American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE

May 31, 2019

Re: CMS-9115-P

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-facilitated Exchanges and Health Care Providers Proposed Rule

Dear Administrator Verma:

On behalf of nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule aimed at advancing interoperability and patient access to health information.

ACEP supports the Trump Administration's commitment to eliminating barriers that impede our ability to provide the best possible care to our patients. Emergency physicians play a critical role in our health care system, serving as the safety net in our communities. However, in general, it is challenging for us to provide comprehensive care to patients who arrive in our emergency departments (EDs) without a medical record that we can easily access. In many cases, we see patients with acute conditions who we have never seen before and may not be able to communicate due to their health condition. We deal with life and death situations and must make near-instantaneous critical decisions about how to treat our patients with limited information. Therefore, we are eager to work with hospitals toward the goal of interoperable electronic health records (EHRs) that will open the door to more comprehensive patient information sharing across sites of care. Linking disparate EHRs will allow us to make more informed decisions and will significantly enhance timely communication with patients, community physicians, and other caregivers. To that end, we strongly support policies that promote our ability to receive and exchange information about our patients.

ACEP believes that both this proposed rule and the companion proposed rule released by the Office of the National Coordinator (ONC) for Health Information Technology are steps in the right direction to reduce information barriers and improve access to data. **However, as emphasized later in our comments, we are very concerned**

about the additional pressure being placed on providers to invest in data sharing technology and the speed at which providers would be required to implement these new technologies. Furthermore, we believe that CMS and ONC did not sufficiently address some of the data and privacy concerns that come with allowing outside vendors that are not considered covered entities under the Health Insurance Portability and Accountability Act (HIPAA) to have access to patient's health data. Although the Office of Civil Rights (OCR) issued a request for information on HIPAA, which included questions about what changes to make to support interoperability[1], the CMS and ONC proposed rules do not propose or seek comment on any modifications. Finally, we are disappointed that the rules are silent in terms of how HHS can work with the Federal Trade Commission (FTC) to regulate application programming interfaces (APIs) that are not covered entities under HIPAA. **Given the magnitude of changes encompassed in these rules, CMS and ONC should publish interim final rules rather than final rules to allow additional opportunity for stakeholder comment. We also recommend that CMS and ONC delay any disincentives and/or penalties until two years after implementation of the rule to allow all stakeholders to have time to address any unforeseen challenges.**

With these principles in mind, we offer the following comments on specific proposals.

<u>**Summary of Comments**</u>

Our comments focus on three major areas: 1) provider-related proposals; 2) health plan proposals, and 3) requests for information. We also share our concerns about apparently incongruent timelines for implementing the proposed requirements in both the CMS and ONC rules.

<u>**Provider-related Proposals**</u>

Proposed Condition of Participation

CMS is proposing a new Medicare Condition of Participation (CoP) that would require hospitals, including psychiatric and critical access hospitals, to send an electronic notification when a patient is admitted, discharged, or transferred (ADT). Under the proposal, hospitals would be required to send ADT notifications with basic patient information to certain licensed and qualified practitioners, other patient care team members, and post-acute care service providers and suppliers following an ADT event. While hospitals would only be required to send out notifications following ADT events, CMS encourages them to extend notifications to other types of events, including ED visits. CMS also seeks comment on whether the agency should require hospitals to send out notifications for these additional events.

ACEP believes that ADT notifications can help improve care and lower costs by helping health care providers better manage patients with significant acute or chronic diseases. However, we do not support the specific CMS proposal to add a new Medicare CoP for hospitals. We believe that the administrative and financial burden that the proposal would place on hospitals and hospital-based clinicians would be significant, and the penalties for non-compliance would be too severe. We also note that these CoPs would create a new set of requirements related to the use of EHRs that are separate from the existing Promoting Interoperability (PI) measures. Hospitals must already spend significant resources to achieve these measures, and the new proposed CoP requirement will likely increase hospitals' overall compliance burden with respect to EHRs. Further, when describing the proposal, CMS failed to acknowledge the feasibility of sharing information of this nature with settings that have yet to fully adopt health IT capabilities. CMS should address exceptions where care settings

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[1]Request for Information on Modifying HIPAA Rules to Improve Coordinated Care, 83 Fed. Reg. 64305 (December 14, 2018).

are not able to receive this information electronically. Finally, we believe that CMS has significantly underestimated the complexity of meeting this mandate, and we do not agree with the agency's estimation that this should require little effort and be a one-time cost.

