American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 26, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-1850

Re: CMS-1717-P

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals -Within-Hospitals

Dear Administrator Verma:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the major price transparency proposal included in the Calendar Year (CY) 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule.

On June 24, 2019, President Trump issued an Executive Order called the "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First" that highlighted specific actions his Administration should take to address this issue.[1] The proposed rule carries out Section 3(a) of the Executive Order. Specifically, while hospitals are already required to make their charges publicly available in a "machine-readable format," CMS proposes two new requirements for hospitals:

1. Post "payer-specific negotiated charges" for all items and services (including emergency services) provided by a hospital in a machine-readable format; and
2. Make available payer-specific negotiated charges for a limited set of "shoppable" services in a consumer-friendly format.

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[1] The Executive Order is available at: https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/.

While ACEP supports the Trump Administration's commitment to improving price transparency, we have concerns with the transparency proposals included in the proposed rule. Although we believe patients deserve meaningful information about the price of their healthcare, doing so in this manner could be unnecessarily burdensome, detract from the relevant patient cost-sharing information, and have unintended effects on the market as providers and payers are pressured to negotiate basic fee schedules. The requirement to disclose rates could lead to anticompetitive behavior by payers once they are aware of the rates that its competitors have negotiated. Numerous legal complications will likely arise from hospitals attempting to meet the requirements to disclose privately negotiated rates with private payers. CMS does not fully address these factors in the rule, including the fact that many current provider-payer contracts include non-disclosure agreements regarding the negotiated rates.

Before we discuss our specific feedback on the proposed requirements, we also wanted to highlight the unique factors of emergency medicine that CMS must consider when proposing and finalizing requirements around price transparency. Like you, we strongly believe that a patient's concern should be focused on receiving the appropriate care, rather than choosing their emergency care based on cost. In the emergency department (ED), minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgment quickly. Patients who have life-threatening illnesses and injuries obviously do not have the ability to shop around for the "lowest cost" provider.

Furthermore, in delivering acute care, knowing what patients' total out-of-pocket costs will be before they are even diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. 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. This is very different from being able to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat. Thus, the complicated and unpredictable nature of emergency care makes it extremely difficult to estimate ahead of time what costs are going to be for an individual patient encounter.

As emergency physicians, we are subject to the Emergency Medical Treatment and Labor Act (EMTALA), which guarantees that we provide patients with emergency medical care regardless of their insurance status or ability to pay. ACEP strongly supports the patient protections embedded within the EMTALA requirements. EMTALA stipulates that a hospital may not place any signs in the emergency department regarding the prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from "coming to the emergency department." To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA, and one of the most foundational principles of an important patient protection that was enacted three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that be an EMTALA violation, but it could also potentially cause the patient's health to deteriorate since it could delay the patient from receiving critical care. While the penalties for violating EMTALA are steep, our bigger concern is that if transparency for emergency care is not approached carefully, we could inadvertently be putting our patients in a position of making life-or-death health care decisions based on costs.

It is also important to note that people who think they are having an emergency have every right to go to the ED without worrying about whether the services they receive will be covered by their insurance. A provision in federal law called the "Prudent Layperson Standard" (PLP) states that payers must cover any medical condition, "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part."

First established under the Balanced Budget Act of 1997, the PLP originally applied to all of Medicare and to Medicaid managed care plans, and then was extended under the ACA to all insurance plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and qualified health plans in the state Exchanges. Furthermore, 47 states (all except Mississippi, New Hampshire, and Wyoming) have passed their own laws making the prudent layperson standard mandatory in their state.

Once again, we appreciate your focus on improving price transparency for the benefit of our patients. We are grateful for the opportunity to share our feedback on your proposals.

Definition of "Items and Services" Provided by Hospitals

In the rule, CMS defines "items and services" provided by a hospital as "all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or outpatient department visit for which the hospital has a standard charge."[2] Within this definition, CMS includes services delivered by physicians and non-physician practitioners who are employed by the hospital but not those services delivered by physicians and non-physician practitioners who are not employed by the hospital.

ACEP does not support this proposal. As described above, we have concerns about the ability of patients and providers to truly understand what costs are going to be ahead of time for emergency care. We also do not support any policies that could potentially deter patients from seeking emergency care. As emergency physicians, most of the services we perform are in hospital EDs. While many of our members are part of groups that independently contract with hospitals, some are directly employed by the hospital (such as those that work at academic medical centers). Regardless of the manner in which an individual emergency physician or group practice is employed, the physician or group practice still provides the same types of emergency services to patients. Further, given all of the various types of business structures and contracting relationships that currently exist, in some cases it would not be clear whether an individual or group practice would meet the definition of "employed by the hospital." For instance, at some large academic medical centers, the faculty are housed in a business entity that bills only for the professional services of those clinicians. In addition, some independent practices have assigned the billing rights to a hospital entity, but in no common sense of the term would be considered "employed." **Therefore, for the reasons listed above, we believe that CMS should treat all**

[2] Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals Proposed Rule. 84 Fed. Reg. 39576 (August 9, 2019).

physicians and non-physicians the same and exclude them all from the definition of "items and services" provided by hospitals.

