November 3, 2022

Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs

Summary and Submittal Instructions

The U.S. Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE). This Request for Information (RFI) is part of the Biden-Harris Administration's ongoing work to advance health equity and reduce health disparities. CMS is committed to engaging with partners, communities, and individuals across the health system to understand their experiences with CMS payment policies and quality programs, particularly how existing and proposed CMS payment policies and quality programs impact the experience of healthcare.

We request comments be written clearly and concisely. Where practical, please include data, example(s), narrative anecdote(s), and recommended action(s). Comments submitted through prior RFIs have helped us better understand specific challenges and experiences and, in turn, informed our work. The targeted topic areas in this request are, in part, based on information from individuals within the populations we serve. You may respond to some or all of the topics listed in this RFI. As applicable, please specify the care setting, geographic area, specialty (e.g., primary care), and/or specific CMS policy (or policies) referred to in your response.

Please note there is no save function that allows you to return to your entries at a later time. We recommend entering your responses and submitting in one sitting.

For assistance or technical problems related to this form, please send an email to OBRHI@cms.hhs.gov

Topic Summaries

We request public comment on the following topics, as summarized below:

Topic 1: Accessing Healthcare and Related Challenges: CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment regarding personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across all our programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Marketplace, and the CMS Innovation Center models.

Topic 2: Understanding Provider Experiences: CMS wants to better understand the factors impacting provider well-being and learn more about the supply and distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, and communications on provider experiences.

Topic 3: Advancing Health Equity: CMS wants to further advance health equity across our programs by identifying and implementing policies that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs, and

strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities: CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE (link here) to identify areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Topic 1: Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, or utilizing healthcare services (including medication therapies) across CMS programs.

Example responses may include, but are not limited to:

- Challenges accessing comprehensive and timely healthcare services and medication, including primary care, long-term care, home and community-based services, mental health and substance use disorder services;
- Challenges in accessing care in underserved areas, including rural areas;
- Receiving culturally and linguistically appropriate care (e.g., tailoring services to an individual's culture and language preferences);
- Challenges with health plan enrollment;
- Challenges of accessing reproductive health services;
- Challenges of accessing maternal health services;
- Challenges of accessing oral health services and the impact on overall health;
- Understanding coverage options, and/or technology to support access to coverage; and,
- Perspectives on how CMS can better communicate quality standards and accessibility information to individuals, particularly those with social risk factors.

ACEP Response

According to a 2020 report by the U.S. Government Accountability Office (GAO), more than 100 rural hospitals have closed since 2013.[1] The closure of a rural hospital can have a ripple effect through a community. Workforce shortages are also especially pronounced in rural and underserved areas throughout the country, and numerous barriers to providing equitable care in these communities persist. Among these are the inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other health care providers. Despite a 28 percent increase in emergency medicine residency positions over the past 10 years, there has been no corresponding increase in emergency medicine residency-trained or emergency medicine board certified physicians working in rural emergency departments (EDs). This is a complex problem due to a variety of factors, including limited opportunities for exposure to these

[1] U.S. Government Accountability Office, "Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services," December 2020, available at: https://www.gao.gov/assets/gao-21-93.pdf.

communities during residency training, fewer full time employment opportunities overall due to ED staffing requirements and continued rural facility closures, a lack of recruitment tools and incentives such as those provided for primary care professions, among many others. Additionally, rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates. And 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. Transportation issues also limit many individuals' ability to reach hospitals, and emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

CMS must focus on the ongoing nursing shortages and the recent practices of nurse staffing agencies that have resulted in exorbitant increases in costs to already-strained health care systems. The extreme physical and mental toll of the COVID-19 pandemic response has inflicted enormous trauma and stress on physicians and nurses, resulting in increased burnout and dissatisfaction for those on the front lines and greater attrition in the health care workforce. This has left many health systems desperate to fill workforce gaps by relying on nurse staffing agencies, some of whom have imposed extreme rate hikes to supply travel nurses to hospitals.

Such shortages also greatly exacerbate the issue of crowding and ED "boarding," a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where the patient can be transferred. Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. Solving ED boarding is not an isolated emergency department issue but rather a hospital-wide imperative. Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

Many emergency physicians report that given ongoing shortages and the influx of patients (both COVID- and non-COVID-related) that ED boarding is at an all-time high. Adding to this challenge is the fact that EDs are also not subject to the same staffing ratio requirements as other parts of the hospital often are, and as a result, the ED too often becomes the only place in which to keep many patients. While we have shared ideas and suggestions with legislators and regulators to provide both short- and long-term solutions to reduce ED boarding (such as regulatory waivers and flexibility around documentation requirements that contribute to burnout among nurses), more fundamental efforts to address the root causes of nursing and physician shortages are needed to ensure patients have timely access to care.