Instead of making these notifications mandatory through a new CoP, we believe that CMS should make them voluntary for hospitals. There are already existing provider-led initiatives to share data and coordinate care. Some of our members are currently sharing their ADT events with their health information exchange (HIE) systems, and all providers (primary care physician, social workers, and care managers) can use the information to help manage follow-up care, including home visits. A specific initiative that ACEP supports to help manage care for patients is the Collective Medical Technologies' (CMT) EDIE™ (a.k.a. PreManage ED) software. EDIE™ is an information exchange that provides EDs with critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their medication 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 can also help identify individuals that have gone to the ED frequently. Finally, it lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Washington state, in the first year alone, experienced a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[2]

In all, ACEP believes that it is best to rely on the innovation of the private sector and voluntary provider-led initiatives rather than imposing new, burdensome government regulations on hospitals and clinicians. However, if CMS does finalize the ADT notification requirement, we believe that it should be phased in slowly over time to ensure that all hospitals are able to comply. CMS could also consider conducting a pilot or demonstration under the Center for Medicare & Medicaid Innovation (CMMI). During the phase-in period or demonstration, CMS could test the effectiveness of hospitals sending additional notifications, especially around ED visits. We believe that there is so much value in notifying primary care physicians and other specialists about their patients' visits to the ED. Being able to identify these patients and develop comprehensive care plans would help avoid unnecessary readmissions to the ED and inpatient admissions. These notifications would especially benefit patients with multiple acute or chronic diseases, who would find the most value from improved care coordination. Finally, systematically tracking ED utilization could help support broader state and local population health and care coordination initiatives.

Information Blocking Background and Public Reporting

CMS proposes to publicly report information about a clinician's attestation regarding the prevention of information blocking under the Promoting Interoperability (PI) category of the Merit-Based Incentive Payment System (MIPS). Specifically, CMS proposes to place an indicator on Physician Compare for clinicians and groups that submit a "no" response to any of the following three statements:

1. Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

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[2] Anderson, S. "Emergency Department Information Exchange Can Help Coordinate Care for Highest Utilizers," ACEP*Now,* https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/

2. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times:
    a. Connected in accordance with applicable law;
    b. Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
    c. Implemented in a manner that allowed for timely access by patients to their electronic health information; and
    d. Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and health IT vendors.

3. Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

ACEP agrees that clinicians should attest to these three statements and that they should be held accountable if they violate any of these principles. However, ACEP has had concerns with the accuracy and usability of data on Physician Compare in the past—and therefore if CMS were to finalize these proposals, we would like CMS to take additional actions to ensure that the agency correctly identifies the clinicians who do not attest to one of these three statements. Further, while we understand that the enforcement and penalty rules for providers have not yet been outlined, we strongly recommend that providers be offered an appeals process.

We also note that many emergency physicians are deemed "hospital-based" and therefore automatically exempt from the PI category of MIPS. CMS states that if any of the statements are left blank, then the attestations would be considered incomplete, and CMS would not include an indicator on Physician Compare. Therefore, it appears that those clinicians automatically exempt from the PI category would not have an indicator placed on Physician Compare. CMS should confirm this understanding, as well as identify a process for clinicians in this situation to review and appeal any inaccurate information placed on Physician Compare.

Provider Digital Contact Information

CMS proposes to increase the number of clinicians with correct digital contact information included in the National Plan and Provider Enumeration System (NPPES) by publicly reporting the names and national provider identifier (NPI) of those clinicians who do not have digital contact information included in the NPPES system. CMS requests comments on the most appropriate way to pursue this public reporting initiative, including where these names should be posted, with what frequency, and any other information stakeholders believe would be helpful. CMS also is interested in enforcement mechanisms to ensure that clinicians make their digital contact information publicly available through NPPES, including potentially including a new MIPS requirement.

