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September 24, 2018

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

Re: CMS-1695-P

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model

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Dear Administrator Verma:

On behalf of over 39,000 members of the American College of Emergency Physicians (ACEP), we greatly appreciate the opportunity to provide our comments on policy proposals included in the Outpatient Prospective Payment System (OPPS) proposed rule and their effects on the practice of emergency medicine.

Off-campus Emergency Department Modifier

CMS is proposing to create a Healthcare Common Procedure Coding System (HCPCS) modifier that must be reported with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department (ED). The proposal to track these services stems from a report from the Medicare Payment Advisory Commission (MedPAC) that there has been a significant growth in the number of EDs located apart from hospitals—both independently owned and hospital-owned. With respect to the off-campus EDs owned by hospitals, there has been an increase in the number of ED visits paid under the OPPS. MedPAC has expressed some concerns about this growth and has recommended that CMS require hospitals to append a modifier to claims for all services furnished in off-campus provider-based EDs, so that CMS can track the growth of OPPS services provided in this setting. This proposal aligns specifically with that MedPAC recommendation.

ACEP believes that this proposal would provide a good opportunity for CMS to collect data on the types of services delivered in off-campus EDs and the severity of the patient population that is treated. However, we caution the agency to move slowly before

making any payment related changes for services delivered in these facilities. CMS must carefully analyze the data collected from the use of the modifier and openly publish any trends the agency is seeing. Acting prematurely could have a detrimental impact on patient access to care.

ACEP believes that "free-standing" EDs (EDs located apart from hospitals) can fill an important access-to-care gap in certain communities and help ensure that all patients with emergency conditions are treated timely and appropriately. Furthermore, we think that all of these facilities, regardless of whether they independently-owned or owned by hospitals, must meet certain standards. Specifically, any facility that presents itself as an ED must:

- be available to the public 24 hours a day, seven days a week, 365 days per year.
- be staffed by appropriately qualified emergency physicians.
- have adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.
- be staffed at all times by a registered nurse (RN) with a minimum requirement of current certification in advanced cardiac life support and pediatric advanced life support.
- have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed

ACEP believes that all free-standing EDs must follow the intent of the EMTALA statute and that all individuals arriving at a free-standing ED should be provided an appropriate medical screening examination (MSE) by qualified medical personnel including ancillary services, to determine whether or not the individual needs emergency care. A free-standing ED should provide stabilizing treatment within the capability of the facility and should have a mechanism in place to arrange an appropriate transfer to the definitive care facility, if appropriate, for the patient to receive necessary stabilizing treatment regardless of the patient's ability to pay or method of payment. Finally, any free-standing ED should have the same standards as hospital-based EDs for quality improvement, medical leadership, medical directors, credentialing, and appropriate policies for referrals to primary and specialty physicians for aftercare.

Pain Communication Questions on HCAHPS Survey

CMS is proposing to update the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey by removing the Communication About Pain questions effective with January 2022 discharges for the FY 2024 payment determination and subsequent years. In last year's rule, CMS had replaced the pain management questions in the survey with communication about pain questions in order to address concerns that some hospitals may receive low scores from patients who believed that the hospital had not provided them with enough pain medications, including opioids. However, despite the fact that the revised questions focus on communications with patients about their pain and treatment of that pain, rather than how well their pain was controlled, many stakeholders believe the revised questions still could potentially impose pressure on hospital staff to prescribe more opioids in order to achieve higher scores on the HCAHPS Survey. Therefore, out of an abundance of caution, CMS is proposing to remove the questions completely.

ACEP supports this proposal, just as we have previously supported the removal of the pain management questions. Although the current pain communication questions do not directly affect OPPS payments, many

of our members believe that any questions about pain (regardless of whether they associated with treatment) will likely cause patients who were unhappy about their pain treatment to provide more negative responses to other, unrelated questions in the HCAHPS survey.

