American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

August 24, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD, 21244-1850

CMS-4203-NC

Re: Medicare Program; Request for Information on Medicare Advantage

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on "Medicare Program; Request for Information on Medicare Advantage." Our comments are limited to those questions that affect emergency physicians and the patients we serve.

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Advance Health Equity

What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- ***Enrollees from racial and ethnic minority groups.***
- ***Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.***
- ***Enrollees who identify as transgender, nonbinary, or another gender identity.***
- ***Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.***
- ***Enrollees with diverse cultural or religious beliefs and practices.***
- ***Enrollees of disadvantaged socioeconomic status.***
- ***Enrollees with limited English proficiency or other communication needs.***
- ***Enrollees who live in rural or other underserved communities.***

As safety net clinicians, emergency physicians see every day how disparities in health care access and affordability affect health care outcomes. It is well documented that racial and ethnic minorities disproportionately use the emergency department (ED) and are more likely to rely on emergency care for both time-sensitive and non-urgent care needs.[1] The Centers for Medicare & Medicaid Services (CMS) must continue to work to reduce barriers to preventive treatment and make services even more affordable for Medicare Advantage (MA) enrollees. If individuals do not have

[1] Richardson LD, Norris M. Access to Health and Health Care: How Race and Ethnicity Matter: ACCESS TO HEALTH AND HEALTH CARE. *Mt Sinai J Med.* 2010;77(2):166-177. doi:10.1002/msj.20174.

access to services, they tend to delay or defer needed care. This delay will often result in the exacerbation of a person's condition or symptoms, and eventually, result in a trip to the ED. At this point, due to the progression of their condition, the person's care in the ED will be much costlier and more complex than if he or she had earlier access to more routine care in a physician's office.

What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

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.[2]

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.[3] 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.[4] 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.

What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

Understanding the full significance that specific social determinants of health have on a patient requires comprehensive screening by trained professionals. While screening can be burdensome, it can help highlight those patients who may need additional services (such as nurse follow up calls, peer counseling, or a visiting dietitian) to

[2] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/
[3] 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
[4] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

prevent the next acute care episode. There are many screening techniques and tools that exist, and while ACEP supports the concept of screening, we have not endorsed a particular approach.

Beyond screening, another way to identify Medicare beneficiaries with social risk factors is to simply look at utilization, particularly in acute care settings such as emergency departments. Edie™, which is described above, can help identify individuals that have gone to the ED frequently. Once these beneficiaries are identified, ACEP believes that it is important to create targeted care coordination plans that can help get the appropriate care to each individual patient.

ACEP is also 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 an alternative payment model (APM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended to the Secretary of the U.S. Department of Health and Human Services (HHS) for full implementation. The AUCM met all ten of the established criteria, and the PTAC gave one of the criteria ("Scope") a "Deserves Priority Consideration" designation since the PTAC felt that the model filled an enormous gap in terms of available APMs to emergency physicians and groups. The PTAC submitted its report to the Secretary in October 2018. The HHS Secretary responded to the PTAC's recommendation in September 2019, requesting that "the CMS Innovation Center […] assess how key mechanisms of action in this model could operate as a component in a larger model dedicated to improving population health."

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, including MA enrollees, and is eager to work with CMS on implementation.

Expand Access: Coverage and Care

> ***What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?***

For years, ACEP has strongly supported the delivery of telehealth services by board-certified emergency physicians. The COVID-19 public health emergency (PHE) has fundamentally changed the landscape of telehealth from how it was utilized prior to the pandemic. While CMS has made substantial changes to telehealth policies in Traditional Medicare, there are a few that particularly impact emergency medicine. The most significant policy, which impacted all telehealth services, was CMS' use of its 1135 waiver authority to waive the originating site and geographic restrictions, allowing health care practitioners to provide telehealth services to patients regardless of where the clinicians or the patients are allocated—in both urban and rural areas. Further, CMS clarified that medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), could be performed

via telehealth. Finally, CMS has temporarily added all five ED E/M codes, some observation codes, and critical care codes to the list of approved Medicare telehealth services on a Category 3 basis.