ACEP believes that information about providers included in NPPES should be accurate and that providers should have responsibility for updating inaccurate or outdated information. However, it is clear that many hospital-based physicians are not even aware of their digital contact information and rely heavily on hospital

informatics divisions to manage this data. We are concerned that publicly reporting and potentially even imposing penalties on clinicians who do not comply with the requirements may unfairly punish those who unknowingly failed to provide their digital information. We also believe that these actions have no impact on the correction of the problem. CMS should include a process for clinicians to review and rectify the situation without the fear of reporting and in partnership with realizing the goals and intention of the rule. Furthermore, if CMS decides to report the names of these clinicians on Physician Compare, then, as noted previously, CMS should include a process for clinicians to review and potentially appeal any incorrect information about them on the site. **In all, ACEP believes that CMS should use positive incentives, rather than "public shaming," to increase the number of clinicians with correct digital contact information in NPPES, as there may be valid or unforeseen reasons for which physicians do not include digital contact information in the NPPES.**

Health Plan Proposals

ACEP agrees with CMS and ONC's overarching principle that patients should own their healthcare data and in general, believes that making this information available to consumers on open APIs is the right policy. While we cannot comment on the ability of health plans to implement these requirements as proposed, we can offer specific comments from the provider's perspective on time requirements for making the data available, privacy and security considerations, provider directories, and providers' access to data stored on APIs.

Patient Access to Information using APIs

One of CMS' stated goals is to make it easier for patients to make informed healthcare decisions, and they are advocating the use of APIs as a way to enable and enhance that access. CMS proposes to require both public and private health plans including Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) programs and managed care plans, CHIP FFS plan and managed care entities and qualified health plans (QHPs) in the federally facilitated exchanges (FFEs), to leverage third-party application developers using HL7 FHIR and APIs to make patient claims and other health information available to patients. The required data would include:

- Adjudicated claims (including cost);
- Encounters with capitated providers;
- Provider remittances;
- Enrollee cost-sharing; and,
- Clinical data, including laboratory results (where available).

Timing for making Data Available

In most cases, CMS is proposing that health plans must make this information available on an open API within one business day after such information is received by the plans. CMS recommends that plans include in their contracts with providers timing requirements for submitting encounter data and claims so that the health plans can, in turn, meet the timing requirements proposed in the rule. **ACEP is extremely concerned that health plans will impose short, unrealistic turn-around times for providers to retrieve the information. This could potentially increase administrative costs for providers, who would be required to update their systems to comply with the demands of the health plans. Furthermore, if providers cannot comply with payers' new contractual requirements around submitting claims and encounter data, they may be forced out-of-network. As described further in the "Provider Information Directory" section below,**

narrow networks can make it difficult for patients to access the care they need. Therefore, we strongly urge CMS to prohibit payers from using these new requirements as an excuse to place additional contractual demands on clinicians.

Quick deadlines could also lead to mistakes and inaccurate information being sent to the plans. These issues would be exacerbated in the emergency care setting. A large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are "chest pain" and "abdominal pain." These initial symptoms have a large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. Due to the unpredictability of emergency care, sorting out claims for individual cases is a complex and timely process. **We therefore strongly recommend that CMS relax the timeline for health plans to put encounter data and claims on open APIs**. While we understand the need to get information to consumers as quickly as possible so that they can make more informed decisions about their health care, what is even more important is that the information they are receiving is accurate.

Finally, we are concerned that some plans may attempt to pull information directly out of a provider's EHR to reduce burden and save time. While this may seem logical, a plan's full access to data could lead to selective, discriminatory reimbursement models and intrusion on physician medical decision-making power. **ACEP strongly opposes any type of automatic, unfettered payer access to a physician's EHR, including through contractual means.**

Privacy and Security of Data

ACEP believes that all physicians have an ethical and legal duty to guard and respect the confidential nature of the personal information conveyed during the patient-physician encounter. We recognize that we are entering into a whole new world in terms of data sharing and consumer access to their healthcare information and that it is even more essential now to protect that information after the initial encounter. As the ways in which information can be exchanged continue to grow, we believe that privacy and security laws need to be updated and extended to cover all possible types of data-sharing. That is why we were surprised that no changes to HIPAA were proposed even though the OCR specifically asked what modifications were needed to support efforts to prohibit information blocking in the recent Request for Information.[3] As CMS notes in the rule, health plans must follow the current rules and regulations under HIPAA up until third-party applications retrieve the data from the open APIs. However, they do not have to take on any responsibility once third-party applications get ahold of the data. Since some of these third-party applications may not be covered entities under HIPAA, they are instead regulated by the FTC, which has the authority to investigate and take action against unfair or deceptive trade practices.

