

February 24, 2022

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

CMS-2022-0021

**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) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.”

In the Advance Notice, the Centers for Medicare & Medicaid Services (CMS) solicits comment on whether enhancements can be made to the CMS-HCC risk adjustment model to address the impacts of social determinants of health on beneficiary health status by incorporating additional factors that predict the relative costs of MA enrollees. CMS seeks input on what data CMS should focus on collecting more comprehensively that may provide more complete information when calibrating the risk adjustment model and welcomes suggestions on how the agency could improve collection of this data. Further, CMS solicits comment on additional factors that it could include in the risk adjustment model, for example, geographic residence, e.g., ZIP codes, that may serve to improve payment accuracy in an effort to advance health equity.

Before responding to this specific request for input, ACEP would like to note that 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 physicians, behavioral health specialists, hospitalists and other specialists, social workers, and community workers—and routinely consult with these colleagues for the sake of our patients. Given the unique role we serve as the health care system’s safety net, we believe that we can be active partners in any policy effort that CMS engages in related to improving care for patients with social risk factors.

In general, ACEP strongly supports accounting for social risk factors in Medicare payment programs, including MA. Emergency department (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

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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 inaccurate payments for care delivered to the highest acuity low-income patients, creating a perverse incentive that could, over the long term, result in these patients being further underserved and having their access to care threatened.

We agree with CMS that data collection is imperative to fully understanding the costs of caring for patients with social risk factors. Understanding the full significance that specific social determinants of health (such as food insecurity, homelessness, and lack of access to transportation) have on a patient requires a comprehensive data collection strategy—which could potentially include 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 prevent the next acute care episode.

Such a data collection strategy would also need to include the gathering of socioeconomic data. Collecting this information, however, is extremely challenging and CMS must establish processes of verifying the accuracy of the data. Data on race, for example, may introduce a risk of bias, potentially exacerbating existing health inequities or perpetuating issues of structural racism. There are also ongoing discussions within the broader field of medicine about the fundamental understanding of the language of “race” and “ethnicity,” and the tendency to use these terms interchangeably when they are not interchangeable—especially when other information like genetics, heredity, or ethnicity may be more appropriate and informative variables than race. Additionally, race is sometimes used as a proxy for social determinants of health, meaning that factors like economic stability, education, health care access, and other data points may be more relevant coefficients that are lost when race is used instead.

For example, we do not think that proposals to estimate an individual’s race or ethnicity based on name and geography are appropriate. Women and children often take the names of their husband and father, respectively. Particularly for women, estimating one’s race or ethnicity based on surname simply does not make sense. Such estimation would also be insufficient for adopted individuals who take their adoptive family’s surname. Additionally, there are discrepancies in how individuals self-report their race on the U.S. Census questionnaire, which would be used in each of the algorithms contemplated by CMS. If CMS plans to use proxies for race and ethnicity data to help identify and address inequities in care delivery and health outcomes, it must incorporate robust mechanisms by which to check conclusions and ensure these algorithms do not result in, exacerbate, or perpetuate negative health outcomes for communities of color. Routine audits of such processes and conclusions would also be ideal, in order to discover and correct errors expeditiously. Further, granular demographic data as related to race and ethnicity provides the degree of detail necessary to effectively understand and recognize differences and set meaningful policy.

In all, ACEP recognizes the importance of incorporating social risk factors into the CMS-HCC risk adjustment methodology to better account for the true costs of caring for Medicare beneficiaries. However, at the same time, it is essential for CMS to ensure that any data collection strategy the agency employs is structured in a way that will ensure that the data collected are valid and accurate and that will mitigate any potential for the data to be biased—which could unintentionally further exacerbate health inequities.

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](mailto:jdavis@acep.org).

Sincerely,

*Gillian Schmitz, MD, FACEP*

ACEP President