

January 26, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

CMS-9911-P

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

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 proposed 2023 Notice of Benefit and Payment Parameters (NBPP). Specifically, we would like to address a few policies proposed in the NBPP that have a significant impact on the coverage of emergency services and access to care for higher risk populations.

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Nondiscrimination based on sexual orientation and gender identity

ACEP strongly supports the Centers for Medicare & Medicaid Services' (CMS') proposal to modify previously altered non-discrimination protections from 2020 that had removed references to sexual orientation and gender identity. We are extremely pleased that CMS is reverting back to the pre-2020 nondiscrimination protections that appropriately protect every patient, regardless of their sexual orientation or gender identity.

We strongly believe that discrimination in any form should be prohibited in health care. Both by law¹ and by oath, emergency physicians must care for all patients seeking emergency medical treatment. Denial of emergency care or delay in providing emergency services on the basis of race, religion, sexual orientation, gender identity, ethnic background, social status, type of illness, or ability to pay, is unethical under our Code of Ethics as emergency physicians.²

As background, Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any health program or activity that receives federal financial assistance. In 2016, the U.S. Department of Health and Human Services (HHS) finalized a regulation that defined "on the basis of sex" to include sex stereotyping, gender identity, and termination of pregnancy. However, in 2020, HHS removed gender identity and termination of pregnancy from the Section 1557 regulation.

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

² ACEP Code of Ethics for Emergency Physicians; Approved Jan 2017;
[https://www.acep.org/clinical---practice-management/code-of-ethics-for-emergency-physicians.](https://www.acep.org/clinical---practice-management/code-of-ethics-for-emergency-physicians)

At that time, ACEP had expressed concern that the modifications represented a direct conflict to the federally mandated provision of emergency services. The Emergency Medical Treatment and Labor Act (EMTALA) requires clinicians to screen and stabilize every patient who presents to the emergency department (ED). Such patients have every right to expect the best possible care and to receive the most appropriate treatment and information about their condition. Patients with life-threatening injuries or illnesses may not have time to wait for a referral to another physician or other healthcare professional to treat them if the present provider has a moral or religious objection. Likewise, EDs operate on tight budgets and do not have the capacity to staff additional personnel 24 hours a day, seven days a week in the event that the available clinician had these objections. The modifications seem to have demanded that, to meet EMTALA requirements, an ED must anticipate treating transgender patients, survey its employees to ascertain who might object to treating such a patient, and staff accordingly. This is an impossible task that we believe jeopardizes the ability to provide care both for standard ED readiness and for emergency preparedness.

In all, we strongly believed that the approach taken in 2020 undermined the critical role that EDs play across the country and jeopardized access to care for specific populations. Therefore, we applaud CMS' decision to reverse course and to reinstate the previous protections established in 2016. **We urge CMS to finalize the policy as proposed.**

Annual Reporting of State-required Benefits

CMS is proposing to eliminate the requirement established in the 2021 NBPP for states to identify the required benefits mandated by state law and which of those benefits are supplementary to essential health benefits (EHBs). The ACA allows states to require qualified health plans (QHPs) to cover other benefits in addition to EHBs. However, states that choose this option must make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional state-required benefits. At the time, ACEP had supported this requirement, as we believed that it would add more transparency and accountability in states that may not have been completely deferring the full costs of the additional benefits.

We understand CMS' rationale for eliminating the requirement based on the stakeholder feedback that the requirement was unnecessary and burdensome on states. If CMS finalizes the proposal, we encourage the agency to continue monitoring states to ensure that they appropriately defray the costs of additional required benefits, as doing so will improve the accuracy of premium tax credits, which many individuals depend on to afford health insurance.

Elimination of EHB Flexibility Policy

ACEP supports CMS' proposal to eliminate the current given flexibility of states to permit issuers to substitute benefits between EHB categories. Although no states have elected this option, we agree with CMS that it could potentially be detrimental for consumers with chronic conditions and disabilities, since issuers could elect to include a narrow set of benefits that do not ensure consumers access to the items and services they need to manage their health conditions. Given the lack of adoption by any state, we do not anticipate any substantial changes to health plans due to this alteration in policy.