Patients must have access to high-quality lifesaving emergency care. We believe the gold standard for care in an ED is via a physician-led emergency care team, with that care performed or supervised by a board-certified/board-eligible emergency physician. Physician Assistants (PAs) and nurse practitioners (NPs) can and do serve integral roles as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. The physician-led emergency care team is the safest care model for our patients and particularly important for Medicare beneficiaries, who are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs and account for nearly 20 percent of ED encounters each year. Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require physician supervision of or collaboration with PAs. Most states require physician supervision of or collaboration with nurse anesthetists, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York and Texas. These states represent more than 85 percent of the U.S. population. Moreover, despite multiple attempts, in the last five years no state has enacted legislation to allow nurse practitioners full-immediate independent practice.

Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. There remain significant shortages of nurse practitioners in rural areas— the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level. We believe that the ongoing challenges in recruiting and retaining all levels of health care professionals in rural and underserved areas are more complex, and that this persistent issue requires more innovative solutions to incentivize physicians and other health care professionals to work in these communities. We would welcome the opportunity to work with you and your colleagues to find more effective and durable solutions to these longstanding workforce challenges to ensure that Americans in rural and underserved areas have access to high-quality emergency care, recognizing the level of expertise and training required for independent practice of emergency medicine and supporting the provision of physician-led team-based care.

Topic 2: Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, operations, or communications on provider well-being and retention.

Example responses may include, but are not limited to:

- Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, attrition, maldistribution);
    - ED violence
    - staffing issues

    - uncompensated care
- The increasing use of digital health technology on provider well-being and retention;
- Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made;
    - Medicare payment inadequacy
    - Medicaid downcoding (in Medicaid RFI)
    - MIPS issues
    - Lack of opportunity to participate in APM
- Impact of CMS policies on patient panel selection, and on providers' ability to serve various populations; and
    - EMTALA – have to see all patients
- Factors that influence providers' willingness or ability to serve certain populations, particularly those that are underserved and individuals dually eligible for Medicare and Medicaid.
    - Additional incentives for rural areas (OPPS response)

- Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.
    - Addressing ED boarding

ACEP Response

Due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for longer-term follow-up treatment. As described in the previous section, these challenges contribute to long ED wait times and aggravate "boarding" issues, a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where they could be transferred. ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system.

Another significant issue impacting the health care workforce is the increased risk of violence against physicians, nurses, and other health care workers, especially those who care for psychiatric patients. **ACEP just released results from an August 2022 survey that shows that 85 percent of emergency physicians report the rate of violence experienced in ED has increased over the past five years, with 45 percent indicating it has greatly increased. Over half (55 percent) of emergency physicians report they have been assaulted while working in the ED, while nearly 80 percent have witnessed an assault in the ED. Emergency physicians report that psychiatric patients and those seeking drugs or under the influence of drugs or alcohol are most often responsible for the assaults experienced (42 percent and 40 percent, respectively).**

This increased risk of violence, along with many other factors, is leading to an extremely high level of burnout among physicians. In fact, the American Medical Association (AMA) recently released a study showing that 62.8 percent of physicians felt burned out in 2021. Further, despite the passage of the monumental *Dr. Lorna Breen Health Care Provider Protection Act*, many health care workers are still hesitant to seek mental health treatment.

ACEP is also concerned that inadequate Medicare and Medicaid payment rates in many states throughout the country will lead to significant access issues. Though Medicare is available for comparison and often used as a benchmark for Medicaid rates, ACEP cautions the use of Medicare payment rates for this purpose. Based on a Kaiser Family Foundation analysis, current Medicaid fee for-service rates are, on average, 72% of Medicare fees for the same service. However, Medicare payment rates themselves are inadequate.

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 the 3.0 percent across-the-board reduction and an additional reduction of 1.4 percent to preserve budget neutrality that may apply to the Physician Fee Schedule conversion factor in calendar year 2023, the 2.0 percent sequestration reduction continues to apply year after year. Furthermore, there is another "Pay-Go" sequester of 4.0 percent that is scheduled to begin at the start of 2023—making the total overall projected cut starting January 1 at 10.4 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.[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.