As a result of member experiences with HCAHPS, ACEP has been closely involved in and tracking the development and testing of CMS' Emergency Department Patient Experience of Care survey (ED-PEC) since 2013. Current versions of the survey that are available on the CMS website include numerous questions related to pain management.[1] We understand that CMS has not yet decided whether to implement the ED-PEC survey or created a timetable for making such a decision. However, if CMS were to finalize the survey, we believe that, given the changes CMS is making to the HCAPHS survey, CMS must be prudent in its wording of pain-related questions in the final version of the ED-PEC survey, or remove the pain-related questions altogether.

Non-Opioid Treatments for Pain

CMS is proposing to provide separate payment for non-opioid pain management drugs that function as a supply when used in a surgical procedure when the procedure is performed in an ambulatory surgical center (ASC). According to CMS, Exparel® is currently the only drug that meets this criterion. The agency is also seeking comment to help determine whether the agency should pay separately for other non-opioid treatments for pain under the OPPS and the ASC payment system.

ACEP strongly supports paying separately for the use of non-opioid alternatives for pain management under the OPPS and ASC payment system. As emergency physicians, we are on the front lines of the opioid epidemic – in the past year alone, there was a 30 percent increase in opioid overdoses presenting in the ED for treatment.[2] In addition to addressing this crisis on the treatment side, emergency physicians are also taking steps to address this crisis on the prevention side by implementing innovative alternative treatments to opioids (ALTO) programs.

ALTO uses evidence-based protocols like nitrous oxide, nerve blocks, trigger point injections, and other non-opioid pain management tools to treat a patient's pain in the ED. Successful ALTO programs in New Jersey and Colorado have dramatically and quickly reduced opioid prescriptions in the ED. In New Jersey, the ALTO program at St. Joseph's Hospital saw opioid prescriptions drop by 82 percent over two years. These results were recently replicated at 10 hospitals in Colorado, where hospital systems noted a 36 percent drop in opioid prescriptions in just the first six months of the program.

In terms of payment, the additional cognitive work involved in implementing an ALTO program is not currently recognized or reimbursed in most settings, including the ED. The individual procedures may be reimbursed depending on the other services the patient receives, but many nerve blocks for example are bundled with the primary surgical procedure. Given the importance of using non-opioid treatments for pain as a means to help address the opioid crisis, we strongly recommend that CMS pay separately for both the facility and professional components of these critical treatments. We also urge CMS to consider introducing a payment model or grant

[1] Information on the EDPEC survey is found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ed.html
[2] The Centers for Disease Control, "Opioid Overdoses Treated in Emergency Departments. https://www.cdc.gov/vitalsigns/opioid-overdoses/index.html.

funded by the Center for Medicare & Medicaid Innovation (CMMI) to help spread best practices for using non-opioids to treat pain.

Request for Information on Interoperability

As indicated in previous comment letters, ACEP supports the Trump Administration's commitment to reducing information blocking and supporting the interoperability of EHRs. Emergency physicians play a very important role in our health care system, serving as the safety net in our communities. In many cases, we see patients with acute conditions who we have never seen before. With limited information, we deal with life and death situations and must make near-instantaneous critical decisions about how to treat our patients. Therefore, we are particularly anxious to work with hospitals toward the goal of interoperable EHRs that will open the door to more comprehensive patient information sharing across sites of care. Linking previously stand-alone EHRs will allow us to make more informed decisions and will greatly enhance timely communication with patients, community physicians, and other caregivers. To that end, we support Medicare policies that promote our ability to receive and exchange information about our patients. However, as CMS considers future policy options, including potential changes to conditions of participation for hospitals and other providers, we urge the agency to carefully assess the impact these policies may have on small and/or rural providers that may not be able to meet the interoperability standards that other larger and/or urban providers can more easily achieve.

Request for Information on Price Transparency

This rule includes a nearly identical request for information to ones that were found in both the FY 2019 Inpatient Prospective Payment Program Proposed Rule and the CY 2019 Physician Fee Schedule and Quality Payment Program Proposed Rule. ACEP responded to those requests for information. A full response to this request for information is also found below.