As more and more third-party applications obtain data from open APIs, we need to think extremely carefully about how to ensure patient's information is protected and that these third-parties do not engage in any deceptive practices that could potentially jeopardize the privacy and security of the data. Since a lot of this data is protected health information (PHI), we believe that it deserves at least the same protections as it receives under HIPAA even though it is not under control of a HIPAA covered entity. Third-party applications can use this data for a variety of purposes and we think it will be extremely difficult for patients to truly understand what aspects of their information are being shared and with whom. In fact, some studies suggest that current

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[3] Request for Information on Modifying HIPAA Rules to Improve Coordinated Care, 83 Fed. Reg. 64305 (December 14, 2018).

applications, like Facebook and Google, share information without the individual's knowledge or informed consent.[4] As the health IT applications ecosystem continues to evolve, patients need to be provided clear guidance and information about what they agree to when signing into an application and that their personal information could be at risk. We are also concerned that providing patients with unfiltered data may be overwhelming and incomprehensible without the proper context and medical expertise to interpret the information. Payer data is often error-prone, and we believe that the burden may fall on the physician to identify and remedy the errors within the data patients receive through the third-party applications. Therefore, we encourage the FTC to put out strong guidance or regulations clearly articulating what are and are not acceptable uses of the data, using HIPAA privacy and security rules as a guiding benchmark. CMS should also commit to working with the FTC on that additional guidance.

We also encourage CMS to go even further to ensure that consumers are protected and that they truly understand how their data are being used. CMS should consider requiring health plans to create an easy-to-understand questionnaire that they would require third-party applications to fill out in order to have access to the data on the open API. This questionnaire would include basic questions about how the third-party application plans to use the data. Consumers should have access to the answers on this questionnaire before using the third-party application. That way, even if the third-party application has a data use agreement that they require consumers to agree to, there will be another mandatory safeguard in place to ensure that consumers understand all the potential uses of their data once a third-party application retrieves all of it from the open API.

Finally, we are pleased that CMS is proposing to require health plans to provide information to their current and past enrollees about how to choose a third-party application, practical strategies to protect the privacy and security of their data, and how to submit complaints either to OCR or to the FTC. We believe that it is critical that our patients learn best practices for protecting their data and understand what to look out for in order to avoid deceptive practices (such as long data use agreements that include inappropriate data uses in the "fine print"). We urge CMS to finalize this requirement.

The API Technical Standard and Content and Vocabulary Standards

CMS proposes to require the use of the U.S. Core Data for Interoperability (USCDI) Version 1 content and vocabulary standards for data available through the API. However, in both this rule and the companion ONC rule, CMS and ONC do not standardize the clinical vocabulary within the USCDI, which could place a burden on physician organizations to define clinical terms in a common way that will support interoperability. Clinicians will need to ensure they accurately and consistently capture all of this additional information, for fear that they risk being classified as "information blocking."

Provider Information Directory

ACEP supports CMS' proposed requirement for health plans to make provider directories available on open APIs, and we encourage CMS to extend this requirement to QHP issuers as well in the final rule. We are extremely concerned about the high prevalence of inaccurate provider directories in Medicare Advantage organizations (MAOs) and other public and private plans. A 2017 survey from CMS showed that over 45 percent of provider directory locations listed in MAO online directories were inaccurate. Recently, CMS

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[4] Huckvale K, Torous J, Larsen ME, Assessment of the Data Sharing and Privacy Practices of Smartphone Apps for Depression and Smoking Cessation, JAMA Netw Open. 2019;2(4):e192542. doi:10.1001/jamanetworkopen.2019.2542.

concluded, after a three-year review of online MAO provider directories, that there has not been any improvement in the accuracy of these directories. Inaccurate provider directories can bring into question the adequacy and validity of a network.[5] When individuals enroll in a plan, they have every right to expect that network adequacy criteria and standards for clinical and institutional providers will be monitored and enforced. Maintaining adequate networks is essential to ensuring that patients have access to the care they need.

Since accurate provider directories are so important and consumers should have up-to-date information about their networks at their fingertips, we believe that QHP issuers should also be required to make this information available on open APIs, even though they are already required to provide this information in machine-readable format. We also urge CMS to require all payers to update their provider directories in real-time, correcting errors as soon as possible. Finally, CMS should implement strong penalties for payers that do not comply with these requirements.

Health Information Exchange Requirements

ACEP supports CMS' set of requirements related to the electronic exchange of data between plans and participation in a trusted exchange network. Patients who switch health care plans should have a way of accessing their data from their previous plan, and we agree that patients should own their data and that it should be transportable across payers and different health care settings. Payers already have information about the current and former enrollees, so we believe that it is appropriate to require them to transmit that information upon request to a different plan within a five-year timeframe. We also believe that requiring plans to participate in a trusted exchange network to improve interoperability and allow for the nationwide exchange of data is a worthwhile endeavor.