Refine EHB Nondiscrimination Policy for Health Plan Designs

CMS is proposing to refine the EHB nondiscrimination policy and implement a clear regulatory framework for entities that are required to comply with the policy. CMS' proposed revisions are "intended to ensure that benefit designs, and particularly benefit limitations and plan coverage requirements are based on clinical evidence."³

³ 87 FR. 664. (January 5, 2022)

ACEP agrees with the proposal and supports the advancement of a nondiscriminatory benefit design of EHBs that is based on clinical evidence. We share the sentiment that consistent application of EHB nondiscrimination policy will better safeguard consumers who depend on nondiscrimination protections for appropriate and equitable medical care.

Network Adequacy

ACEP strongly agrees that robust network adequacy standards are necessary to achieve greater equity in health care and enhance consumer access to quality, affordable care through the Exchanges.

FFE Network Adequacy Reviews

HHS proposes to evaluate the adequacy of provider networks of QHPs offered through the federally facilitated Exchanges (FFEs), or of plans seeking certification as FFE QHPs, except for FFEs in certain states.

ACEP strongly supports this proposal. Network adequacy standards are highly variable across states. Therefore, consistent evaluation and enforcement of quantitative network standards is needed to ensure objective monitoring of the care delivered to FFE enrollees. We agree with the proposal to designate standards that are equivalent to those laid out in [45 CFR §156.23](#), which includes provisions for access to provider directories, increasing consumer transparency, provider transitions, and out-of-network cost sharing. We believe that all beneficiaries of QHPs offered through FFEs deserve fair access to a full range of health care services. If network adequacy standards fall short and enrollees are not provided with appropriate access to care, they are more likely to avoid seeking more routine care or visiting a primary care physician or specialist for minor conditions or symptoms. Such deferral or delay will often result in exacerbation of their condition or symptoms, and eventually, may result in a trip to the ED. At this point, due to the progression of their condition, their care in the ED will be much costlier and more complex, increasing the already great burden on emergency physicians and the healthcare system at large.

Time and Distance Standards

Beginning in plan year (PY) 2023, CMS proposes adoption of time and distance standards that would assess whether FFE QHPs (or QHP candidates) fulfill network adequacy standards. These proposed provider lists are informed by prior HHS network adequacy requirements, consultation with stakeholders, and other federal and state health care programs, such as Medicare Advantage and Medicaid. To provide proactive consumer protections and incentivize contracting between emergency physicians and issuers to increase enrollee access to in-network providers, the agency proposes adding emergency physicians to its provider specialty list for time and distance standards. The time and distance standards proposed would be calculated at the county level, vary by county designation, and be based on and aligned with Medicare Advantage.

ACEP has long advocated for the enforcement of strong network adequacy standards across both Medicare and Medicaid and has commented specifically in the past on the network adequacy requirements CMS has established for the Medicare Advantage program. In 2020, CMS issued a rule⁴ that codified many of its existing Medicare Advantage network adequacy requirements—including formalizing the list of specialty types that are included in the time and distance standards. When that 2020 rule was first proposed, ACEP [specifically requested](#) that emergency medicine be added to the list. We stated that we believe that it is essential for all beneficiaries enrolled in Medicare Advantage to know from their Medicare Advantage health plan in advance of an emergency if the emergency physician treating

⁴ 85 FR. 33796. (June 2, 2020).

them is in-network (NOT during or after an emergency has occurred). The very nature of ED care, more than any other type of specialty care, precludes the opportunity for patients to preferentially go to facilities with in-network emergency physicians. CMS ultimately did not adopt our recommendation to add emergency medicine as a specialty type in its Medicare Advantage network adequacy requirements.