If CMS does decide to include physician services in the definition of "items and services" provided by a hospital, we urge CMS to exclude emergency physician and emergency non-physician practitioner services. ACEP also would strongly object if CMS decided to broaden the definition in the final rule to include services delivered by all physicians and non-physician practitioners, even those who are not employed by the hospital.

Definitions for Types of "Standard Charges"

CMS proposes to define a "payer-specific negotiated charge" as "the charge that the hospital has negotiated with a third-party payer for an item or service."[3] ACEP has some concerns with this proposed definition. First, we would like to reiterate our comments expressed above that requiring hospitals to disclose payer-specific information could lead to anti-competitive behavior in the marketplace. Further, we note that it is unclear whether CMS has the actual authority to define negotiated charges as "standard charges." Section 2718(e) of the Public Health Service Act (PHSA) does not clearly provide CMS with the authority to establish these requirements. If CMS decides to finalize the proposal, the agency must do a much better job explaining both the legal and policy rationale for instituting the requirements.

In addition, while ACEP understands the concept of a payer-specific negotiated charge, we believe that the terminology CMS uses is extremely confusing. In the section describing this definition, CMS also refers to the term "negotiated rates." In our view and experience, the term "charge" applies to the amount a hospital or other provider bills for an individual service, which, in most cases, is the same amount regardless of payer. The term "negotiated rate" is the payment amount that an in-network hospital negotiates with a third-party payer for a particular service. ACEP suggests that CMS adjust their terminology in the final rule so that it aligns with accepted standard definitions of charges and rates.

"Consumer-Friendly" Display of "Shoppable Services"

CMS proposes to define a "shoppable service" as "a service package that can be scheduled by a health care consumer in advance."[4] Although CMS has identified CPT codes that are used by emergency physicians, we agree with CMS' decision to exclude services performed in the ED from the list of shoppable services.

While we have reservations about the proposed requirement for hospitals to display this information publicly, if CMS decides to finalize the proposal, we at least urge CMS to ensure, going forward, that the definition of "shoppable services" will always clearly exclude ED services and that CMS never introduces a definitional change that could in any way be misconstrued to include them. To reiterate our previous comments, we strongly believe that it is almost impossible to know ahead of time what the total cost will be for a particular emergency episode, and the last thing we want to do is provide patients with potentially incorrect information that would deter them from seeking vital emergency care.

Request for Information (RFI): Quality Measurement Relating to Price Transparency for Improving Beneficiary Access to Provider and Supplier Charge Information

[3] 84 Fed. Reg. 39579 (August 9, 2019).
[4] 84 Fed. Reg. 39585 (August 9, 2019).

To further CMS' future efforts to improve policies related to transparency in health care charges, the agency is seeking comment on a number of "quality of health care" issues around the following two topics:

- Improving availability and access to the existing quality of health care information for third parties and health care entities to use when developing price transparency tools and when communicating charges for health care services; and
- Improving incentives and assessing the ability of health care providers and suppliers to communicate and share charge information with patients.

ACEP supports the concept of providing quality-related information to consumers. However, we have general concerns with how CMS displays performance-related information to the public in their current programs, including the Quality Payment Program (QPP). Individual and group performance on the QPP is displayed on Physician Compare. However, a physician's rating on Physician Compare does not always directly correlate to their score in the Merit-based Incentive Payment System (MIPS) track of the QPP. Further, Physician Compare publicly reports all quality measures reported in MIPS, providing the incentive for clinicians to "cherry-pick" the six quality measures that they would perform the best on. We believe this policy leads to a less accurate depiction of a clinician or group's overall quality performance and disincentivizes clinicians to report on as many measures as possible in an attempt to improve overall quality and patient safety. Beyond Physician Compare, we also have concerns about the ability for patient experience and satisfaction measures to measure performance that is attributable to an individual clinician.

Overall, we believe the concerns about accurate quality measurement and public reporting must be addressed before CMS introduces any new requirements that would compel health care providers to share quality information with patients. Providing incorrect or incomplete quality information to patients, especially during emergency encounters, could potentially cause patients to avoid or delay receiving vital services simply because they were misinformed.

Finally, we want to re-emphasize that EMTALA forbids emergency physicians from attempting to get pricing information to patients prior to stabilizing them since doing so could lead patients to leave prior to receiving a medical screening examination. If CMS considers implementing a future policy to require health care providers to integrate quality data with pricing information, CMS must consider how such a proposal would interact with this important EMTALA protection.

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,

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ACEP President