During the COVID-19 PHE, emergency physicians provided telehealth services in the following three different clinical situations, all of which added clinical value to patients:

1. ***Preventing Medicare Beneficiaries from making unnecessary visits to the ED.*** Medicare beneficiaries who had urgent medical needs, but were unsure if they were having a medical emergency, were able to contact their EDs and have a telehealth visit with an emergency physician to assess whether the patient could stay at home, go to an urgent care clinic, or visit the ED. While Medicare beneficiaries previously had the opportunity to go to the ED if needed, this type of telehealth visit has now provided Medicare beneficiaries with a safe way of getting their condition evaluated before making that decision. Emergency physicians are trained in rapid diagnosis and evaluation of patients with acute conditions, so they are most capable of providing these type of telehealth services. In many cases, emergency physicians are able to provide treatment to patients with minor illnesses and injuries completely via telehealth.

2. ***Providing MSEs to Patients who came to the ED.*** As alluded to above, CMS released guidance stating that physicians (or other qualified medical persons) can perform MSEs via telehealth and where appropriate meet the MSE requirement without an in-person examination. Hospitals are temporarily allowed to set up alternative locations "on campus" for patients to receive an MSE other than in the ED. For example, patients presenting with possible symptoms of COVID-19 and meeting certain criteria (i.e., vital sign parameters) can be sent to a negative-pressure tent, where they are seen by an in-person nurse and a physician via telehealth (video and audio) who determines if the patient can be discharged from the tent or needs to be seen in the ED. After completing this process, a low percentage of patients need ED evaluation.

3. ***Ensure appropriate follow-up care after ED discharges.*** Emergency physician groups have set up systems and protocols to follow up with patients once they are discharged from the ED, ensuring that patients are taking their medications appropriately or are seeing their primary care physician or specialist if needed. These follow-up services have helped enhance care coordination efforts and avoid trips back to the ED or inpatient admissions. In addition, for patients under investigation for COVID-19, the treating ED group has been able to follow up with the patient to make sure their COVID symptoms are not progressing. Some groups have sent patients home with portable pulse oximeters and followed up to check their general status and oxygen levels.

ACEP expects to see improved health outcomes due to the proliferation of emergency telehealth services. For example, telehealth has the potential to improve care coordination and limit avoidable trips to the ED or hospital. Further, it improves access to care for beneficiaries, a clear clinical benefit, by connecting patients with clinicians from any location in a timely manner. Some EDs have been able to track data that could be used to evaluate clinical outcomes, such as monitoring whether a patient required an additional medical visit after the telehealth visit and determining the percentage of patients who avoided an ED or urgent care visit for the illness or injury.

There is definitely a case to be made to continue reimbursing for emergency telehealth services in both Traditional Medicare and MA. However, we do recognize that while the COVID-19 pandemic has increased the use of telehealth, rural areas still suffer from inconsistent availability of telehealth access and structural challenges like limited/nonexistent broadband access. Addressing the lack of broadband access may require a significant investment.

Adoption of new technology is usually very expensive and strains already-limited resources for rural and underserved facilities. Some states (Alaska, for example) have a rural supplement program aimed at supporting more broadband in rural areas. Federal investments to expand broadband access would be a substantial improvement for America's rural communities and would provide exponential positive downstream effects on health care delivery and outcomes. ACEP notes and appreciates the initial advances to address this issue through the Infrastructure Investment and Jobs Act; P.L. 117-58, which included a total of $65 billion for broadband development, digital equity, and low-income internet subsidies, wherein $42.5 billion is devoted to grants to support broadband buildout in rural and underserved communities.

> ***What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?***

ACEP has 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 to a full range of health care services. Emergency medicine is not one of the specialty types that CMS has established as permanently subject to MA 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.

CMS did decide in the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Final Rule" to add emergency medicine to the specialty list for the network adequacy time and distance standards that apply to qualified health plans (QHPs) in the federally facilitated Exchange.[5] CMS stated in the proposed rule that its rationale for adding emergency medicine to the specialty list was to "provide proactive consumer protections, and […] to increase enrollee access to in-network providers."[6] **CMS should follow suit and also add emergency medicine to the MA network adequacy time and distance standards.**

<u>Drive Innovation to Promote Person-Centered Care</u>

> ***What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?***

Emergency physicians play a vital role in their communities, serving as safety net providers who care for people at

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[5] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023. 87 Fed. Reg. 27326. (May 6, 2022).

[6] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023. 87 Fed. Reg. 681. (January 5, 2022).

their greatest time of need. As they treat each patient, emergency physicians must make the critical decision about whether the patient should be kept for observation, admitted to the hospital, or discharged. Fundamentally, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in APMs that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on downside risk and participate in Advanced APMs, there simply are not any opportunities to do so.