CMS is requesting comments on a number of issues related to price transparency. In the rule, CMS encourages "all providers and suppliers to undertake efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain, and to enable patients to compare charges for similar services. We encourage providers and suppliers to update this information at least annually, or more often as appropriate, to reflect current charges." ACEP appreciates CMS' willingness to better understand the costs of health care and improve price transparency and accountability for patients and would like to respond directly to the questions posed by CMS.

As CMS considers any potential changes to provider requirements, we urge you to keep in mind issues that are unique to emergency medicine. 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 judgement 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 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. Further complicating the issue is the fact that emergency care is billed in two separate components, the facility fee and the professional fee. Therefore, patients must sort through costs included in at least two different bills, each of which may have different cost-sharing obligations associated with it.

Emergency physicians have been significantly impacted by two laws that are not entirely aligned – the Emergency Medical Treatment and Labor Act (EMTALA) that guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay, and the Affordable Care Act (ACA), which includes emergency services as an essential benefit. Taken together, both laws have had the effect of increasing overall volume, while discouraging incentives for health plans to enter into fair and reasonable contracts to provide services at reasonable in-network rates. The majority of emergency physicians would prefer to practice in-network and ensure that patients are not subject to gaps in their insurance coverage that could lead to unexpected bills and high out-of-network rates. However, the current environment leaves both emergency physicians and their patients subject to the practices of insurance companies, which we believe in some instances have been inappropriate and interfered with patient access to care. These companies must be held accountable to negotiate and establish reasonable in-network agreements with hospitals and hospital-based providers.

The requirements of EMTALA are mandatory and are unaffected by in-network or out-of-network insurance status or payment considerations. In fact, EMTALA stipulates that a hospital may not place any signs in the emergency department regarding 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. The last thing we want to do is put 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 some kind of 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 responses to your questions. To better inform your request for input, our responses that follow for the most part address only emergency medical care, rather than the entire health care system.

How should we define "standard charges" in various provider and supplier settings? Is there one definition for those settings that maintain chargemasters, and potentially a different definition for those settings that do not maintain chargemasters? Should "standard charges" be defined to mean: average or median rates for the items on a chargemaster or other price list or charge list; average or median rates for groups of items and/or services commonly billed together, as determined by the provider or supplier based on its billing patterns; or the average discount off the chargemaster, price list or charge list amount across all payers, either for each separately enumerated item or for groups of services commonly billed together? Should "standard charges" be defined and reported for both some measure of the average contracted rate and the chargemaster, price list or charge list? Or is the best measure of a provider's or supplier's standard charges its chargemaster, price list or charge list?

ACEP believes the best measure of standard charges is the usual and customary physician charge ("U&C charge") procured from a not-for-profit, independently owned and operated entity. This entity should maintain an open and transparent database that collects physician charge data from actual claims information and makes that data commercially available to the public for consumption. The information itself must be statistically striated, geographically adjusted, and specialty specific. The "gold standard" for databases is the FAIRHealth database[3], which was found to be the best national U&C charges database to determine out of network (OON) reimbursements in two separate studies by the non-partisan and objective research organization (NORC) at the University of Chicago. [4]

The mission of FAIRHealth is to provide transparency to the health care and health insurance marketplaces. It was established in 2009 as the result of health plan litigation settlements facilitated by then Attorney General of New York, Andrew Cuomo, in response to an investigation he had conducted against Ingenix and its parent company UnitedHealth Group. In 2008, Attorney General Cuomo found that rates of health care charges maintained by Ingenix were lower than the actual costs of certain medical services and that the Ingenix charge data had been manipulated by certain health plans, resulting in greater than necessary out-of-pocket costs to patients and consumers. After the Attorney General sued, the major health plans settled the litigation over their use for many years of the Ingenix database for over $1 billion including 35 BCBS plans, Aetna, CIGNA, Humana, UnitedHealth (UNH) & Anthem. Ingenix and Attorney General Cuomo reached a settlement agreement that UNH and Ingenix would help fund a non-profit entity that would develop a new healthcare pricing database. Out of this agreement came the creation of FAIRHealth.