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.

The level of both Medicare and Medicaid payment rates is simply unsustainable, and clinicians, especially front-line providers, need a stable level of reimbursement—especially considering what we have faced during the COVID-19 public health emergency (PHE). With respect to emergency medicine particularly, it has been more expensive than usual to provide appropriate care to patients, as emergency physician groups have had to incur additional expenses for treatment, such as developing and implementing protocols for alternative sites of care, enhancing telehealth capabilities, purchasing

[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.

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). All of these additional costs are weighing down on group practices as they try to maintain the minimum staffing levels necessary to serve patients night and day in the emergency department (ED) and prepare for surge staffing when COVID-19 cases actually do increase in their area. These additional needs and expenses likely will carry on throughout 2022 and perhaps even into 2023. Looking forward, many emergency physicians are already very concerned about the viability of their group. We believe that CMS has an obligation to health care professionals and patients to do everything in its power to address payment deficiencies in both Medicare and Medicaid and impose payment rates that increase with inflation.

As emergency physicians, we appreciate our essential role in strengthening the health care safety net for our communities. We treat all patients who come through our doors, regardless of their insurance status or ability to pay. Over the years, certain laws have been put into place to help enforce and protect patients and the emergency health care safety net, including the "prudent layperson" (PLP) standard. First established under the Balanced Budget Act of 1997, the PLP allows people who reasonably think they are having an emergency to come to the ED without worrying about whether the services they receive will be covered by their insurance. Under the PLP, payors cannot deny reimbursement to providers based on the patient's final diagnosis. An "emergency" versus a "nonemergency" must be determined on a case-by-case basis based on whether the patient's symptoms and complaints reasonably represented to them as a prudent layperson a potential emergency condition. In all, if the PLP standard applies (which happens almost all the time), ACEP asserts that the care provided to patients meets the requirements of medical necessity and therefore, should be covered by insurers. Unfortunately, ED claims are denied by insurers, including Medicaid managed care organizations (MCOs), due to a "lack of medical necessity" after seeing a final diagnosis. ACEP strongly believes that such a denial represents a fundamental violation of the PLP standard. Patients with symptoms consistent with a possible emergency health condition should not be expected to self-diagnose before deciding whether to come to the ED. Even as experienced emergency physicians, we cannot determine a patient's final diagnosis (or whether they have an emergency or non-emergent medical condition) based on the patient's symptoms when they first present to the ED. Many conditions share very similar symptoms, and a full work-up and examination (sometimes with additional diagnostic tests) is frequently required before the ultimate diagnosis becomes clear. Claims denials violate the PLP standard, but they are not the only bad practice by payors that discourages provider participation in programs including Medicaid and CHIP.

Downcoding, in which services are still covered by the payors (rather than denied), but the level of service on the claim is changed, has become a major issue in emergency medicine. Payors have instituted algorithms or lists of final diagnosis to automatically down code certain claims without a medical chart review—again based on the final diagnosis and thus in violation of the PLP standard. CMS has issued statements dating back to 1995 that clearly dictate that modifying payments for emergency services based on a list of diagnosis codes is a violation of the PLP standard. However,

given that this practice is still occurring in states such as Virginia, we ask that CMS take more direct actions to enforce the PLP standard.

It is important to note that both the Obama and Trump Administrations have clearly stated that the PLP standard prevents plans from modifying payment of (downcoding)–emergency claims based on diagnosis. In 2016, the Obama Administration issued the Medicaid Managed Care Rule which states "The final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens" (emphasis added). In a March 15, 2018, letter to EDPMA, former CMS Administrator Seema Verma reiterated that "Whenever a payer […] denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)" (emphasis added). Beyond payment denials and downcoding, another harmful practice employed by insurers is prior authorization. Emergency services are exempt from prior authorization in most cases.

It would be extremely unsafe and impractical to require patients in the emergency department (ED) to receive prior authorization before being able to receive critical services. However, as emergency physicians, we still see how prior authorization can affect the ability of our patients to receive the most appropriate treatment in the most appropriate care setting. We have experienced numerous occasions where patients who are unable to receive services in other care locations because of a prior authorization denial come to the ED to receive those services (sometimes at the direction of their provider). Patients come to the ED because they and or their physician recognize that the patient can receive the service without undergoing prior authorization. This clearly is not an appropriate reason for a patient to receive treatment in the ED, but it reflects a fundamental flaw in the health care system resulting from extremely stringent prior authorization protocols. Therefore, ACEP recommends that CMS address this issue as quickly as possible and do more to streamline and automate the prior authorization processes under all federal health programs, including Medicaid and CHIP.