We therefore strongly encourage the Center for Medicare & Medicaid Innovation (CMMI) to consider developing models geared towards emergency physicians that could be used in the MA, Traditional Medicare, and Medicaid populations. As stated above, ACEP has developed its own APM called the Acute Unscheduled Care Model (AUCM). 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 accountable care organization (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.

To that end, ACEP has worked with the American Medical Association on a new concept called "Payments for Accountable Specialty Care (PASC)." Under this approach, ACOs and specialists could enter into voluntary agreements designed to support high-quality care for a subset of ACO patients who have specific health conditions. The specialist or specialty group would take accountability for improving specific aspects of quality and utilization for these patients that will help the ACO achieve its overall quality and spending goals. In turn, the specialist would receive an extra payment from CMS for each patient that enables provision of diagnosis, treatment, and management services beyond what is supported by standard fee-for-service payments. We strongly encourage CMS to explore this concept as a way to include specialists such as emergency physicians in value-based care initiatives.

Another such innovation that ACEP has implemented to support special populations is our Geriatric Emergency Department Accreditation Program (GEDA). GEDA established criteria for three levels of geriatric emergency departments (GEDs), which incorporate specially trained staff, assess older patients in a more comprehensive way, and take steps to make sure the patient experience is more comfortable and less intimidating for older adults. All of this allows for a better care experience for older adults while in the ED and safer transitions to a community setting for those who do not need medical admission. GEDs are linked to decreased hospital admissions and readmissions by addressing underlying risk factors (such as fall risks, polypharmacy, elder abuse, caregiver fatigue, etc.) that may have precipitated the ED visit in the first place. ACEP is pleased with the tangible results sparked by GEDA and invites CMS to consider similar innovations for the MA program.

Support Affordability and Sustainability

What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

ACEP is extremely concerned about the level of payments under the Medicare Physician Fee Schedule (PFS), which is often used by MA plans as the basis of which to compensate physicians in their network. Physicians must continue to deal with annual updates to Medicare payments that do not cover the increased costs due to inflation of providing care. CMS, in the calendar year (CY) 2023 PFS proposed rule, is proposing a 4.4 cut to the PFS conversion factor. Along with this reduction, the two percent sequestration reduction continues to apply year after year. Furthermore, there is another "Pay-Go" sequester of four percent that is scheduled to begin at the start of 2023—making the total overall projected cut starting January 1 at 8.4 percent. 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.[7] 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.[8] 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.

Emergency medicine clinicians will experience this across-the-board reduction to their reimbursement in 2023. This cut to emergency medicine, if finalized, would jeopardize the nation's critically needed safety net and leave emergency physicians in an untenable financial situation, and we request that CMS do everything within its authority to mitigate the reduction.

A 4.4 percent reduction to Medicare reimbursement for emergency physicians and other emergency medicine health care professionals on top of the pending sequestration cuts would have rippling effects across the health care system and have a detrimental impact on access to care. During the COVID-19 PHE, it has been more expensive than usual to provide appropriate care to the patients who do come to the ED. Most emergency physicians are not employed by hospitals, but rather work for independent groups that contract with the hospital to provide emergency services in the ED. ACEP conducted a survey in 2020 that showed that the majority of hospitals have not provided any financial support to these independent groups during the COVID-19 pandemic to help cover any losses or increased expenses. Instead, the groups have had to incur additional expenses for treatment, such as developing and implementing protocols for alternative sites of care, enhancing telehealth capabilities, purchasing their own personal protective equipment (PPE), and taking on other new administrative costs due to staffing shortages (such as taking over nursing functions including as triaging, treating, and performing nurse discharge responsibilities for patients with potential COVID symptoms in ways that limit possible exposure to the disease).

Given the potential impact of this payment reduction on emergency medicine and the safety net, compounded by the PHE, we believe that CMS has an obligation to health care professionals and patients to do everything in its power to eliminate the reduction.

> *What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?*

ACEP has long supported accounting for social risk factors in Medicare payment programs. ED patients in rural parts of the country, as well as those in urban, medically underserved areas, often have many more social risk factors than those in geographic areas that are better served, with less access to the many resources and community services needed to ensure better health outcomes. Inadequate risk adjustments that do not account for these factors could result in unfair penalties for providers that care for the highest acuity low-income patients, creating a perverse incentive that could result in these patients over the long term being further underserved and having their access to care threatened.

