency department (ED) visits from the denominator of the measure. CMS states that ED visits and withdrawal services alone are not suggestive of ongoing or planned treatment for individuals with SUD and thus do not signal that a member is already engaged in comprehensive care, so these were removed from the measure's negative SUD history period.

ACEP is concerned that such a decision would discourage the tracking of buprenorphine initiation in the ED. There is a plethora of evidence around the benefits of initiating medications for opioid use disorder (MOUD) for the treatment of opioid use disorder (OUD) and other substance abuse disorders (including alcohol abuse disorder) in the ED. Initiating MOUD in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths.[4] In addition, the available data demonstrate that patients with OUD who are started on buprenorphine in the ED – and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD than patients who receive a referral alone (78 percent of patients started on MOUD in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone).[5] Additional studies also demonstrate that the initiation of MOUD in the ED leads to increased participation in treatment.[6] [7]

Furthermore, studies of patients with OUD in California and elsewhere have demonstrated an instantaneous reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available.[8] A study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal also found a greater than 50 percent reduction (17 percent versus 8 percent) in return-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care.[9] Finally, a recent article from JAMA Psychiatry showed that the use of telehealth for the treatment of OUD among Medicare beneficiaries significantly increased during the COVID-19 pandemic. Beneficiaries who received these services were more likely to stay in treatment and less likely to experience an overdose.[10]

Given the benefits of initiating MOUD in the ED, we believe that CMS should reconsider excluding ED visits from the denominator of this measure.

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[4] Bao YP, Wang RJ, et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2018 Jun 22.

[5] D'Onofrio G, O'Connor PG, Pantalon MV, et al, JAMA. 2015 Apr 28;313(16):1636-44.

[6] Kaucher K, Caruso E, Sungar G, et al. Evaluation of an emergency department buprenorphine induction and medication-assisted treatment referral program. Am J Emerg Med. 2019 Jul 30.

[7] Hu T, Snider-Adler M, Nijmeh L, Pyle A. Buprenorphine/naloxone induction in a Canadian emergency department with rapid access to community-based addictions providers. CJEM. 2019 Jul;21(4):492-498.

[8] Elizabeth Evans et al., "Mortality Among Individuals Accessing Pharmacological Treatment for Opioid Dependence in California, 2006-10," Addiction 110, no. 6 (June 2015): 996-1005.

[9] Berg ML, Idrees U, Ding R, Nesbit SA, Liang HK, McCarthy ML. Evaluation of the use of buprenorphine for opioid withdrawal in an Emergency Department. Drug Alcohol Depend. 2007;86:239-244.

[10] Jones CM, Shoff C, Hodges K, et al. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* Published online August 31, 2022. doi:10.1001/jamapsychiatry.2022.2284.

Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C)

ACEP supports the inclusion of this measure in the Part C Start Ratings. This clinical quality measure assesses the percentage of acute events requiring an emergency department visit or hospitalization for one of six chronic conditions where outpatient, non-emergent follow-up is received within a guideline-recommended timeframe after discharge to the community for each chronic condition.

ACEP agrees with CMS that follow-up care is a "critical aspect of care coordination, ensuring patients understand and are adhering to their medication regimen, providers are monitoring patients for adverse events, and providers are educating patients to recognize warning signs." In fact, ACEP developed an alternative payment model (APM) designed to help improve care coordination for certain patients discharged from the ED. Specifically, in 2017, ACEP created an emergency medicine APM called the Acute Unscheduled Care Model (AUCM). The AUCM, if implemented, would be the first, and only, APM specifically designed for emergency physicians. The model would reward emergency physicians for reducing inpatient admissions and observation stays when appropriate. Emergency physicians would become key members of the continuum of care, as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-ED services, and avoiding post-ED discharge safety events.

The AUCM was highly recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and endorsed by the former HHS Secretary. Although ACEP created the AUCM as a stand-alone APM, the model can be integrated into other population health or disease/procedure specific risk contracts, episode-based models, or ACO initiatives. While much effort has gone into managing readmissions and post-inpatient care, the AUCM focuses on enabling safe discharge and rewards patient-focused care coordination. **ACEP believes that CMS should consider incorporating the AUCM or similar concept into value-based initiatives that MA plans are currently utilizing.**

Addressing Unmet Health-Related Social Needs on HOS (Part C)

In the 2023 Advance Notice and Rate Announcement, CMS described a new measure focused on screening and referral to services for social needs. CMS is working on developing an additional measure that would complement this measure, as CMS continues its focus on health equity. This new measure would be a survey-based assessment of enrollee health-related social needs, specifically housing instability, food insecurity, and transportation availability.

Overall, ACEP believes that quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. As emergency physicians, we see patients from all backgrounds who have various social risk factors. Many interventions are being employed in the ED to 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 providers 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, which 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.[11]

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.[12] 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.[13] 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.

Although ACEP believes that quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans, we are concerned about the ability of emergency physicians to report this measure since ED systems do not always have access to records from other parts of the hospital. Without access to this data, this quality measure cannot be fully calculated and scored. We also note that this screening is done at the facility level, and it may be difficult for individual physicians to report the measure at the individual reporting level.

In addition, many institutions have limited resources to conduct these types of screening on every patient. It may be more feasible to limit the screening to certain patients where it would yield the most benefit—for instance patients who are homeless or lack health insurance.

Consumer Assessment of Healthcare Providers and Systems (CAHPS, Part C and D)

In the Advance Notice, CMS discusses certain questions the agency is testing that could be included in CAHPS related to unfair treatment, with one being: "In the last 6 months, did anyone from a clinic, emergency room, or doctor's office treat the enrollee in an unfair or insensitive way because of their disability, age, culture or religion, language or accent, race or ethnicity, sex (female or male), sexual orientation, gender or gender identity, or income?"

ACEP understands CMS' rationale for asking this question. However, we want to make it unequivocally clear that emergency physicians have a moral and ethical duty to treat everyone who comes through the doors of the ED. Both by law[14] and by oath, emergency physicians care for all patients seeking emergency medical treatment. Denial of emergency care or delay in providing emergency services on the basis of race, religion, sexual orientation, gender

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[11] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/.

[12] 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.

[13] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

[14] 42 U.S. Code § 1395dd - Examination and treatment for emergency medical conditions and women in labor.

identity, ethnic background, social status, type of illness, or ability to pay, is unethical.[15] While the implementation of this question likely supports broader awareness of these issues, CMS should evaluate whether the question could result in biases based on the characteristics of the physician providing the care (e.g., women, physicians of color). Understanding whether these biases could occur and what impact they may have on physician performance must be understood and addressed prior to implementing this question in the CAHPS measure.

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,

Christopher S. Kang, MD, FACEP

ACEP President

[15] ACEP Code of Ethics for Emergency Physicians; Approved Jan 2017; https://www.acep.org/clinical---practice-management/code-of-ethics-for-emergency-physicians.