Emergency physicians are also legally and ethically bound by the Emergency Medical Treatment and Labor Act (EMTALA), which requires that physicians at Medicare-participating hospitals provide stabilizing treatment to any patient that presents with an emergency condition that has the potential to cause serious harm to the patient or that endangers their life. However, along with this critical responsibility comes a significant amount of uncompensated care. CMS estimates that 55 percent of an emergency physician's time is spent providing uncompensated care. Approximately 95.2% of emergency physicians provide some EMTALA-mandated care in a typical week and more than one-third of emergency physicians provide more than 30 hours of EMTALA-related care each week. EDs, as the nation's safety net, should be appropriated funded and supported as such.

Finally, we believe that in order to incentivize physicians and other clinicians to work in rural and underserved areas, CMS should increase payments for clinicians, similar to the additional facility payment that will apply to rural emergency hospital (REH) starting in 2023. Under the Consolidated Appropriations Act, covered outpatient department services provided by REHs will receive an additional five percent payment for each service. CMS should consider creating an add-on code or modifier under the Medicare Physician Fee Schedule that clinicians could append to claims for services delivered in rural areas. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each Current Procedural Terminology (CPT) code that is billed.

Topic 3: Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Example responses may include, but are not limited to:

- Identifying CMS policies that can be used to advance health equity:
    - Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services;
    - Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences;
    - Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias. For example, input on how we might mitigate potential bias with clinical tools that have included race and ethnicity, sex/gender, or other relevant factors. Further, input on potential policies to prevent and/or mitigate potential bias in technology, treatments or clinical tools that rely on clinical algorithms.
    - Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid; and
    - Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.

ACEP Response

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 represent a disproportionate share of patients in the emergency department (ED) and are more likely to rely on emergency care for both time-sensitive and non-urgent care needs. We appreciate CMS' ongoing effort to assess how best to measure healthcare disparities and report those results to health care providers.

Another point of consideration in this discussion and in conversations within ACEP is the fundamental understanding of the language "race" and "ethnicity." There is a tendency to use these terms interchangeably when they are not interchangeable, especially when other aspects like genetics, heredity, or ethnicity may be more appropriate and informative variables. We also recognize that race is sometimes used a proxy for social determinants of health, meaning that factors like economic stability, education, health care access, and other social determinants may be more relevant coefficients that are lost when race is used instead. Our understanding of these questions is an evolving educational process and we continue to seek more definitive answers that for questions that are not well understood today.

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) recommended to the HHS Secretary for full implementation. The AUCM provides incentives to participants to safely discharge patients from the ED by facilitating and rewarding post discharge care coordination. Under the model, a person who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socioeconomic 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 patients and is eager to work with CMS on implementation.

Understanding the full significance that specific social determinants of health have on a patient also 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 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 patients 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.

CMS can also do more to support mental health patients and ensure that Medicaid Managed Care Organizations (MCOs) are complying with the Mental Health Parity and Addiction Equity Act. This is a critical time for mental health care in our country. As you well know, our nation's mental health and substance use disorder (SUD) crises have been exacerbated by the myriad impacts of COVID19. EDs throughout the country have witnessed the worrisome trends in Americans' overall mental health and continued lack of access to desperately needed acute and long-term mental health care services. More than 100,000 Americans died due to overdose in 2021 – what some have noted as an "epidemic within a pandemic." We have also seen sharp increases in ED visits related to mental health, especially for children and young adults. As a recent U.S. Department of Education report, "Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs," notes, children have experienced isolation, bereavement, depression, worry, and other issues throughout the pandemic, leading to reports of anxiety, mood, and eating disorders, as well as increased self-harm behavior and suicidal ideation at nearly twice the rate of adults. Pediatric emergency department visits related to mental health significantly increased during the pandemic – a 24 percent increase for children 5-11 years of age, and 31 percent for children 12-17. These stressors affect children's development and ability to learn in both the immediate and long-term with lasting consequences should their mental health needs not be adequately addressed.