Although enrollment in MA is increasingly popular, with racial and ethnic minorities enrolling at higher rates than their white counterparts, a 2016 study by the Leonard Davis Institute of Health Economics found that Medicare

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

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

Advantage plans offered to racial and ethnic minority groups generally had lower quality ratings, and the beneficiaries ultimately enrolled in the low-rated plans more often than white enrollees.[9] The study suggests that the payment adjustment used by the MA plan tends to overpay plans for healthier enrollees and underpay for complex enrollees. As patients in urban, historically underserved areas tend to have more social risk factors for clinical complexities, and these patients tend to be racial minorities, this may result in "systematic underpayments for racial and ethnic minority enrollees, providing little incentive to offer health plans in communities where a large number of racial and ethnic minority group members reside." Enrollees with poorer health negatively affects MA performance score, which in turn decreases potential payment bonuses, leading insurers to offer lower-quality plans to racial and ethnic minorities due to their predisposition to poor health based on structural social disadvantages. CMS should consider adjusting quality ratings for social factors to reduce disparities in access to high-quality health plans.

As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

ACEP has been monitoring the significant growth in MA enrollment. According to the HHS Budget in Brief, in 2023, MA enrollment is expected to total about 32 million beneficiaries, or 53 percent of all Medicare beneficiaries. Between 2013 and 2022, private plan enrollment grew by 15.3 million, or ***103 percent***. MA plans have historically been paid around 104 percent of what it costs to provide Medicare coverage under the traditional program. These payments keep increasing each year. While physicians received a cut to the PFS conversion factor in 2022, MA plans got a four percent pay increase (and they will experience a payment increase of ***8.5 percent*** in 2023).

The pay increases and growth in MA enrollment will have significant effects on the Medicare program and the insurers, clinicians, and beneficiaries that participate in it. First, since costs are greatly increasing, the growth in Medicare Advantage may affect the solvency of the Medicare Part A Trust Fund. Second, the trend will lead to increased health insurance consolidation as the larger insurance companies become more dominant in a very attractive and popular market. As of this year, seven national health insurance companies claimed nearly 70 percent of the MA market (UnitedHealthcare, Humana, Aetna, Anthem, Centene, Cigna, and Molina). And third, the growth will affect the payments that are calculated for clinicians and facilities in Medicare. Currently, CMS uses data from the Traditional Medicare program to set payment rates for the PFS and the other Medicare payment systems. These fee-for-service payment rates in turn are used in Medicare Advantage and by many private health plans as well. As Medicare Advantage becomes the dominant Medicare option, there will be less and less data available on which to base payment rates. This could lead to inaccurate payment rates that are not reflective of the cost of providing care. **ACEP strongly urges CMS to develop a comprehensive plan to address these foreseeable issues.**

How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks?

CMS recently added an additional requirement to ensure greater compliance with MA network adequacy requirements.[10] The policy 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

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[9] Park, S, Werner, RM, Coe, NB. Racial and ethnic disparities in access to and enrollment in high-quality Medicare Advantage plans. *Health Serv Res*. 2022; 1- 11. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13977.

[10] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Final Rule. 87 Fed. Reg. 27710. (May 9, 2022).

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 policy goes far enough to truly ensure that MA organizations are abiding by them. Although CMS has stated that it has identified a "pattern" that MA organizations continue to have failures in their networks even after their contracts are operational,[11] CMS has chosen 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 policies and require all MA organizations to routinely demonstrate to CMS that they meet CMS network requirements.

Engage Partners

> ***How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?***

As a professional association, ACEP appreciates the opportunity to engage with different centers within CMS, including the Center for Medicare & Medicaid Innovation, the Center for Medicare, and the Center for Clinical Standards and Quality. These centers and others within CMS, in addition to staff divisions within the U.S. Department of Health and Human Services (HHS), play a critical role in operating and overseeing the MA program. It would be useful to have all federal offices involved in the MA program engaged in ongoing conversations with external stakeholders, including professional associations, and hear directly from the public about what major issues both providers and patients are facing and potential solutions to address these problems.

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,

Gillian Schmitz, MD, FACEP

Gillian R. Schmitz, MD, FACEP

ACEP President

[11] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule. 87 Fed. Reg. 1893. (January 12, 2022).