However, given that the data being exchanged between plans would come from clinicians, ACEP would like to reiterate our previous concern about payers being able to place additional contractual requirements on clinicians. CMS should clearly state that payers cannot condition provider participation in a plan based on whether a clinician will provide the plan with data in an unreasonable timeframe. Further, clinicians should not be penalized for using their best judgement when responding to a request from a payer for clinical information to the extent allowed by HIPAA. Finally, CMS should explicitly prohibit payers from using data in ways that potentially could harm patients, including denying or delaying coverage or increasing rates.

Request for Information on Information Sharing Between Payers and Providers through APIs

While the CMS rule includes proposals focused on health plans, consumers, and hospitals, it does not include any requirement that would increase clinicians' access to health care data. It also does not discuss in detail how clinicians can take advantage of open APIs and other proposed changes that would enhance the exchange of information. CMS only seeks comment for consideration in future rulemaking on how providers could access patient information, leveraging the APIs discussed in the rule. ACEP supports providing clinicians access to the information that CMS is proposing to require plans to put on open APIs. However, at the same time, we understand that processes need to be established to ensure that patients' information is properly protected. In general, we believe that confidential patient information may be disclosed when patients or their legal surrogates

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[5] Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter, January 30, 2019, 164. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part2.pdf.

agree to the disclosure, when mandated or permitted by law, or when there exist overriding and compelling grounds for disclosure, such as the prevention of substantial harm to other people.

As discussed previously, having data on a patient could truly help emergency physicians make what could be life or death decisions. Furthermore, upon ED discharge, enabling all clinicians who are part of the patient's care team to have access to the information from that encounter will improve the whole team's ability to coordinate care for that patient.

Requests for Information (RFIs)

Advancing Interoperability Across the Care Continuum

CMS is seeking comment on strategies for advancing interoperability across care settings, particularly in post-acute facilities. ACEP believes that improving the exchange of information between EDs and post-acute facilities, such as skilled nursing facilities (SNFs) is critical to improving overall population health and reducing unnecessary inpatient admissions and readmissions or ED visits. As referenced above, ACEP supports provider-led initiatives, such as EDIE™, that facilitate the collaboration between emergency physicians and other clinicians, including post-acute providers. However, we understand that post-acute facilities may not be able to share information as quickly or participate in information exchanges as seamlessly as hospitals or other providers. These facilities did not receive incentive payments under the Meaningful Use Program. Thus, they may need additional financial incentives or time to upgrade their EHR systems to be able to support the exchange of information.

Advancing Interoperability in Innovative Models

CMS is seeking comment on how models developed by CMMI can promote interoperability across the health care spectrum. In general, ACEP supports the concept of making interoperability a core feature of CMMI models. However, if CMMI makes it a requirement for all providers in models to provide patients access to their electronic health information or to third-party developers via APIs and to participate in trusted exchange networks, the Center must build in exceptions for cases where providers are unable to engage in these activities through no fault of their own, but because they have an issue with their EHR vendor. Many times, physicians do not have any control over their EHR's ability to help achieve the model's goals. Health IT companies frequently charge fees for each and every requirement imposed by federal reporting programs. EHR vendors need to be held accountable for producing tools to advance care outcomes without burdening physician practices or APMs with exorbitant fees. CMMI may also want to consider providing up-front payments to providers to help them invest in their IT systems and upgrade their EHR capabilities as needed. Finally, CMMI should phase-in interoperability requirements for small and rural providers so that they are not discouraged from participating in models and, once actively participating, are not penalized for not immediately having the necessary health IT capabilities to seamlessly exchange information.

ACEP would also like to note that in order for emergency physicians to take advantage of any of the benefits of enhanced interoperability requirements in these models, we must first find chances to participate in them. Although emergency physicians play a significant role in our healthcare system—making critical decisions every day about whether their patients should be kept for observation, admitted to the hospital, or discharged— we have no opportunity to be meaningful participants in value-based arrangements and alternative payment models (APMs). To address this gap in available models, ACEP developed an APM called the Acute Unscheduled Care

Model (AUCM) that is focused on Medicare providers and beneficiaries. On September 6, 2018, a federal advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended the AUCM to HHS Secretary for full implementation. The Secretary is currently reviewing the PTAC recommendation, and we are waiting for the Secretary's detailed response.

The AUCM focuses on improving care and reducing costs for Medicare beneficiaries. The model enhances the ability of emergency physicians to reduce inpatient admissions, and observation stays when appropriate through processes that support care coordination and consider patient preference. Emergency physicians become members of the continuum of care as the model focuses on ensuring follow-up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits.