We are therefore extremely pleased that CMS is adding emergency physicians to the provider specialty list for time and distance standards for FFE QHPs. Similar to the impact we believe such a policy would have on the Medicare Advantage population, we feel that this is an important step in helping to improve access to in-network emergency care for QHP enrollees. We do ask that CMS clarify that emergency physicians must be board-certified in emergency medicine in order to count towards the time and distance standards. Specifically, physicians must be board-certified either through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).

ACEP also agrees with the proposal to align the parameters of the time and distance standards to those set by Medicare Advantage. CMS currently requires that Large Metro and Metro organizations contract with enough providers and facilities to ensure that at least 90 percent of enrollees within a county can access care within specific travel time and distance maximums. In the same 2020 rule referenced above, CMS finalized a proposal to reduce this standard to 85 percent in in Micro counties, Rural counties, and Counties with Extreme Access Considerations (CEAC). We also suggest aligning to the current time and distance standards for Large Metro, Metro, Micro, Rural and CEAC counties as laid out in the Medicare-Medicaid Plan Health Service Delivery Reference File, which adequately provides flexibilities needed in rural areas where provider or plan shortages may exist.

Since emergency physicians are not included in the Medicare Advantage network adequacy standards, we recommend, as a proxy to emergency care, aligning the emergency medicine standards for QHP plans with the acute inpatient hospital time and distance standards listed in [42 CFR § 422.116](#):

Provider/Facility type	Large		Metro		Micro		Rural		CEAC	
	metro									
	Max	Max	Max	Max	Max	Max	Max	Max	Max	Max
	Time	distance	time	distance	time	distance	time	distance	time	distance
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100

ACEP would like to note that strong enforcement of these standards is crucial to ensure their execution. Creating these standards without proper enforcement would definitely undermine their overall effectiveness. As such, we seek further clarification on what penalties would exist for organizations that are non-compliant with these time and distance standards.

Telehealth Services

Beginning with the QHP certification cycle for PY 2023, CMS proposes to require all issuers seeking certification of plans to be offered as QHPs through the FFEs to submit information regarding the offering of telehealth services. The collection of this data would be intended to help inform future development of telehealth standards; thus, it would not be displayed to consumers.

For years, ACEP has strongly supported the delivery of telehealth services by board-certified emergency physicians. Though the use of telehealth services had been steadily increasing prior to the COVID-19 pandemic, the current public health emergency has rapidly expanded telehealth use in emergency medicine. ACEP supports the proposal for increasing the amount of information about telehealth use to inform future developments of telehealth standards.

ACEP also believes in the high value of promoting emergency telehealth services as a high-quality, cost-effective method of care. Telehealth programs can expand patient access to an emergency physician in inner city or rural ED settings that would not normally be able to economically support that level of provider. We support the incorporation of telehealth availability into network adequacy standards, while at the same time affirming that telehealth services should not be used in lieu of in-person services for complex medical emergencies. We believe that telehealth services – if used appropriately – may support or expedite the delivery of emergency care.

Solicitation of Comments – Unintended Impacts of Stronger Network Adequacy Standards

ACEP agrees with CMS that the network adequacy standards proposed are reasonable, necessary, and appropriate to ensure that QHPs enrollees have the access to the in-network providers required by the ACA. However, in the rule, CMS states that it believes that there may be some risk that stronger network adequacy standards could be leveraged to create an uneven playing field in network agreement negotiations that could ultimately result in higher health care costs for consumers. **We strongly disagree with this suggestion.** ACEP firmly believes that an increase in the strength of network adequacy standards would not create any incentives for providers or hospitals to try to leverage higher rates, and in fact enables the reverse: it would provide more incentive for health plans to negotiate fairly.

In fact, implementing strong network adequacy requirements could help counteract the **disincentive** that health plans now have, through the administration’s implementation of the *No Surprises Act*, to negotiate fairly with providers. As stated in ACEP’s [response](#) to the second interim final rule implementing the *No Surprises Act*, the flawed independent dispute resolution (IDR) process established by the administration will result in many providers being forced out-of-network by health plans. **This practice is already happening**, and since the publication of the second interim final rule, numerous physician practices have already received unilaterally-initiated termination notices from insurance plans for long-standing in-network agreements, including agreements that currently protect patients in rural and underserved communities. Many health plans even cite implementation of the new law as the reason for the changes.