CMS needs to do more to ensure that mental health services are covered and appropriately reimbursed. In Maryland, for example, Optum instituted a policy applying to its Medicaid managed care population that only allowed certain specialists who identify as "mental health practitioners" to bill for services delivered to patients in the ED who have a primary diagnosis related to a mental health condition. Therefore, emergency physicians in Maryland who treat people with mental health disorders on a routine basis were not allowed to bill for any mental health services they delivered to their Medicaid patients. Although this particular policy has mostly been rescinded, these types of policies continue to crop up and jeopardize the overall goal to ensure parity between physical and mental health services.

In addition, improving coordination of care across the health care continuum must be one of the highest priorities for any mental health reform effort. The ED serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis – they are often hectic, noisy, and particularly disruptive for behavioral health patients. Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding.

Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.

ACEP Response

As CMS continues this important work, ACEP offers the following points to consider:

- Ensuring Data are Accurate and Meaningful: ACEP believes that in order to effectively stratify quality measure results by race and ethnicity, there must first be assurance that such data are accurate and collected in a way that allows for their meaningful use. Granular demographic data as related to race and ethnicity (e.g., specifying discrete categories of Asian Americans like Korean American and Filipino American rather than a monolithic Asian

American racial designation) provides the degree of detail necessary to effectively understand differences and set meaningful policy.

- Accounting for Bias: Universal race and ethnicity data collection is a fundamental prerequisite for disparities quality measurement. We believe that patient self-reported race and ethnicity data should be collected through use of standardized surveys and questionnaires. Use of surveys and questionnaires to capture race and ethnicity data should incorporate adequate training to ensure data collection is culturally competent and respectful. Patients should be informed that demographic data will be used exclusively to improve the quality of care and not to limit access to care. If such data are unavailable, ACEP also does not think that estimating an individual's race and ethnicity based on name and geography is appropriate. Women and children often take the names of their husbands and fathers, respectively. Particularly for women, estimating one's race/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. 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. Routine audits of such processes and conclusions would also be ideal in order to discover and correct errors expeditiously.

- Attribution of Quality Measures: A critical consideration of quality measure development is measure attribution, or the process of selecting a patient population for which a group or entity will be held accountable for providing appropriate health services and achieving adequate health outcomes. ACEP encourages evaluation at the *clinician group level* in order to ensure that gaps are fairly attributed to entities with adequate agency to be responsible and accountable for outcomes.

- Accounting for Under-Resourced Facilities: There should be sensitivity, and perhaps an actual formulaic coefficient applied, when evaluating under-resourced facilities to ensure some congruency between their quality performance relative to facilities with more resources. CMS should consider adjusting programmatic requirements to ensure that reporting on quality measures is feasible for all facilities and that under-resourced facilities do not face undue difficulty or burdensome penalties that could affect access to care for vulnerable populations.

- Minimizing Variation: While CMS states that there should be some discretion to individual facilities to use quality measures in a way that most benefits their populations, there should be clear guidelines, suggestions, and guardrails in place to minimize variation amongst facilities. Providers who treat less-resourced, more diverse patient populations may lag in collecting data compared to providers who treat less diverse patient populations. Particular attention should be paid to support institutions with limited resources that serve a large volume of historically disadvantaged patients in acquiring health information technology that supports adequate data collection for quality improvement. Health systems and provider groups must also be cautious that disparities measurement does not lead to other unintended or adverse consequences such as provider selection or avoidance of certain patient populations.

- Ensuring Access to Specialists: In certain populations, including tribal citizens, there is a pronounced inequity in access to specialists and higher-level care. When these patients have to be referred to a specialist, the process can be significantly delayed. This causes patients to land back in the ED for with underlying illnesses that could have been managed as an outpatient had they been able to get the referral to the appropriate specialist.

Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Example responses may include, but are not limited to:

- Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on health care providers, suppliers, patients, and other stakeholders.
    - Telehealth
    - Planning for future pandemics

ACEP Response

ACEP for years has strongly supported the delivery of telehealth services by board-certified emergency physicians. During the COVID-19 PHE, CMS took numerous steps to expand the use of telehealth under Medicare. While CMS has made substantial changes to telehealth policies, 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 temporarily 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. Congress, in the Consolidated Appropriations Act, 2022, extended this waiver for 151 days past the end of the PHE. Further, CMS clarified that the medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), could be performed via telehealth. Finally, CMS temporarily added all ED evaluation and management (E/M) codes, the observation codes, and critical care codes to the list of approved Medicare telehealth services through the end of 2023. These are the codes that emergency physicians typically bill.