The FAIRHealth database includes data on claims from 150 million covered lives and billions of medical procedures, and these figures are growing. The database contains claims from private insurance in all 50 states, and, through the Qualified Entity Program, has access to all Medicare Parts A, B, and D claims data. Twice a year, the database is updated with claims for the most recent 12 months available. FAIRHealth provides

[3] More information on the FairHealth database is available at https://www.fairhealthconsumer.org/.
[4] NORC at the University of Chicago, Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement, April 18, 2018.

analytical resources and tools that serve the full spectrum of healthcare stakeholders: payers, hospitals and healthcare facilities, physicians, the Government, and consumers. Importantly for patient educational purposes, FAIRHealth has an extensive glossary of terms and definitions that would benefit patients in today's high deductible health plan (HDHP) environment.

FAIRHealth has been designated by the state as the benchmark tool for determining out-of-network reimbursement in Alaska (since 2004 by DOI regulation), New York (by DFS regulation) and Connecticut (by statute for emergency medicine). In New York, the State Department of Financial Services, which provides oversight to insurance companies, issued guidance implementing Part H of Chapter 60 of the Laws of 2014 that identifies FAIRHealth as an authorized, "independent source" for health plans to determine the "usual and customary cost" for out-of-network services. If health plans in New York choose to use a source other than FAIRHealth for determining the usual and customary cost, they must seek approval from the State Department of Financial Services.

With regard to consumers and their ability to access this information in an easy and transparent manner, FAIRHealth maintains a website and mobile app that use data from its vast database to help consumers understand the costs of medical and dental services and procedures in their specific geographic area. For example, if a person wanted to know the cost of getting a gall bladder removed, he or she could find an estimate of the in-network and out-of-network cost in that person's zip code.

Beyond the FAIRHealth database, there is little to no price data available to consumers that is provided in a clear, consistent, informative, and easily-accessible manner with data for geozips for the entire United States. While there are some attempts to rectify this product offering, including state-sponsored all payer claims databases (APCDs) or insurers' own proprietary offerings to members such as price estimation tools, it is widely accepted that none of the currently available tools fully explain the costs of care and none of the state-based APCDs contain national data by geographical zip codes. Further, not all of these state-based tools are available to all consumers. The availability, requirements, and capabilities of APCDs, for example, vary widely from state to state. Determining prices, out-of-pocket costs, and quality represents a significant burden on the consumer. Currently, the FAIRHealth database represents the most consumer-friendly tool to ascertain regional costs for procedures, both in-network and out-of-network.

What types of information would be most beneficial to patients, how can providers and suppliers best enable patients to use charge and cost information in their decision-making, and how can CMS and providers and suppliers help third parties create patient-friendly interfaces with these data?

Insurers, including CMS, should be responsible for clearly providing information to consumers about the potential costs of seeking care under their particular coverage. Providers can participate by helping patients interpret their cost-sharing responsibilities (of note not during the emergency but rather at a non-emergent time such as upon purchase of a policy) but the onus should be on insurers to make these costs transparent to patients. We believe that patients today truly do not understand their "high deductible" health plans and there is a dearth of information on "co-insurance," "deductibles," and "co-pays."

While providers and hospitals may be able to provide raw pricing information upfront to patients, without accompanying information from insurers concerning the manner and methodology the insurer has utilized to

adjudicate the patient's benefits, little can actually be achieved in the form of true transparency. In fact, this information from insurers is an essential component to transparency. Further, knowing that an insurer paid a member benefit 'at the usual and customary benefit level consistent with the member/patient's plan benefits' is not acceptable. Rather, the insurer must define in specific terms and in plain English the manner and methodology utilized by the insurer to adjudicate the patient's plan benefits, notwithstanding an assertion by the insurer that the information is proprietary or confidential—which, more often than not, is an all too frequent insurer response. This often provides the patient with a cryptic response and a limited understanding on what they're ultimately responsible for. Therefore, placing this responsibility exclusively on the shoulders of the hospital, physician, or patient is unfair and of little use in satisfying the objective of CMS' present request for true transparency. In order to truly enhance transparency, we believe that CMS should promote and educate Medicare beneficiaries about the non-biased independent pricing data provided by FAIR Health through www.fairhealthconsumer.org. It is free and easy for Medicare beneficiaries to access and understand. It also does not require any new systems to be set up or extra dollars spent to maintain