Once again, we would like to strongly refute the implied assertion that providers would take advantage of network adequacy requirements. Strong network adequacy requirements are needed to ensure high quality health plans and ensure the best quality patient safety, equity, and care.

Solicitation of Comments – Network Adequacy in State Exchanges

The rule notes that the network adequacy requirements would only apply to FFE QHPs and that there are 21 states that operate their own Exchanges. These state Exchanges have a mix of network adequacy policies in place. ACEP supports network adequacy standardization to ensure that all state Exchange enrollees can access the benefits and services under their plans as required by the ACA. We agree that the gaps in provider accessibility that exist under disparate state Exchange network adequacy standards could be addressed through greater federal regulation of network adequacy standards across all Exchanges. We encourage states to align their standards to those of the federal government.

Quality Standards: Quality Improvement Strategy

Persistent inequities in health care outcomes exist in the United States, including among populations enrolling in QHPs across Exchanges. CMS proposes to require QHP issuers to address health and health care disparities as one topic area of their Quality Improvement Strategy (QIS) in addition to at least one other topic area described in section 1311(g)(1) of the ACA beginning in 2023. As background, section 1311(g)(1) of the ACA defines a QIS as a payment structure that provides increased reimbursement or other incentives for implementing activities related to the five health care topic areas defined in statute: improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, promoting wellness and health, and reducing health and health care disparities.

ACEP fully supports the acknowledgment and elimination of healthcare disparities and therefore agrees with CMS' proposal.

Solicitation of Comments on Health Equity, Climate Health, and Qualified Health Plans

CMS seeks comment from stakeholders on advancing health equity through QHP certification standards; advancing CMS's understanding of the existing landscape of issuer collection of health equity data; and assessing data sources that focus on population-level factors made available by governments, quasi-governmental entities, data vendors and other organizations. Specifically, CMS seeks comment on the requirement of QHP issuers to obtain the [National Committee for Quality Assurance \(NCQA\) Health Equity Accreditation](#) in addition to their existing accreditation requirements and the challenges QHP issuers could face in implementing a new accreditation product on health equity. CMS also seeks comment on which data elements should be collected to advance health equity within QHPs and what other health equity tools made available by organizations should be considered to address health disparities within QHPs.

ACEP believes that in order to effectively stratify quality measure results by race and ethnicity, there must first be assurance that such data is accurate and collected in a way that allows for its meaningful use. The NCQA Health Equity Accreditation supports health care organizations in evaluating and elevating the health of the populations they serve. We believe that the NCQA Health Equity Accreditation is an appropriate and beneficial accreditation for healthcare organizations to obtain. Use of the data could help identify and address disparities in care to support better health outcomes.

We also suggest that quality measures should include data accounting for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. As emergency physicians, we see patients from all backgrounds, with varying social risk factors. Many interventions are being employed in the ED to help identify barriers to health, such as lack of access to adequate transportation, food, and housing. One tool that ACEP specifically 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 platform that provides critical information on patients, such as how many ED visits the patient has had in the last year, where they presented, their drug history, other providers involved with the patient, and 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. Utilization of the tool also lowers health care costs by eliminating redundant tests and through better case management, reducing hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year of the implementation of the tool alone, experienced a 24 percent decrease in opioid

prescriptions written from EDs, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than \$32 million.⁵

Some EDs across the country are attempting to use other health equity tools 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 utilize paramedics as community health workers to follow up on discharged patients who are at risk of readmission.⁶ Many of these patients are Medicare beneficiaries. Another program in the East Bay, California involves 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.⁷ ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients and is committed to advancing health equity for our patients.

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

Sincerely,



Gillian R. Schmitz, MD, FACEP

ACEP President

⁵ <https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/>

⁶ 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>

⁷ For more information on the Health Advocates Program, please go to <http://www.levittcenter.org/ed-social-welfare-in-collabor/>.