With these flexibilities granted during the pandemic, 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, we 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 medical screening examinations (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.

Being able to provide emergency services via telehealth initially helped preserve personal protective equipment (PPE) when supplies were limited and has helped reduce unnecessary exposure to COVID-19 for physicians and patients alike. Emergency physicians in particular have been at increased risk of contracting COVID-19 due to frequent and close physical interactions among patients and other health care workers. Having the ability to provide telehealth services has reduced face-to-face contact without compromising care, and patients have been able to safely receive services either from their home, the ED, or an alternative location within the hospital.

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.

Preliminary, anecdotal evidence has suggested that the use of telehealth services has resulted in improved health outcomes and helped limit avoidable trips to the ED or hospital. It has also improved access to care for beneficiaries, a clear clinical benefit, by connecting patients with clinicians from any

location in a timely manner. Finally, some systems have shown overall cost savings by diverting patients from expensive care settings and by averting transfers to inpatient facilities.

However, despite the benefits of telehealth, CMS has created a difficult process for adding new telehealth services to the list of Medicare-approved telehealth services. We recognize that the ED E/M services will remain on the list until December 31, 2023, and that in order for the codes to remain permanently on the list of approved telehealth services, CMS needs to see more data and evidence about the benefits of providing these services via telehealth to meet a "Category 2" review. Meeting the Category 2 criterion is an unreasonably high bar, and it will take a significant amount of time to collect the data needed to meet it; ACEP is still compiling the data needed to make a compelling case to CMS.

The requirement to produce ample data and evidence to show that providing certain services adds clinical value is a time-consuming and costly endeavor. It could also take years to gather this amount of evidence. ACEP also believes that CMS should not need to look at whether the act of providing a service via telehealth adds additional clinical value. Telehealth is simply a means by which health care providers deliver services—an extremely useful tool that providers can employ to expand access to care. In other words, if a physician provides a specific high-quality service to a patient, we should expect it to be as effective and add as much clinical value regardless of whether it was delivered in-person or via telehealth. We should not have to prove that providing a service via telehealth adds even *more* clinical value than conducting the service in-person. Rather, we should only be required to demonstrate that a service delivered via telehealth is *as clinically effective* as the service would have been if it were performed in-person. Therefore, ACEP suggests that CMS consider revising its Category 2 criterion in future rulemaking.

As hospitals and emergency physician practices have invested in new telehealth platforms to serve patients during the pandemic, one concern many emergency physicians share is how to sustain these investments if the underlying funding and reimbursement for telehealth services do not continue. As noted above, starting in 2024, the codes that emergency physicians typically bill—including the ED E/M codes, some observation codes, and critical care codes— may be removed from the list of approved Medicare telehealth services. It is also unclear whether Congress will continue to extend or make permanent the originating site and geographic restrictions beyond the 151-day extension it just provided. While CMS does not have the legal authority to lift the originating site and geographic restrictions, it does have the regulatory authority to extend certain telehealth policies past the end of the PHE without congressional action. We urge the Biden Administration to explore all these policies and extend those that will allow telehealth to remain a financially viable method for providing high-quality care going forward.

Another significant barrier is state licensing. Currently, there are regulatory barriers that restrict the ability for physicians to get licensed and credentialed in multiple states so they can provide telehealth services to patients across state lines. During the PHE, CMS issued a temporary waiver to allow physicians who are licensed in one state to provide services to a patient another state. This waiver only applies to Medicare and Medicaid patients. Further, for the waiver to be effective, the state

where the physician is performing the telehealth service must also waive its licensure requirements. While many states have allowed this flexibility during the PHE, it is not clear whether they will continue doing so once the PHE ends.

Finally, ACEP believes that telehealth should continue to be available to treat patients with opioid use disorder (OUD). The Drug Enforcement Administration (DEA) adopted protocols to allow DEA-registered practitioners to prescribe controlled substances to their patients without having to interact in-person with their patients. Under the DEA's policy (which became effective on March 31, 2020), authorized practitioners can prescribe buprenorphine over the telephone to new or existing patients with OUD without having to first conduct an examination of the patient in person or via telehealth. This flexibility is scheduled to be terminated once the PHE ends.