With respect to acute unscheduled emergency care, patients have the right to know from their insurers in advance if the physician treating them is in-network and, as required by the ACA, should pay the same cost-sharing if they receive care from an out-of-network clinician that they would have paid to an in-network physician. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties.

Should providers and suppliers be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service? How can information on out-of-pocket costs be provided to better support patients' choice and decision-making? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? How can CMS help beneficiaries to better understand how co-pays and co-insurance are applied to each service covered by Medicare? What can be done to better inform patients of their financial obligations? Should providers and suppliers of healthcare services play any role in helping to inform patients of what their out-of-pocket obligations will be?

As stated above, EMTALA does not allow providers to discuss costs with patients in the ED before they are stabilized. ACEP believes that it is the responsibility of insurers to clearly provide information to consumers prior to the emergency about the potential costs of seeking emergency care under their particular coverage. Providers in the ED can participate by helping patients interpret their cost-sharing responsibilities after a medical screening exam has been performed, but the onus should be on insurers to make these costs transparent to patients. Ultimately, while providers and hospitals could provide raw charges upfront to patients, without information from insurers far prior to an emergency condition, it is of little use and could scare patients into not seeking emergency care when they need it most.

Patients should also be able to know in advance of an emergency if an emergency physician is in-network, and should not be financially penalized if they need to receive care from an out-of-network emergency provider. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. Patients should also be provided with reasonable and timely access to in-network physicians for non-emergent care.

With respect to network adequacy, the ACA initially had very general, non-specific standards which – as recent years' surprise billing problems demonstrate – did not improve network adequacy among ACA plans. Rather than address this, though, in June of 2017, CMS relinquished virtually all responsibility for establishing and enforcing network adequacy standards for Federally-Facilitated Exchange plans and instead deferred this activity to private organizations and the States. [5]

Our experience with network quality and network adequacy standard development and enforcement in purely state-regulated insurance markets leaves us profoundly concerned about this framework. We hope CMS is at least looking closely at network conditions under it – in terms of the quality of plans being approved; the specific time/distance and patient-to-provider ratio standards in place, particularly for specialty physicians; and the enforcement of any applied network standards – and we would be delighted to see or hear what the Agency has learned.

Another barrier that affects our patients' access to high-quality, affordable care is that insurance companies do not release or make public their contracted, in-network rates for individual procedures or services, or even their out-of-network coverage rates. As such, under the current system what is actually charged is virtually never what is paid, leaving the consumer unable to compare costs and further distorting the true costs of care.

ACEP is particularly concerned about the lack of transparency around out-of-network rates for services, and has pushed for years for this to be improved. The current methodology that CMS uses to determine reasonable payments for out-of-network emergency services is called the "greatest of three" (GOT) methodology. This methodology was originally established by Obama Administration in an interim final rule (IFR) in 2010 and was most recently reaffirmed by the Trump Administration in a clarification to a final rule released on April 30, 2018. Under the methodology, when determining payment for out-of-network emergency services, an insurer must pay the greatest of the following:

1) the insurer's in-network amount;
2) the amount calculated by the same method the plan generally uses for out-of-network services, such as the usual, customary, and reasonable ("UCR") amount; or,
3) the Medicare amount.