The use of certified electronic health record technology (CEHRT) is essential for the AUCM's goal of improving care coordination for patients and is an integral part of the model's overall quality strategy. The AUCM also would benefit from stricter requirements around interoperability. 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 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 and is eager to work with HHS on implementation.

Policies to Improve Patient Matching

Although CMS is prohibited from adopting a unique patient identifier (UPI), the agency is seeking comment on how to improve patient identification to help enhance patient safety efforts, coordinate care, and advance interoperability. As emergency physicians, we recognize the critical importance of being able to quickly identify our patients and track them across different health care settings. When it comes to treating patients with acute medical needs, minutes and even seconds matter, therefore, the inability to know who our patients are, and what other services they may have previously received, really impacts our ability to provide the best possible care. To underscore the problem, in 2016, Harris Health System in Houston reported it had 2,488 records with the name "Maria Garcia;" of those, 231 shared the same birthdate, suggesting some of them refer to the same individual.[6] Notably, if all health care organizations collected certain pieces of demographic data uniformly, patient-match rates would increase significantly.

Therefore, in general ACEP supports efforts to create a patient identifier or tracking system. We are cognizant however about privacy and security concerns around creating a patient identifier. An identifier could become as sensitive as a person's social security number, so creating safeguards to protect it is essential. Further, if the patient identifier is based on a patient's date of birth, former address, or any other background piece of information about the patient, even that has its potential issues. Some patients, especially those who have

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[6] Giuseppe Lippi et al., "Patient and Sample Identification: Out of the Maze?" Journal of Medical Biochemistry 36 (2017): 1-6, http://dx.doi. org/10.1515/jomb-2017-0003; Harris Health System, "Harris County Hospital District Puts Patient Safety in the Palm of Your Hand" (April 5, 2011), https://www.harrishealth.org/en/news/pages/patient-safety-biometric-palm-scanner.aspx.

suffered a trauma, may not know or be able to easily recall this information, which could lead to confusion and potential medical errors.

In addition, we ask CMS to consider the concept of an "error reporting registry" to track patient mismatches and common mistakes that may or may not be HIPAA violations. This registry could help inform further process improvements and necessary updates to both the API and provider processes pertaining to patient record matching. A simple, straightforward way for providers and patients to report instances of information blocking under any variety of circumstances, including faxing, would be of great benefit, particularly to smaller providers.

Beyond patient identification, the number of administrative roadblocks that currently exist to get information about our patients is equally as concerning. We often see patients who have received care from another ED, hospital, or provider, sometimes the same day. When a patient comes to the ED, emergency physicians can rarely see any of the information from the previous healthcare encounter. When we reach out to the other ED, hospital, or provider to ask what happened to avoid duplication of workup and make sure nothing is being missed, we are referred to a medical records office instead of the treating provider and are told that we need to have the patient sign a consent form for release of information and that they cannot be given information over the phone. When health care providers have the opportunity to talk directly to each other, they almost always share all the relevant information that is necessary to treat individual patients. Breaking down the barriers that inhibit or delay these types of conversations from taking place could improve clinical workflow and our ability to provide effective patient care, while still preserving patient privacy and data security.

Finally, CMS requests feedback on whether the agency should support connecting EHRs to other complementary verifying data sources for identity proofing. The agency specifically asks what potential data source should be considered. ACEP strongly recommends that providers should have access to CMS claims data as this could dramatically improve patient matching.

<u>Incongruent Implementation Timelines</u>

Due to the complexity of the CMS and ONC proposed rules, there are a number of overlapping timelines that are not fully aligned and do not seem entirely feasible. For example, the CMS proposed rule has more aggressive timelines for API deployment than the ONC proposed rule (proposals to require some plans to support the functionality by January 2020 – other plans by July 2020). These compressed timeframes could result in problems in software being deployed that is not up to the right standards – and could have implications on patient care. Additionally, the information blocking provisions within both proposed rules will go into effect before the technology upgrades to facilitate information exchange are required and safely implemented. **In all, ACEP recommends that CMS and ONC align the timelines in the final rules while giving all stakeholders sufficient time for implementation. As stated earlier in our letter, we also urge CMS and ONC to publish interim final rules rather than final rules to allow additional opportunity for stakeholder comment.**

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,

Vidor E. Friedman, MD, FACEP
ACEP President