Ever since the IFR was promulgated in 2010, we have repeatedly voiced concern with the second of the GOT standards. We believe that the UCR amount is subject to insurer manipulation unless it is verifiable, and the term "usual, customary, and reasonable amount" is not an objective standard for calculating out-of-network payments because it is not defined. Accordingly, we have recommended that the data supporting the calculation be subject to independent verification. This issue is crucial because Medicare rates are some of the lowest in the industry, and in-network amounts are also depressed because in-network providers accept lower reimbursement in exchange for the volume and other benefits that accompany in-network status. Thus, the second of the GOT standards, if calculated fairly and accurately, will nearly always be the greatest of the three and will determine the out-of-network payment.

The current GOT regulation represents the greatest threat to the financial viability of the emergency medicine profession and to patient access to qualified emergency physicians and ED on-call specialists than any other

[5] See at the changes made to 45 CFR §156.230 at https://www.regulations.gov/document?D=CMS-2017-0021-4021.

federal regulation to date. In fact, emergency physicians have seen payments for out-of-network services drop significantly since the GOT regulation was issued in 2010. By giving insurers an incentive not to contract for emergency services, the GOT method may impact the ability of EDs to provide care to patients due to inadequate reimbursements that do not cover the cost of stabilizing and treating patients who present at the ED.

Can we require providers and suppliers to provide patients with information on what Medicare pays for a particular service performed by that provider or supplier? If so, what changes would need to be made by providers and suppliers? What burden would be added as a result of such a requirement?

ACEP believes that insurers, including CMS, should make coverage terms and conditions available to their consumers. Emergency physicians do not know what the final cost of services provided to our patients will be, and it may be overly burdensome to expect them to figure this out given the myriad of different insurance policies and cost-sharing arrangements their patients could all have. For example, with respect to Medicare, quite often emergency physicians are faced with the tough decision of either sending a patient home or keeping the patient in the hospital for observation. Beyond the Medicare Outpatient Observation Notice (MOON) that hospitals are required to provide to beneficiaries, emergency physicians could potentially discuss the cost of keeping the patient in the hospital for observation as well. However, emergency physicians may not have all of the appropriate or accurate information easily accessible, including whether the patient is enrolled in Medicare Part B or has any supplemental insurance. The worst thing emergency physicians or any other physicians can do is give their patients incorrect information.

We also note that the Medicare physician fee schedule should not be used as a marker to assess appropriate payment for physicians. As noted earlier in our comment letter, the 2018 Medicare Trustees Report, acknowledges that annual updates for physician reimbursement do not keep pace with the increasing cost of providing physician services and that access to Medicare-participating physicians will become a significant issue in the long term.

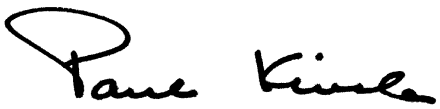
How does Medigap coverage affect patients' understanding of their out-of-pocket costs before they receive care? What challenges do providers and suppliers face in providing information about out-of-pocket costs to patients with Medigap? What changes can Medicare make to support providers and suppliers that share out-of-pocket cost information with patients that reflects the patient's Medigap coverage? Who is best situated to provide patients with clear Medigap coverage information on their out-of-pocket costs prior to receipt of care? What role can Medigap plans play in providing information to patients on their expected out-of-pocket costs for a service? What state-specific requirements or programs help educate Medigap patients about their out-of-pocket costs prior to receipt of care?

Like all health plans, Medigap plans should be required to provide the information described above to patients. How coordination of benefits may be achieved and issues of primary versus secondary or tertiary supplemental insurance policies are best described and explained by the health plans as they are the best source to turn to for adjudicating claims and providing sufficient transparent member benefit information pursuant to policies and procedures that they themselves have created, implemented and sold to consumers in the marketplace. Clinicians are often unknowing that a patient's secondary or tertiary supplemental policy is a Medigap policy nor its terms and conditions, and often do not know or have access to this information until after claims have

been adjudicated by the supplemental insurer and the patient is well into the revenue cycle process. Requiring clinicians and hospitals to explain detailed terms and conditions of Medigap policies before or during patient care would be an unreasonable regulatory burden.

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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